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BEFORE THE DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION

STATE OF MISSOURI

DIVISION OF INSURANCE)
COMPANY REGULATION,)

Petitioner,)

vs.) Case No. 160325191C

AETNA INC.)

and HUMANA INC.,)

Respondents.)

HEARING

VOLUME II

(Respondent's Case in Chief)

May 16, 2016

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1 HEARING OFFICER ERICKSON: We are
2 back on the record. Mr. Whitmer, you may present
3 evidence on behalf of Aetna.

4 MR. WHITMER: At this time we'd
5 request leave to submit our deferred opening
6 statement.

7 HEARING OFFICER ERICKSON: You may
8 proceed.

9 MR. WHITMER: Thank you, your Honor.
10 There's really one issue before you today, and that
11 one issue concerns the three lines of insurance
12 we've been talking about since the beginning of the
13 morning: Comprehensive group, comprehensive
14 individual and Title XVIII Medicare.

15 So here's the issue: With respect to
16 those three lines, is there substantial evidence
17 that the effect of the proposed transaction may be
18 substantially to lessen competition in the state or
19 intend to create a monopoly therein?

20 The evidence will firmly establish
21 that the answer to this question is no. Now, you
22 heard this morning about a prima facie case, and if
23 certain thresholds are exceeded, a prima facie
24 violation is presumed under Missouri law. But
25 pursuant to Section 382.095.4, sub 4, further

1 explanation is required.

2 What that part states is that even
3 though an acquisition is prima facie violative of
4 the competitive standard under subsection 2 of this
5 section, a party may establish the absence of the
6 requisite anti-competitive effect based on other
7 substantial evidence. And then the statute goes on
8 to identify what some of the relevant factors might
9 be.

10 It states, relevant factors in making
11 a determination under this subdivision include, but
12 are not limited to the following: Market shares,
13 volatility of ranking of market leaders, number of
14 competitors, concentration, trend of concentration
15 in the industry, and ease of entry and exit into
16 the market.

17 So what we're here today to talk
18 about in our case is that very evidence that will
19 establish that there are no competitive concerns
20 presented by this transaction.

21 Now, we started with more than a
22 dozen lines of insurance in the Form E, and you
23 heard about that. We're down to these three. This
24 is what the parties have agreed to talk about here
25 today, these three lines.

1 Now, you're going to be presented
2 with three witnesses. The first witness is Gregory
3 Martino, and he's the assistant vice president for
4 state government relations. Mr. Martino will
5 provide some background and set the stage about
6 this transaction and how it led to this proceeding.
7 He will also discuss the rationale for this
8 transaction, a description of this transaction, and
9 will talk about the Form E filing process that led
10 us to today. You will also hear Mr. Martino
11 testify about the synergies of this transaction and
12 the expected benefits to the consumers of this
13 state.

14 Second, your Honor, you will hear the
15 testimony from economist John Orszag, and you just
16 heard about him during the examination of
17 Dr. Gruber. John Orszag is a senior managing
18 director of Compass Lexecon, which is an economic
19 consulting firm, and he's also served in several
20 senior government roles. You're going to hear
21 about that shortly.

22 Importantly, Mr. Orszag is one of the
23 leading economists in the country on the question
24 of whether mergers benefit or hurt consumers. You
25 don't need to take my word for that. You just

1 heard Dr. Gruber talk about the fact that
2 Mr. Orszag is the merger guy, and he is.

3 And Mr. Orszag will explain that with
4 respect to this transaction, he has reviewed the
5 report of Professor Gruber, and he's prepared to
6 explain why that analysis is flawed. He will
7 explain that the data on which Professor Gruber
8 relied is outdated, it's not specific to Missouri,
9 and has nothing to do with this transaction.

10 But he will go further. Mr. Orszag
11 will explain that he actually has conducted an
12 empirical -- an extensive empirical analysis about
13 the very issues that Dr. Gruber was concerned
14 about, and that Mr. Orszag's data and his evidence
15 concluded that there are no competitive concerns
16 with respect to this transaction.

17 Third, you will hear from Dr. Thomas
18 McCarthy. For more than 30 years Dr. McCarthy has
19 been one of the leading experts in the health care
20 industry. In fact, Mr. McCarthy has provided
21 testimony for eight other health care mergers in
22 this country. And in fact, he has previously
23 provided testimony for this very transaction,
24 including just a few months ago, for example, he
25 provided live testimony to the Florida Office of

1 Insurance Regulation with respect to this very
2 transaction.

3 Now, Dr. mcCarthy will testify that
4 for this transaction he did the analysis that's
5 supposed to be done to evaluate the statewide
6 competitive implications of a proposed merger. He
7 will explain why a merger of Aetna and Humana will
8 not result in a lessening of competition or tend to
9 create a monopoly in any of these three lines we're
10 talking about here today.

11 In sum, your Honor, through this
12 hearing through this afternoon, Aetna and Humana
13 will provide you with compelling evidence
14 establishing that, with respect to all three of
15 these lines of insurance, there are no substantial
16 concerns about competition issues.

17 We thank you for the opportunity to
18 present the evidence this afternoon, and at this
19 time I have nothing further, other than I request
20 to call my first witness.

21 HEARING OFFICER ERICKSON: You may
22 proceed.

23 MR. WHITMER: Aetna calls Gregory
24 Martino.

25 GREGORY MARTINO, being sworn, testified as follows:

1 DIRECT EXAMINATION BY MR. WHITMER:

2 Q. Mr. Martino, what is your current
3 title and position?

4 A. I am currently employed by Aetna, and
5 I am assistant vice president for Aetna Inc. in
6 state government affairs.

7 Q. What are your responsibilities in
8 that position?

9 A. My responsibilities, I have a number
10 of different responsibilities primarily focusing on
11 regulatory aspects, dealing with state insurance
12 regulators, dealing with the NAIC, legislative
13 issues in selective states, and also involved in
14 corporate transactions, corporate licensing, and
15 recently involved in the Coventry transaction
16 several years ago.

17 Q. I'm going to make a request,
18 Mr. Martino. Could you pull the microphone just
19 away from you a bit?

20 A. (Witness complied.)

21 Q. Thank you. Now, before you came to
22 Aetna, you worked for the Pennsylvania Insurance
23 Department. Can you tell us about that?

24 A. Yes. I worked for the Pennsylvania
25 Insurance Department for a number of years, for

1 approximately 10 to 12 years I was with the
2 Pennsylvania Insurance Department serving in a
3 number of different capacities.

4 **Q. What capacities did you serve in?**

5 A. Yeah. I served as the director for
6 market conduct activities, overseeing the market
7 conduct operations in the Commonwealth of
8 Pennsylvania. Served as the deputy insurance
9 commissioner for consumer services and market
10 conduct. Also served as the deputy insurance
11 commissioner for rates and company regulation, and
12 then also served as acting insurance commissioner.

13 **Q. For approximately how long did you**
14 **serve as the acting insurance commissioner for the**
15 **state of Pennsylvania?**

16 A. Yeah. I served for approximately six
17 months as the acting insurance commissioner for the
18 commonwealth of Pennsylvania.

19 **Q. Thank you for the clarification.**

20 **Let's move over to Aetna.**

21 A. Certainly.

22 **Q. Could you give us some background**
23 **information about Aetna Inc.?**

24 A. Aetna Inc. is a company which was
25 founded in 1853 with an ultimate goal today of

1 providing very diverse health care products and
2 benefits to today approximately 46 million members.

3 **Q. And just briefly, can you give us a**
4 **brief overview of Humana?**

5 A. Humana is a publicly traded company
6 in Delaware, corporately headquartered in Delaware
7 with a background and innovative -- for innovative
8 and leading edge both products and quality of
9 service for the Medicare marketplace, the Medicaid
10 beneficiaries, serving, I believe, approximately
11 4 million members.

12 **Q. Maybe closer to 14 million?**

13 A. I'm sorry. Yeah, 14.

14 **Q. Sir, let's talk about this**
15 **transaction. First of all, what has your role and**
16 **involvement been this transaction?**

17 A. I've been involved in this
18 transaction since it was publicly announced on
19 July 2nd, 2015. I've been involved with preparing
20 the Form Es throughout the country. I've been very
21 involved in preparing the Form Es throughout the
22 country.

23 In addition to that, I have traveled
24 around the country meeting with a number of
25 different insurance commissioners to brief them and

1 give them an overview of this transaction to help
2 them to understand the benefits of this
3 transaction.

4 **Q. Let's start with just a big picture**
5 **question about the rationale for this transaction.**
6 **What can you tell us about that?**

7 A. Aetna has a mission of really
8 creating healthy days for individuals and really
9 improving the health of American citizens and the
10 people we serve. In that we strive every day to
11 bring technology, high-quality services, innovative
12 products to people to help them advance to those
13 healthy days.

14 As we looked around, as we -- in
15 further developing this, we also found a partner
16 with Humana, who had shared similar goals and
17 similar objectives. And as we looked into this
18 deeper, we really began to realize that the
19 combination of these two companies was really very
20 unique in that it really brought together
21 complementary nature, a company that really focused
22 significantly and had its foundation, Aetna, in
23 commercial insurance, and then you had Humana who
24 had its foundation in Medicare, Medicare Advantage.
25 Bringing those companies together would benefit

1 both consumers for both products.

2 Q. I'm going to ask you more of a
3 specific question about this transaction and how
4 it's formed and organized. Provide a brief
5 description of how the transaction is set up.

6 A. Sure. The transaction is set up for
7 a lot of integration of companies, the merging
8 together of some companies, but ultimately when all
9 is said and done, the Humana companies and Humana
10 will be a subsidiary of Aetna Inc.

11 Q. And the terms of this agreement -- or
12 the deal is set forth where?

13 A. The terms of that deal and the
14 acquisition are set forth in the sales agreement,
15 which was dated July 2nd of 2015.

16 Q. What can you tell us about who the
17 leadership of the merged company would be?

18 A. Post closing, the CEO from Aetna
19 today, Mark Bertolini, will continue on as the CEO
20 for the new combined organization.

21 Q. And what about the board of directors
22 post closing?

23 A. The board of directors will be
24 expanded and we will be adding four additional
25 Humana board of director members to the Aetna

1 board.

2 Q. What can you tell us, Mr. Martino,
3 about the transaction negotiations?

4 A. The transaction negotiations were
5 really done independently for both Aetna and Humana
6 and were done at arm's length by both the legal and
7 the financial review by both companies.

8 Q. And was this transaction approved by
9 the boards of directors?

10 A. Yes. The board of directors for
11 Humana, as well as the board of directors for Aetna
12 Humana universally approved this transaction.

13 Q. And what about the stockholders?

14 A. Stockholders for both companies,
15 Aetna and Humana, voted in October on this
16 transaction and overwhelmingly approved it. I
17 believe 99 percent of the shareholders that voted
18 voted in support of this transaction.

19 Q. I'd like to shift gears here and talk
20 a little bit about the Form E filing process that
21 we're here to talk about here today. Approximately
22 when was the Form E submitted?

23 A. The Form E was submitted to Missouri
24 on October 14th of 2015.

25 Q. Now, we've been talking here today

1 about the data that's in the Form E. You heard a
2 little bit about this this morning, but from your
3 perspective, where does the data come from?

4 A. The data comes from SNL, which is an
5 organization that aggregates data from the NAIC,
6 and they pull in from the NAIC annual statements as
7 they're submitted by the insurance companies.

8 Q. And that's the data that was used by
9 Aetna in the Form E that was submitted to the
10 Division in this case?

11 A. Yes, it was.

12 Q. Now, what can you tell us about the
13 Form A and Form E process around the country
14 generally?

15 A. Regarding this transaction, Aetna had
16 20 Form As for change of controls, regulatory
17 filings with a number of different jurisdictions
18 across the country. In addition to those, those
19 are much more comprehensive of these that are done
20 in the Form As, as I'm sure you are familiar. In
21 the Form E, the Form E-only states there was
22 17 Form E-only states which we were required to
23 submit just Form Es.

24 Q. With respect to 17 Form E-only
25 states, for how many of those has Aetna received

1 written confirmation of approval or
2 non-disapproval?

3 A. 16 of those 17.

4 Q. So the only Form E, only state that's
5 left is Missouri?

6 A. That's correct.

7 Q. I'd like to ask you some questions
8 about the impact of this transaction on consumers.
9 Starting with a question about, what types of
10 general benefits will this transaction provide to
11 consumers?

12 A. This transaction will benefit both
13 the Humana consumers, the Aetna consumers, as well
14 as potential consumers in general, in that it
15 really brings together the benefits of both -- of
16 both companies, the Aetna commercial policies and
17 the Humana commercial policies, and it will afford
18 them really the best of both services.

19 Humana is recognized as the best in
20 class for the Medicare lines. We will obviously be
21 able to share those opportunities with the Aetna
22 Medicare folks once post-transactions close, and
23 that will benefit everyone.

24 In addition to that, as a result of
25 this transaction, we really will be able to develop

1 high-quality products and offer individuals more
2 affordable plans.

3 **Q. Let's talk about synergies,**
4 **Mr. Martino. What types of synergies are expected**
5 **as a result of this transaction?**

6 A. There's projected to be approximately
7 \$1.25 billion in synergies by 2018.

8 **Q. And just generally, what types of**
9 **categories make up those synergies?**

10 A. There's three general categories that
11 we like to put them in, and the three categories
12 really are really redacting and eliminating some of
13 the duplicate corporate functions and
14 administration. For instance, you don't really
15 need two CEOs when you combine the companies, so
16 there will be streamlined efforts in that sense.

17 In addition, another major -- and a
18 major one really is the IT combination. IT
19 platform and maintenance are very expensive, and
20 combining these and being able to streamline these
21 over the next three years really will result in
22 synergies going forward.

23 Lastly, just the eliminating the
24 duplication from a publicly traded company, dealing
25 with the filings and the maintenance of records,

1 will also accrue savings also.

2 **Q. Will these synergies, Mr. Martino,**
3 **lead to lower costs for customers than they**
4 **otherwise would have had?**

5 A. Yes. Yes, they will. The
6 significant portion of these synergies will be
7 passed along to consumers to provide for them new
8 products, better opportunities, and lower premiums
9 than they would have otherwise seen.

10 **Q. And what other benefits will these**
11 **synergies lead to?**

12 A. Additionally, Aetna will be
13 investing. As we talked earlier today, the health
14 care markets dynamically change. We need to be
15 able to change with that. This will afford Aetna
16 an opportunity really to respond to those changes
17 and really to invest in new products, to invest in
18 high-quality relationships with providers and to
19 really invest in benefits to consumers ultimately.

20 **Q. And, sir, before you finish your**
21 **testimony, is there anything else you want to share**
22 **with the hearing officer generally or specifically**
23 **about this transaction?**

24 A. The only thing I would really
25 conclude with is really this is a very beneficial

1 transaction for the policyholders, existing
2 policyholders and future policyholders. It really
3 is an opportunity when you look at the portfolios,
4 when you look at the specializations of these two
5 companies, Aetna specializing in the commercial
6 marketplace, Humana specializing in the Medicare
7 marketplace.

8 Bringing them together will really
9 afford the opportunity to best of class services,
10 case management and utilization services will be
11 available to both. So you're really taking two
12 companies, identifying the best of the services,
13 bringing them together and making that available to
14 really benefit consumers in the future.

15 MR. WHITMER: Thank you, Mr. Martino.
16 I have no further questions at this time.

17 HEARING OFFICER ERICKSON: Division?
18 CROSS-EXAMINATION BY MR. HOPPER:

19 Q. Mr. Martino, on a nationwide basis,
20 do you consider Aetna and Humana companies to be
21 complementary?

22 A. Yes, I do.

23 Q. What is the focus of Aetna group
24 nationwide?

25 A. Nationwide Aetna focuses on the

1 commercial marketplace, which includes your
2 individual market, your small group market and your
3 large group market.

4 **Q. Nationwide, what is the focus of**
5 **Humana group?**

6 A. Nationwide, they focus on Medicare,
7 specifically Medicare Advantage.

8 **Q. Do you consider Aetna and Humana to**
9 **be complementary to Missouri health insurance**
10 **markets?**

11 A. While the numbers do not necessarily
12 reflect their national averages, in fact, they are
13 complementary as you, in fact, review just the
14 nature of them.

15 **Q. What would you say the focus of Aetna**
16 **group is in Missouri?**

17 A. The -- as a result of the acquisition
18 of Coventry, there's been a continued emphasis on
19 commercial and commercial marketplace and, in fact,
20 there continues to be a strong commercial presence
21 here.

22 **Q. Would you say that the Aetna group**
23 **focuses on Medicare products as well in Missouri?**

24 A. Our role is not necessarily in any
25 particular market to focus on one particular line.

1 We really look at the entire market and where our
2 opportunities lie and really don't focus on one
3 particular line.

4 **Q. Is the Aetna group a strong**
5 **competitor in the Medicare Advantage market in**
6 **Missouri?**

7 A. I hope so.

8 **Q. What is the focus of Humana group in**
9 **Missouri?**

10 A. Well, I can't respond to what
11 Humana's business strategy is.

12 **Q. What is your understanding based on**
13 **public information of the Humana group focus?**

14 A. I'm not familiar with what the focus
15 is.

16 **Q. Isn't it true that the Aetna group**
17 **covers more Missourians in individual Medicare**
18 **Advantage plans than any other group?**

19 A. I'm not familiar with the numbers. I
20 really haven't researched the numbers. They
21 haven't been presented to me.

22 **Q. You would disagree with that**
23 **assertion?**

24 A. Without seeing the numbers, I
25 couldn't tell you.

1 **Q. Isn't it true that Aetna covers more**
2 **Missourians in individual Medicare Advantage plans**
3 **than Humana does?**

4 **A. Once again, I haven't reviewed the**
5 **numbers and can't respond to that.**

6 **Q. Would you expect the numbers to**
7 **reflect that Humana covers more Missourians in**
8 **individual Medicare Advantage plans than Aetna,**
9 **based on the nationwide focus of groups?**

10 **A. As I say, specific market strategies**
11 **are something that are kept to the companies. I**
12 **really don't know what Humana's focus is and what**
13 **their strategy is in the state of Missouri.**

14 **Q. Are you aware of any states where the**
15 **Aetna group covers more individuals in individual**
16 **Medicare Advantage plans than any other company?**

17 **A. I have not looked into those numbers**
18 **of state-specific membership.**

19 **Q. Are you aware of those numbers on a**
20 **nationwide basis?**

21 **A. On a nationwide basis, I know**
22 **approximately the percentages.**

23 **Q. If this acquisition were to be**
24 **consummated, on the day of that consummation will**
25 **Missouri consumers be provided with any additional**

1 insurance products that would not be available to
2 them absent consummation of this merger?

3 A. The integration process for this
4 transaction is really just beginning, and we really
5 can't talk about what happens. We don't know
6 exactly what will be happening on the day the
7 transaction closes. There is a significant amount
8 of process, review and time that goes into the
9 integration.

10 It's important that you don't just
11 simply try to immediately impact consumers. Our
12 desire is to really make this as smooth as possible
13 and to gain the benefits through the integration
14 process of both companies. So at this point in
15 time there isn't any specific plans identified for
16 day one of post-closing.

17 Q. I appreciate antitrust concerns with
18 the merger and not being able to discuss future
19 plans. However, based on the standards of the
20 statute, the director will consider the potential
21 increased availability of insurance. So my
22 question to you is, can you reveal any definite
23 plans of Aetna to offer any new products
24 post-merger in Missouri that are not currently
25 offered by either Aetna or Humana?

1 A. Well, the only thing I would honestly
2 tell you is that the strategy at this point in time
3 is really not public information. I don't think we
4 have any information to share at this point in time
5 with future -- with future plans.

6 Q. So you cannot reveal any definite
7 plans?

8 A. That is correct.

9 Q. Setting aside all other
10 considerations for a moment, would the proposed
11 acquisition of Humana by Aetna, if consummated,
12 decrease the number of competitors in the Missouri
13 health insurance markets where both companies
14 operate?

15 A. I'm not familiar with the competitive
16 markets, the number of competitors in the
17 marketplace in Missouri.

18 Q. If both companies operate in a market
19 and the companies are merged, will that reduce the
20 number of competitors in that market absent any
21 other considerations?

22 MR. WHITMER: Objection. Objection
23 to improper hypothetical for a fact witness, and
24 also incomplete one.

25 HEARING OFFICER ERICKSON:

1 Mr. Hopper, would you like to rephrase the
2 question?

3 MR. HOPPER: Sure.

4 BY MR. HOPPER:

5 Q. Let me try again my first question.

6 I'm not sure we were on the same page. I'll try to
7 shorten it for you. Setting aside all other
8 considerations, would the merger, if consummated,
9 between Humana and Aetna reduce the number of
10 competitors in Missouri health insurance markets
11 where both companies currently participate?

12 MR. WHITMER: Same objection,
13 incomplete hypothetical, setting aside issues that
14 need to be considered. It's a better question for
15 the experts, and it's an incomplete hypothetical.

16 HEARING OFFICER ERICKSON:

17 Mr. Martino, were you here earlier through the
18 presentation of evidence from -- starting with the
19 hearing at eight o'clock this morning, nine
20 o'clock?

21 THE WITNESS: Yes, I was.

22 THE COURT: Were you able to hear the
23 testimony of Director Nelson and Director Rehagen
24 with their particular divisions?

25 THE WITNESS: I was in and out of

1 room, so I can't fully respond but I was here the
2 entire thing.

3 HEARING OFFICER ERICKSON: Do you
4 feel qualified to respond to the question that
5 Mr. Hopper is asking you?

6 THE WITNESS: I think that question
7 would be better suited for the experts dealing with
8 the antitrust.

9 MR. HOPPER: Let me try this even
10 simpler.

11 BY MR. HOPPER:

12 Q. In markets where Humana and Aetna
13 currently participate in Missouri, are they two
14 distinct competitors?

15 A. Yes, they are today.

16 Q. Following consummation of this
17 proposed acquisition, will they be two distinct
18 competitors?

19 A. No, they will not.

20 Q. Can Aetna make any commitment today
21 to lowering health insurance premiums in Missouri
22 following consummation of its acquisition of
23 Humana?

24 A. As I discussed earlier, we do
25 anticipate synergies. We do estimate 1.25 billion

1 in synergies, and this money, this savings will be
2 used to, in fact, reduce premiums and provide
3 higher quality -- lower premiums than what they
4 otherwise would have seen.

5 Q. So you said lower premiums than they
6 otherwise would have seen?

7 A. That's correct.

8 Q. That's not quite the same thing as
9 lowering health insurance premiums; is that
10 correct?

11 A. That is correct.

12 Q. Can Aetna commit today to keep health
13 insurance premiums constant in Missouri for any
14 definite length of time following consummation of
15 its acquisition of Humana?

16 A. I've indicated --

17 MR. WHITMER: I'm going to object to
18 the extent that he's asking for something that
19 should not be discussed in an open hearing about
20 what rates will be post-closing. It's not a proper
21 question, and it's also irrelevant.

22 HEARING OFFICER ERICKSON:

23 Mr. Hopper?

24 MR. HOPPER: I disagree with the
25 objection. I'm certainly not asking Mr. Martino to

1 reveal any confidential information.

2 MR. WHITMER: Same objection. The
3 question is, what will rates be post-closing? And
4 there is information perhaps about --

5 HEARING OFFICER ERICKSON: I don't
6 believe that was the question. Counsel, approach.
7 Off the record.

8 (AN OFF-THE-RECORD DISCUSSION WAS
9 HELD.)

10 HEARING OFFICER ERICKSON:
11 Mr. Hopper, you may proceed.

12 BY MR. HOPPER:

13 Q. Mr. Martino, are you aware of any
14 significant entry into the Missouri comprehensive
15 individual health insurance market in the last five
16 years?

17 A. I'm not familiar with the entrance or
18 the market in Missouri, the entrance in Missouri
19 market.

20 Q. Are you familiar -- excuse me. Are
21 you aware of any significant entry into the
22 Missouri small employer group health insurance
23 market in the last five years?

24 A. Once again, I haven't studied the
25 Missouri-specific market and am not familiar with

1 that.

2 Q. Is it fair to say, then, since you
3 are not familiar with the market share of Aetna in
4 Missouri markets, specifically Medicare Advantage
5 individual, I believe you said, and since you are
6 not familiar with any potential entry into Missouri
7 markets in the last five years, your testimony is
8 more nationwide in scope and does not apply
9 specifically to Missouri?

10 MR. WHITMER: Objection to form.

11 MR. HOPPER: That was a very long
12 question.

13 MR. WHITMER: It was a compound
14 question. It was inappropriate.

15 BY MR. HOPPER:

16 Q. Are you giving any testimony here
17 today specific to Missouri health insurance
18 markets?

19 A. Specific to the numbers of Missouri,
20 my testimony is overall in the transaction and the
21 impact of the transaction, which does, in fact,
22 discuss an impact to consumers in Missouri.

23 HEARING OFFICER ERICKSON:

24 Mr. Martino, I'm going to ask a follow-up to that.
25 Specifically as to Missouri, you are not offering

1 testimony regarding Missouri's insurance market; is
2 that correct?

3 THE WITNESS: I am offering testimony
4 regarding the consumers and the -- Missouri
5 consumers and the benefits they will receive and
6 the impact of this transaction on them, not
7 necessarily regarding the specific market dynamics
8 and market numbers in Missouri.

9 HEARING OFFICER ERICKSON: Thank you,
10 sir.

11 BY MR. HOPPER:

12 Q. Those benefits that you're testifying
13 to today, are those nationwide benefits?

14 A. Yes, they are.

15 Q. Is there anything about the benefits
16 to which you have testified today that apply
17 specifically to Missouri and not to other states?

18 A. No.

19 Q. How much in synergies does Aetna
20 project due to decreased competition in the health
21 insurance markets?

22 A. I don't think the numbers have been
23 defined as well as that. I think we've estimated
24 approximately 1.25 billion. I outlined for you the
25 three major areas we're identifying those synergies

1 in, and while there may be other areas, we haven't
2 identified all the specific line items. It's
3 rather premature to identify that.

4 **Q. Is it fair to say that Aetna will**
5 **reap some synergies due to the decreased**
6 **competition in the health insurance markets?**

7 A. Without recognizing and studying that
8 issue, I don't think that we're prepared to say
9 whether or not there will be an impact there.

10 **Q. How much in synergies does Aetna**
11 **project due to its increased market power,**
12 **customers?**

13 A. I don't think we've concluded that at
14 all. I think the areas that I've outlined really
15 are the main areas which we've identified synergies
16 in.

17 **Q. Those are the main areas. What minor**
18 **areas have you identified?**

19 A. Well, quite honestly, there will be a
20 lot of areas. We're beginning the integration
21 process. You need to recognize that we have two
22 separate companies operating, and there are many
23 antitrust issues that don't allow you to share the
24 information. So we're really beginning the
25 integration process now and we really identify

1 where we believe the major synergies to be.

2 **Q. Do you believe this acquisition will**
3 **increase Aetna's market power in Missouri health**
4 **insurance markets?**

5 A. I don't necessarily know how you're
6 defining market power, so it's a very difficult
7 question to respond to.

8 **Q. Do you believe this transaction will**
9 **decrease competition in any health insurance**
10 **markets?**

11 A. I think, as I mentioned earlier, we
12 really view this as a complementary nature. As a
13 result of that, I think that it will not
14 necessarily -- it will benefit consumers
15 significantly, and I think the economists will
16 really be able to address whether or not
17 anti-competitive issues exist in states.

18 **Q. You said complementary again. Do you**
19 **believe this acquisition is complementary in**
20 **Missouri?**

21 A. I believe it is, yes.

22 **Q. What are you basing that belief on?**

23 A. Basing it on the belief that there
24 are programs that Humana has that are best in class
25 services which are not available to the Aetna

1 members today, and there are programs and services
2 Aetna provides to its members which are not
3 available to Humana today, and post-closing, those
4 best of class services will be available to all
5 members for both sides and both companies.

6 **Q. Are you basing that belief in any way**
7 **upon market share numbers in Missouri health**
8 **insurance markets?**

9 A. No. I'm believing it based upon the
10 simple fact that across the country we have
11 complementary natures. We both have best of class
12 services in what we specialize in, what we do, and
13 those will be afforded for both companies
14 post-transaction.

15 **Q. So just to clarify, that belief is**
16 **not based on Missouri market share numbers?**

17 A. That is correct.

18 MR. HOPPER: Nothing further for the
19 witness.

20 HEARING OFFICER ERICKSON:

21 Mr. Whitmer, redirect?

22 MR. WHITMER: I have none. Thank
23 you.

24 HEARING OFFICER ERICKSON: My
25 microphone keeps going in and out, so I guess I

1 will project.

2 QUESTIONS BY HEARING OFFICER ERICKSON:

3 Q. When Mr. Whitmer was questioning you,
4 you mentioned there were 40 -- pardon me --
5 20 Form As filed nationally; is that correct?

6 A. That is correct. 20 Form As or
7 change of controls.

8 Q. Thank you. And I do understand the
9 difference. Of those 20, are there any still
10 pending?

11 A. We have approved, 15 approved.

12 Q. Okay. So five are still pending?

13 A. That is correct.

14 Q. Are there hearings set for any of the
15 other five?

16 A. There are no hearings set for the
17 other five.

18 HEARING OFFICER ERICKSON: Thank you.

19 In light of my additional question, I offer the
20 opportunity to counsel to ask additional questions.

21 MR. WHITMER: No additional
22 questions.

23 MR. HOPPER: Nothing further.

24 HEARING OFFICER ERICKSON: Thank you,
25 Mr. Martino.

1 MR. WHITMER: Aetna's next witness is
2 John Orszag.

3 (AN OFF-THE-RECORD DISCUSSION WAS
4 HELD.)

5 HEARING OFFICER ERICKSON: We are
6 back on the record. Mr. Whitmer, you may proceed.

7 JOHN ORSZAG, being sworn, testified as follows:

8 DIRECT EXAMINATION BY MR. WHITMER:

9 Q. Mr. Orszag, what is your current
10 position?

11 A. I am a senior managing director at
12 Compass Lexecon, which is an economic consulting
13 firm. I also hold the position of senior fellow at
14 the Center for American Progress, which is a think
15 tank in Washington, D.C.

16 Q. Let's start by you briefly describing
17 how you got into the world of economists.

18 A. Well, that's a long story. I'm the
19 son of a mathematician and a -- and a business
20 woman. When you combine a mathematician and a
21 business woman, you can think of that being an
22 economist. I started studying economics in
23 college, and one of my professors brought me to
24 Washington, D.C. to serve in the Chief of Commerce
25 office of the Department of Labor. I was then

1 asked to serve on President Clinton's economic
2 council, and I did that for a number of years. And
3 then I was asked to serve as the director of policy
4 and strategic planning at the US Department of
5 Commerce.

6 And so that then led me to my initial
7 part of my economics work in terms of government
8 service, and then I entered the private sector
9 after that.

10 **Q. What did your work at the White House**
11 **under President Clinton involve?**

12 A. Well, the National Economic Council
13 is responsible for coordinating economic policy
14 throughout the government. And so in that role,
15 the National Economic Council helps to provide
16 disinterested advice to the President of the United
17 States, taking in information from all different
18 parts of the government and helping to provide the
19 policy process to ensure that the President's
20 getting the best information possible. And so in
21 that role, I covered all different types of areas,
22 including major budget issues such as a health
23 care, Medicare, et cetera.

24 **Q. Do you still advise President Clinton**
25 **today?**

1 A. Yes, I do. I've been involved with
2 his foundation, and I travel with him occasionally
3 to advise him on economic issues.

4 Q. I want to talk about what you did
5 after you left government. Before we do that,
6 let's get a little bit of background on your
7 education. What can you tell us about your
8 post-high school education?

9 A. Sure. I received a degree in
10 economics from Princeton University. I then
11 attended Oxford University on a Marshall
12 scholarship and studied economics and history there
13 and received my master's of science there.

14 Q. Did you graduated summa cum laude
15 from Princeton?

16 A. That made my mom quite happy.

17 Q. Okay. Let's go back to what you did
18 after you left government. What was your first
19 job?

20 A. I started an economic consulting
21 firm, and the economic consulting firm was focused
22 on really competition or regulatory issues, and I
23 have built that over many years. It's now over
24 400 folks, and what I spend my days doing is focus
25 on antitrust issues, and specifically with

1 antitrust merger-related issues. I stopped
2 counting when I'd worked about 100 mergers either
3 for or against them, and that was a number of years
4 ago, so at this point I've worked on well more than
5 that.

6 **Q. So these hundred or so mergers you've**
7 **worked on, what has really been your focus? What**
8 **are you looking at?**

9 A. The critical question when you
10 analyze a merger isn't whether there's harm or
11 benefits to a company. The question is what effect
12 does the merger have on the marketplace? What
13 effect does that have on competition itself? That
14 is the appropriate standard. That is what we focus
15 on, and that's what we care about.

16 And the Horizontal Merger Guidelines
17 that we heard a little bit about about an hour ago
18 or so is really the guidance on horizontal mergers,
19 and that's what we're talking about here. This is
20 a merger of two horizontal competitors, Aetna and
21 Humana. So guidelines are the guidelines that
22 would help provide guidance on what type of
23 analysis is appropriate.

24 **Q. Could you identify a few of the**
25 **companies that you provided services to with**

1 **respect to mergers and this type of analysis you're**
2 **talking about?**

3 A. Over the years for many, from
4 companies like Comcast to Office Max/Office Depot
5 merger, firms like GE to mergers in the health care
6 space involving United Health Care when they bought
7 a specialty Medicare client called Excel Health, to
8 a merger of two companies that specialize in the
9 leasing of doctor networks, MultiPlan and Viant.

10 So it's been a wide range of
11 industries and a wide range of locations,
12 geographies, and it's that application of
13 competition policy to a wide range of industries
14 that I find absolutely fascinating and has made it
15 so enjoyable for me.

16 Q. For example, sir, you've consulted
17 for IBM, Microsoft, Yahoo, Google, AT&T, Oracle,
18 many others. Those are all companies you've worked
19 for?

20 A. Those are all companies I've worked
21 for, that is correct.

22 Q. Sir, have you received any
23 professional honors or awards for your work in the
24 field of economics?

25 A. Yes, I have.

1 Q. What can you tell us about that?

2 A. When I was in government service, I
3 received an award for expanding economic
4 opportunities for Americans from the Corporation
5 for Enterprise Development, which is a think tank
6 in Washington DC. I've received multiple awards
7 for -- Dr. Gruber talked about being 40 under 40.
8 I won a similar award in the competition economic
9 space twice, and then this year was ranked as one
10 of the top ten competition economists in the world.

11 Q. Competition economist, what does that
12 mean?

13 A. Well, there's an area of economics
14 called industrial organization, and economists
15 often like to make things more complicated and use
16 words like industrial organization. What they
17 really mean are the analysis of how firms compete
18 or mergers, and so it's also known as antitrust
19 economics.

20 Those are all synonymous terms, so
21 industrial organization economics, antitrust
22 economics or competition economics, I use them all
23 in the same way, depending upon the audience that
24 one's talking to. If you're talking to economists,
25 they know it as IO or industrial organization.

1 **Q. And you're one of the top ten**
2 **economists in the country that focuses on that type**
3 **of work?**

4 A. An organization ranked me as that.
5 Where I put myself and where they put me may be two
6 different things.

7 **Q. Have you published any articles in**
8 **the field of economics?**

9 A. Yes, I have.

10 **Q. What can you tell us about that?**

11 A. On a range of issues from issues with
12 regard to patent settlements in health care to pay
13 television to college sports to internet access. I
14 have a paper coming out very soon on the merger
15 guidelines themselves and about efficiencies in the
16 merger guidelines.

17 **Q. Have you testified before any courts**
18 **or other tribunals?**

19 A. Yes, I have. I've testified before
20 the United States Congress, both when I was in
21 government and after I left government. I've
22 testified before US courts, before foreign courts,
23 before regulatory bodies. For example, I testified
24 between the European Court of First Instance, which
25 is, in essence, the court that antitrust issues are

1 appealed to on the Microsoft matter against
2 Microsoft in that case.

3 **Q. Mr. Orszag, what was your assignment**
4 **in this matter?**

5 A. My assignment was to review and
6 analyze the report submitted by Dr. Gruber, and
7 which -- in terms of the part that focused on the
8 competition between TM and MA or traditional
9 Medicare and Medicare Advantage and to comment on
10 that.

11 **Q. Okay. And have you reached any**
12 **conclusions with respect to this assignment?**

13 A. Yes, I have.

14 **Q. And what are they?**

15 A. I have two broad conclusions, and I
16 have a PowerPoint that I put together to help
17 hopefully make this easier and enlighten everyone.

18 Contrary to Professor Gruber or Dr.
19 Gruber's testimony, there is substantial
20 competition between traditional Medicare and
21 Medicare Advantage, between TM around MA. In fact,
22 the competition between TM and MA is more
23 significant than the competition between the
24 merging parties themselves.

25 **Q. Wait. What do you mean?**

1 A. So we'll get into some of my analyses
2 on this point, but when one looks at the metrics
3 that the Department of Justice and the Federal
4 Trade Commission or antitrust economists look at,
5 the competition between Medicare Advantage and
6 traditional Medicare is more significant. There's
7 more head-to-head competition there than the
8 competition between the Humana Medicare Advantage
9 plan and the Aetna Medicare Advantage plan.

10 **Q. So are you saying that based on just**
11 **a gut you had today or is that based on empirical**
12 **data?**

13 A. I consider myself an empirical
14 economist. I base everything on empirics unless
15 there's not a theory to support that.

16 **Q. Let's go to your second point. What**
17 **is the empirical evidence that you're going to talk**
18 **about here today and show?**

19 A. Well, based on data from right here
20 in Missouri, in recent data, not outdated data, it
21 shows that traditional Medicare constrains the
22 amount of Medicare Advantage plans to
23 hypothetically raise price or harm competition in
24 some way.

25 **Q. So just to summarize, you performed**

1 an empirical analysis that looked specifically at
2 this transaction, specifically looked at the impact
3 of this transaction on Missouri, and you have data
4 that you want to share today that provide
5 conclusions on that analysis?

6 A. Yes, I do.

7 Q. Okay. Then let's walk through this.
8 First of all, I'd like to start with Dr. Gruber.
9 You were here when he testified, you had the chance
10 to listen in?

11 A. Yes, I did.

12 Q. And you and Dr. Gruber go back a few
13 decades?

14 A. Yeah. I think we met each other for
15 the first time in 1993 or '94.

16 Q. What is your understanding -- let's
17 start with your understanding of Dr. Gruber's
18 testimony in this matter as it pertains to
19 competition between TM and MA.

20 A. He -- just listening to him, sort of
21 repeat, and hopefully I can do this briefly. He
22 said that the competition between traditional
23 Medicare and Medicare Advantage is, quote,
24 incomplete. And he based that on four pieces of
25 evidence.

1 **Q. And those are the four that are up on**
2 **the screen?**

3 A. Yeah. I've summarized his position.
4 You can probably summarize these in three. The
5 first is that he said that the products themselves
6 are different. That would be his Point 1.

7 Second is, he said that there are
8 academic studies showing that higher payments to
9 Medicare Advantage plans are passed on to consumers
10 at less than a rate of 100 percent. And then Point
11 3 and 4 really are virtually one and the same point
12 from an economic perspective, that studies show
13 that changes in Medicare Advantage payments in 2010
14 responded to the exit of private fee for service
15 plans, PFFS, and that studies show that
16 pass-through on consumer surplus respond to changes
17 in competition. And I talk about empirical
18 evidence that I have directly relevant to those two
19 points.

20 **Q. Do you want to draw any general**
21 **description of your response to Dr. Gruber?**

22 A. Sure. The first, and I think this
23 was obvious from what he said is, he based it all
24 on literature, and not even on, just to use his
25 word, not a complete version of the literature. It

1 was incomplete. He left out many relevant studies
2 that were directly relevant to his analysis, and
3 I'm not sure why. He didn't explain. I'm going to
4 talk about a few of those studies here.

5 And as he describe, most of the
6 studies he looked at, especially the ones with
7 regard to Medicare Advantage are based on outdated
8 data. And by outdated data, I mean data prior to
9 the introduction of Obamacare.

10 **Q. What year was that?**

11 A. It was passed in 2010, and provisions
12 started to be put into place in 2013 through I
13 believe it's 2020.

14 **Q. So if you're looking at data that**
15 **predates 2011, for example, how does the ACA make**
16 **that data less than interesting?**

17 A. Because Obamacare or the ACA had a
18 fundamental change in the Medicare markets that we
19 observe today, and so data from prior to that
20 period is less informative than data that postdates
21 that period, because it provides the postdated
22 data. The data since then reflects the market that
23 we observe to that relevant for this transaction,
24 not data from, say, 1995 or 1997, when Medicare
25 Part C was just being formalized and Medicare

1 Part D was not even in existence.

2 So those -- those are big changes
3 that occurred even before Obamacare.

4 Q. And in a nutshell, that's why you
5 chose as part of your empirical study to look at
6 recent data?

7 A. Of course, yes.

8 Q. I'm going to give you a chance to
9 talk about that in more detail, but what I'd like
10 to start with, what does product differentiation
11 mean?

12 A. Well, we observe this in every day of
13 our life. I mean, no -- it's very few products are
14 precisely identical. You can think about -- I see
15 a Toshiba computer here and a Mac right here. They
16 both provide computing functions but they're
17 different. This computer I presume operates a
18 Microsoft operating system. Mac is operating an
19 Apple operating system. They provide different
20 service. They have different inputs. But, yes,
21 they're both competing with each other for
22 consumers.

23 You see this with regard to satellite
24 television and cable television. You see this with
25 regard to airlines. I mean, Southwest Airlines

1 doesn't cover first class. It doesn't offer a
2 lounge. It provides a lower-cost experience.
3 Whereas United or American, even if their flights
4 are delayed like mine was last night, they have
5 first class, they have lounges, they fly
6 internationally, and those are things that
7 Southwest does not do.

8 Q. So have you reviewed Dr. Gruber's
9 opinion that both the products offered and the
10 nature of the beneficiaries differ broadly between
11 TM on one hand and MA on the other?

12 A. Yes, I have.

13 Q. Okay. What's your response?

14 A. The very fact that there are
15 differences in the products, that does not mean
16 they don't compete vigorously. In fact, a lot of
17 his discussion seems to ignore critical elements of
18 the marketplace that we observe.

19 He talks about in his -- in his
20 report the fact that he compares Medicare Advantage
21 with protections in terms of costs to recipients
22 and prescription drugs to what I'll just say is a
23 stripped-down version of traditional Medicare.
24 That is traditional Medicare without either the
25 prescription drug plan included or med supp or

1 Medicare supplemental.

2 So the right comparison compares
3 those two choices. And if you go to, for example,
4 the government websites, they lay this all out for
5 consumers, putting Medicare Advantage and
6 traditional Medicare side by side with each other,
7 showing consumers the choice, allowing them to pick
8 which choice they want, which one they desire,
9 which one best fits their own needs.

10 **Q. So you heard Dr. Gruber testify today**
11 **that even products that are different, they can**
12 **differ substantially even in highly competitive**
13 **markets. Do you agree with that?**

14 A. Absolutely. You see this in the
15 merger guidelines, which I'm surprised that
16 Dr. Gruber was not familiar with. Maybe it wasn't
17 too surprising given that his focus is really on
18 health care markets, not on competition or mergers.

19 But this is the core of how
20 competition economists analyze mergers. And they
21 devote pages and pages to the product
22 differentiation and how you analyze mergers in the
23 context of product differentiation and the
24 discussion with regard to what economists would
25 call homogeneous products, identical products, is

1 quite short.

2 Q. Just for curiosity, what is a product
3 that fits in that bucket?

4 A. That fits a homogeneous product?

5 Q. Right.

6 A. Screws, say. You can buy the same
7 quality screw from one company and you go to a
8 different store and it's the identical size,
9 identical color, identical strength. That would be
10 a homogeneous product. The brand name of the screw
11 doesn't really have an effect. It's identical
12 quality. That would be homogeneous.

13 A heterogeneous product would be, as
14 I was describing, these computers, cable television
15 versus satellite. One you get through a wire. One
16 gets beamed up into the sky and then down to a dish
17 on your house, and offers a different package of
18 program. You see this in stores. Oftentimes
19 there's certain products only available at one
20 store but not another and that makes differences
21 between the stores.

22 Q. Let's take a look at Slide 9. And
23 you were talking a little bit about the government
24 website and showing that you have a choice between
25 traditional Medicare and Medicare Advantage. Just

1 give us in a nutshell why you think this matters.

2 A. Well, it shows the choices that
3 consumers make in the marketplace, and so this is
4 the Medicare.gov website taken right from the
5 website. They get it right from the website. A
6 consumer first goes there and walks through the
7 decision process.

8 It asks you first to make a decision
9 between what they call original Medicare, we've
10 been calling traditional Medicare. They're one and
11 the same. Make a choice between traditional
12 Medicare and Medicare Advantage. That's your first
13 choice. It's a little bit of a choose your own
14 adventure. So you first make that choice.

15 Once you've made that choice, now you
16 have other choices to make. The second choice is,
17 if you've chosen, either plan asks you, do you want
18 one with prescription drug coverage? If you choose
19 traditional Medicare, you're going to get Part D of
20 the Medicare program. If you choose an MA program,
21 you're going to get an MADP -- or MAPD -- I'm
22 sorry -- or a Medicare Advantage prescription drug
23 program. There's obviously -- there's also
24 Medicare Advantage programs that don't offer
25 prescription drugs.

1 And then it asks the question of, do
2 you want further protections with regard to
3 supplemental coverage, and that's in Step 3.

4 **Q. So you've got an initial choice. Is**
5 **that when you age in around the age 65 or so?**

6 A. You actually have two choices. You
7 have an age-in choice. So everyone when they turn
8 64 or 65 have to make a decision about what
9 Medicare choice, whether they choose MA or
10 traditional Medicare. And then annually you get a
11 choice to -- during the enrollment period, which is
12 in the last quarter of the year, to switch. And
13 you can switch from traditional Medicare to
14 Medicare Advantage. You can switch from Medicare
15 Advantage to traditional Medicare or you can switch
16 between Medicare Advantage plans.

17 There's also the opportunity to
18 what's called disenroll, so you can then at that
19 point switch as well in the first quarter of the
20 year, but it's a one-way option. It's not
21 bilateral.

22 **Q. So what is your understanding of the**
23 **functionality of the two options of receiving**
24 **Medicare? What -- functionally what are the**
25 **differences?**

1 Q. Well, there's -- I have a chart, if
2 we go to the next page. It lists some of those
3 differences. And this is not dissimilar to the
4 types of differences that we see with computers or
5 retail stores or cable companies or whatever it may
6 be.

7 So we can focus in on, say, the
8 second -- second one, supplemental insurance. When
9 you have -- FSS Medicare is also traditional
10 Medicare. They're all synonymous, just so the
11 terminology is clear. You have the option of
12 buying more. We talked about. That allows you to
13 have additional protections in terms of the
14 payments that you would owe for service.

15 In Medicare Advantage you just have
16 the option of buy the insurance that already
17 protects you for that. One may cover dental,
18 vision, et cetera; one way not.

19 One -- and Dr. Gruber talked about
20 this. There's differences in the provider
21 networks, which I should also note there's
22 differences likely in the provider networks that
23 the different companies offer. And so there's
24 always some differences between the networks and
25 options that people have.

1 So all of these options are available
2 to consumers to consider the options, and we know
3 that the vast majority of consumers take
4 traditional Medicare and the minority take Medicare
5 Advantage.

6 Q. So just before we leave the context
7 of differentiated products, let me see if I can get
8 this boiled down to the main points here. You're
9 not disagreeing there are some differences between
10 TM and MA, are you?

11 A. Not at all. There are differences.

12 Q. Are you saying that the fact that
13 there are differences in of and itself is
14 irrelevant because there's always going to be
15 differences when you're comparing products in the
16 marketplace other than, for example, corn?

17 A. In any differentiated product there
18 are differences, and then it's an empirical
19 question about the degree of competition.

20 Q. I'm going to let you get to that
21 empirical evaluation, but not yet. Because I want
22 to take you now to a concept called pass-throughs.
23 Econ 101. What is a pass-through?

24 A. It's a rate at which a cost, an
25 increase or decrease, is passed through to

1 consumers in terms of prices. And I listened to
2 Professor Gruber, and this is an area where his
3 economic theory was deeply flawed and really
4 problematic actually, because he sets up a straw
5 man. He sets up the straw man of what's called
6 perfectly competitive markets, and it's a textbook
7 construct. He actually noted that he focuses most
8 of his life on the ivory tower and I focus most of
9 my life, since we parted ways in the government, on
10 the practical application of competition economics.

11 This is truly a textbook model.
12 There's no such thing as the type of model
13 competition that he envisioned. It just doesn't
14 happen in the real world. But even if it did
15 happen in the real world, what he describes is that
16 theoretical target of 100 percent pass-through is
17 not correct. Because that's only in the case where
18 all say -- let's say all hospital costs in Missouri
19 went up by \$10. In a perfectly competitive market,
20 let's just -- we're hypothesizing it's perfectly
21 competitive. They would all go up by \$10. That
22 would be 100 percent pass-through.

23 But in markets that -- that just
24 affects one firm. The pass-through rate actually
25 approaches zero. So his discussion of this didn't

1 take into account those kind of differences and,
2 most importantly, in markets that have some
3 imperfections, the type of markets that the
4 Department of Justice, Federal Trade Commission
5 discussed as differentiated products mergers, the
6 pass-through rate could be anywhere between zero
7 and well more than 100 percent, and that's
8 precisely why.

9 The Department of Justice, the
10 Federal Trade Commission, the federal agencies that
11 examine antitrust in mergers would not even
12 consider looking at the relative pass-through rate
13 to determine the competitiveness of the market.
14 It's just not something I've ever heard of as a
15 matter of competition economics. It makes no
16 economic sense.

17 **Q. So not to be disrespectful, but you'd**
18 **say that this point Dr. Gruber's making is really**
19 **silly from an economic perspective?**

20 A. Those are your words. I'd say it's
21 just not right.

22 **Q. Let's talk more concretely.**
23 **Dr. Gruber's opinion, you heard him say, higher**
24 **reimbursement of MA plans is not fully passed onto**
25 **consumers. Your point is it just doesn't matter.**

1 A. Well, it's not probative of the
2 competitive facts. It just doesn't tell us how
3 competitive the market is, because you could have a
4 market that is very, very competitive with
5 extremely low pass-through rates and markets that
6 are imperfectly competitive, that lack competition
7 that have pass-through rates well over 100 percent.
8 And so what am I supposed to -- how's that inform
9 my discussion when the pass-through rate in a very
10 competitive market is close to zero, and a market
11 that's not competitive is well more than
12 100 percent and the pass-through rate according to
13 the economic theory is 15 percent.

14 So it's -- the point is an imperfect
15 competition and pass-through rate can be anything,
16 and that's precisely why the Department of Justice
17 doesn't even examine this issue in the context of
18 analyzing the impact of the merger on competition,
19 except for issues with regard to say efficiencies
20 where they're trying to figure out how much gains.
21 I don't want to say it's a zero issue in the
22 competitive analysis, but the issue about
23 determining degree of competition, he's just way
24 off base.

25 Q. So let me see if I can summarize this

1 point. Pass-throughs, from your perspective, is
2 not something that you would want to look at if
3 you're trying to determine the competitive impact
4 of a transaction like this one?

5 MR. ANGOFF: Objection, leading.

6 HEARING OFFICER ERICKSON: Can you
7 rephrase, please.

8 BY MR. WHITMER:

9 Q. Sir, in a nutshell, can you summarize
10 your point on pass-throughs?

11 A. Pass-through is not a relevant metric
12 for assessing whether the market is highly
13 competitive or less competitive.

14 Q. Let's move forward then to the third
15 bucket of what you're looking at, okay, and just
16 put some context to it. First bucket we talked
17 about was product differentiation. The second
18 bucket was pass-throughs. And the third bucket is
19 competitive effect. What does that mean? Why does
20 that matter?

21 A. Well, Professor Gruber made a correct
22 point which is that if the market is appropriately
23 defined broadly to include traditional Medicare,
24 one would expect that changes in the market
25 structure of MA should have no significant effect

1 on market outcomes. And he points to a couple of
2 old studies, and we've already talked about the
3 fact that the studies he pointed to were from
4 basically the 1990s to early 2000s, I think two out
5 of the three were in that period, and one was
6 sometime between 2006 and 2010. I forget the
7 precise dates. We look at data that's more recent
8 than that, post the introduction of the ACA.

9 **Q. And so what do you take away from**
10 **this point on competitive effects? Is it the right**
11 **to be looking at?**

12 A. It's definitely the right thing to
13 look at. I looked at it before I'd ever seen
14 Dr. Gruber's analysis as part of the fuller
15 presentation that I'd made to the Department of
16 Justice on this merger. And then I also look at it
17 here with regard to data with regard specifically
18 to Missouri.

19 **Q. Look at slide 16. Up on the board,**
20 **what is it about this slide that you want to share**
21 **with us?**

22 A. Well, what I basically just said,
23 that he just bases his -- Dr. Gruber, that he just
24 bases his entire analysis on relatively outdated
25 academic literature not specific to Missouri. As

1 I'm about to describe, I look squarely at data for
2 Missouri from the last several years.

3 Q. Let's transition now, not to what
4 Dr. Gruber has done, but what you've done with
5 respect to this transaction. Okay? You tell us
6 about the empirical analysis that you've performed.

7 A. Sure. And this is a subset of the
8 analyses that I've conducted over the past year
9 analyzing this merger. And the first one really
10 goes to the question of market shares, and I just
11 should mention that in order to measure market
12 shares, one has to actually appropriately define
13 the market. Something that one has to do with
14 data. You can't just hypothesize it. You have to
15 measure it with data. And it's precisely the data
16 that I have here that shows that traditional
17 Medicare and Medicare Advantage are in the same
18 relative product market. So then I can measure
19 market shares, and what this shows is that this is
20 for Missouri, that 72 percent of Medicare eligible
21 beneficiaries choose traditional Medicare. And
22 that means roughly 28 percent choose a Medicare
23 Advantage plan. Combined, Aetna and Humana about
24 14 percent of the overall Medicare eligible
25 beneficiaries.

1 Q. I'm going to ask you to take the
2 binder that's right in front of you. It's marked
3 binder 3. And turn to Exhibit K.

4 A. Yes, sir.

5 Q. What is Exhibit K?

6 A. This is the presentation that myself
7 and my colleague, Bryan Keating submitted to the US
8 Department of Justice analyzing the impact of
9 Medicare competition in this merger, the merger
10 between Aetna and Humana.

11 Q. Approximately how long have you been
12 working on this? You heard Dr. Gruber talk about
13 being retained a few weeks ago. How long ago were
14 you retained to look at the competition issues
15 we're talking about here today?

16 A. Roughly a year ago.

17 Q. And in this paper, is this paper
18 national in scope or is it specific to just certain
19 states?

20 A. What I'd say is it's built up from
21 the micro data state by state, individual data. We
22 presented it nationally, but all of the individual
23 states were embodied in that data. And so the data
24 that I'm showing here is now broken out for
25 Missouri specifically.

1 Q. So part of what you did was specific
2 to Missouri in this transaction, correct?

3 A. Yes, sir.

4 Q. And that's the evidence that's
5 empirical data that you're here to talk about
6 today?

7 A. Yes, sir.

8 Q. You're not asked to talk about
9 empirical data for other states today; it's just
10 Missouri?

11 A. If you ask me about other states, I
12 can talk about it, but I'm here to talk about
13 Missouri.

14 Q. Okay. Well, in a nutshell, what
15 conclusion have you reached with respect to
16 Missouri?

17 A. I think the evidence is absolutely
18 overwhelming that traditional Medicare and Medicare
19 Advantage plans compete vigorously and that that
20 competition constrains the ability of Medicare
21 Advantage plans to increase price, harm competition
22 in some way, shape or form.

23 Q. Okay. Let's look at slide 18. And
24 let's go through these one of at a time. First you
25 said that traditional Medicare counts for a

1 majority of Medicare enrollment in Missouri?

2 A. Actually probably called it the vast
3 majority.

4 Q. 72 percent?

5 A. 72 percent.

6 Q. Okay. And second -- let's go to
7 slide 19 -- you said that there's substantial
8 substitution between TM and MA. Explain that.

9 A. I'm sorry that this chart's not
10 as -- I'm going to walk through it slowly because I
11 think it's important and it's perhaps not as clear
12 as it could be. I'm going to focus first on the
13 top right corner, the words that I have. The first
14 thing to note is that every year it shouldn't
15 surprise folks that there are, quote, terminations,
16 that's not my terminology, that's the terminology
17 used, from Medicare Advantage plan. So they lose
18 people.

19 And what they have to do to is every
20 year replace those folks. And they replace folks,
21 and that's an incredibly important source of
22 business for them. And so roughly speaking, new
23 enrollees account for 22 percent of Aetna's
24 Medicare Advantage enrollment in Missouri and
25 36 percent of Humana's. So new enrollees are

1 really important. And then what we do is we
2 analyze where they get those new enrollees.

3 So I'm now moving from the top right
4 where I've defined that they get roughly 22 percent
5 for Aetna and 36 percent for Humana to the two
6 graphs on the left, and this is where they get them
7 from. And if you look are for Aetna, roughly
8 69 percent of their -- of their new enrollees come
9 from either the age-ins, those are the newly
10 eligible, or people who are switching from fee for
11 service Medicare from traditional Medicare. So
12 when you think about where they're getting their
13 business, their new business, where they're getting
14 their new people, 69 percent of it, more than
15 two-thirds is coming from either age-ins, where
16 they're competing head to head with Medicare, as
17 evidenced by the Medicare.com website, or people
18 who have affirmatively decided to switch from
19 traditional Medicare to Medicare Advantage.

20 And then for Humana, the numbers are
21 somewhat lower, but you get a similar kind of
22 result, that 51 percent are coming from the newly
23 eligible and coming from traditional Medicare. And
24 obviously, the remainder are coming from other
25 Medicare plans.

1 **Q. Let's take a look at slide 20, then.**
2 **Tell us about switching from Medicare Advantage**
3 **plans?**

4 A. So this is looking more narrowly at
5 what's called switch-outs. These are people who
6 are terminating their service with either Aetna or
7 Humana. They are disenrolling from their Medicare
8 Advantage plan and we're looking at where they go.
9 And of the people who discontinue, roughly 17 to
10 19 percent -- this is again for Missouri -- go to
11 traditional Medicare.

12 **Q. Now, the numbers we're looking at**
13 **here, 17 and 19 percent, Dr. McCarthy's going to be**
14 **providing testimony this afternoon. His numbers**
15 **are a little bit different than yours?**

16 A. They're very slightly different
17 because when I did Exhibit K, which we talked
18 about, we didn't have the most updated data. And
19 for this presentation today, I've updated it to
20 include the most up-to-date data, and
21 Dr. McCarthy's report was due based on his -- the
22 previous data that we've submitted to the
23 Department of Justice.

24 **Q. But the data's within a few**
25 **percentage points?**

1 A. It doesn't change any of the
2 qualitative results. It's just quantitatively
3 slightly different.

4 **Q. So back to the slide here, why does**
5 **this matter with respect to this transaction? Why**
6 **is this information pertinent to the hearing**
7 **officer's consideration today?**

8 A. Because we can go to one of my
9 favorite documents in the whole world, the
10 horizontal merger guidelines. And the horizontal
11 merger guidelines talk about a concept called
12 diversion ratios. What a diversion ratio is, is
13 the idea if a firm raises price, what percentage of
14 the customers go to the say competing firms. And
15 that's what a diversion ratio measures. A
16 diversion ratio is directly relevant to defining
17 the relevant market. So I can calculate with these
18 switching rates the different version ratios using
19 the most up-to-date literature or I can even do it
20 using the literature that Dr. Gruber cited. So I
21 can do it either way.

22 I like the most up-to-date literature
23 it is a much better paper, in my opinion. It's a
24 paper he didn't cite. I'm not sure why not, but
25 it's directly relevant paper to the issues at hand

1 here and that's -- we're on slide 21, and again, I
2 apologize for a little bit of economics here, but
3 it's unavoidable for explaining this issue. So I
4 can walk through this table if you'd like me to.

5 **Q. I think it would be helpful. A lot**
6 **of information. Tell us what we should be looking**
7 **at.**

8 A. So what I'm doing is I'm taking the
9 two papers, so Curto and three other co-authors
10 estimate a parameter, again, I apologize for this,
11 called sigma. And sigma is, in essence, the -- you
12 can view it as the degree of competition between
13 traditional Medicare and Medicare Advantage.
14 That's one way to sort of -- it's a quantitative
15 Greek measure, quantitative measure of that. And
16 Town and Liu have a different measure. That's
17 based on the 1993 to 2000 data that Professor
18 Gruber talked about and this paper's from 2003.

19 So if I were thinking about this, I'd
20 prefer vastly the column on the left, but because
21 Professor Gruber talked about that paper, I also
22 present it for the column on the right. And all I
23 do then is take that measure, use the market shares
24 that we have already discussed, the switching rates
25 we've already discussed, and what it shows is that

1 the diversion ratio from Aetna to Humana is roughly
2 13 percent. That is if there was an increase in
3 price by Aetna for it's Medicare Advantage plan,
4 13 percent of its users would go to Humana.
5 26 percent would go to other to MA plans, and
6 61 percent would go to traditional Medicare. What
7 that tells us is that traditional Medicare is a far
8 stronger competitor, a far stronger competitive
9 constraint on Aetna's ability to raise price, harm
10 competition in some way than any other MA plan.

11 Q. So you said that earlier, and I think
12 it's an important point. I want to make sure we're
13 focusing on it. What numbers on this sheet up on
14 the screen prove the point you just made, which is
15 that there is more robust competition between
16 traditional Medicare and Medicare Advantage than
17 compared to Aetna versus Humana?

18 A. Do you mind if I actually stand up?

19 Q. No.

20 MR. WHITMER: Is that okay?

21 HEARING OFFICER ERICKSON: Go ahead.

22 THE WITNESS: This is so much fun for
23 me, by the way. It's much more entertaining like
24 this. I was tal-- the real numbers that are
25 relevant, and I just want everyone to be able to be

1 see, are right here and right here (indicating).
2 So what this says is diversion from Aetna to Humana
3 is 13 percent. Diversion from Aetna to other MA
4 plans is 26 percent, and diversion from Aetna to
5 traditional Medicare is 61 percent. So if Aetna
6 tried to harm competition some way, if they tried
7 to do something that was adverse to the
8 marketplace, 13 percent of the customers would go
9 to Humana today, 26 percent would go to other
10 Medicare and the vast majority would go to
11 traditional Medicare.

12 If you look at from Humana, you see
13 something very similar, 20 percent going from
14 Humana to Aetna, 24 percent going from Humana to
15 other MA plans, and 56 to traditional Medicare. So
16 this is absolutely critically relevant for defining
17 the relevant factor because in the merger
18 guidelines they have something called the circle
19 principle. And so I can discuss, but I think I'm
20 done with this if you want me to move back.

21 BY MR. WHITMER:

22 Q. Before you leave that thought
23 process, I would like you to tie this to the circle
24 principle and explain to us why it matters.

25 A. So if we go to the next slide, and

1 I'm going to quote the merger guidelines, and it's
2 Section 4.1.1 of the merger guidelines. It says,
3 when applying the hypothetical monopolist test, and
4 that's the test to define a relevant market, so
5 when applying the hypothetical monopolist test to
6 define a market around a product offered by one of
7 the merging parties, if the market includes a
8 second product the agencies will normally also
9 include a third product, if that product is a
10 closer substitute for the first product than is the
11 second product. The third product is a closer
12 substitute if, in response to a SNIP on the first
13 product, greater revenues are diverted to the third
14 product than to the second product.

15 So if I just convert these words into
16 what I just presented, what that would say is if
17 say Aetna tried to raise price, which is a SNIP,
18 which is a small but significant nontransitory
19 increase in price. If they tried to do that, more
20 customers would go to traditional Medicare, the,
21 quote, third product than to Humana's Medicare
22 Advantage plans. That means directly from the
23 merger guidelines you have to include traditional
24 Medicare in the relevant market.

25 **Q. So tying this back to Dr. Gruber,**

1 what you're talking about right now, how does this
2 fit in to the question that's before the hearing
3 officer today, which is, how do you define the
4 relevant market when talking about Medicare?

5 A. What it says is that Medicare is a
6 competitive constraint, that traditional Medicare
7 is a competitive constraint. It's from -- the
8 competition far more fulsome than the type of
9 competition Dr. Gruber suggested but had not
10 analyzed.

11 Q. Put another way, when looking at
12 Medicare, you need to look at both traditional
13 Medicare and Medicare Advantage in order to get a
14 fair view of how the competition will be impacted?

15 MR. ANGOFF: Objection, leading.

16 MR. WHITMER: Your Honor, that's
17 summarizing what he just said. It's not leading.
18 That's -- it's responding to what the witness just
19 said.

20 HEARING OFFICER ERICKSON: I'll
21 overrule. Please answer.

22 THE WITNESS: I actually forgot the
23 question, but I think you said you have to look at
24 both products. And the answer is, yes, you have to
25 look at both traditional Medicare and Medicare

1 Advantage to understand the competitive situation
2 at hand here.

3 BY MR. WHITMER:

4 Q. Let's go forward to slide 23. I want
5 to read something to you. Okay. This is right
6 from Dr. Gruber's report. I want to read it word
7 for word. If there were truly complete competition
8 between TM and MA, then a change in the I'll call
9 it HHI from movements within MA should have only a
10 modest effect since the dominant competitor would
11 remain. Those were Dr. Gruber's words. What's
12 your response?

13 A. I agree. And I tested this.

14 Q. How did you do it?

15 A. Well, I did it a number of different
16 ways, but I both looked at simple averages, but I
17 also used what's called econometrics or statistical
18 analysis. And so what econometrics allows us to do
19 is to control the factors, and one of the factors
20 that is -- and I think this is really important,
21 because a number of the studies in the marketplace
22 haven't done this or a number of the studies in the
23 literature.

24 We're fortunate, that's me and Brian
25 Keating who I did this work with, and then

1 obviously Dr. McCarthy, et cetera, that we have
2 very good data on cost information for Aetna and
3 Humana. And that cost information is again
4 extremely important, because without it, there are
5 biases in these studies as best I can tell. And we
6 control for those costs and we control for other
7 relevant factors, and in the analysis we do, we
8 find no significant either economically significant
9 or statistically significant results, suggesting
10 that the Medicare Advantage market structure has an
11 effect on the relevant market outcomes, for
12 example, out of pocket costs for patients or
13 revenues for Aetna or Humana or margins or other
14 factors like that.

15 **Q. Let's go forward to the next slide.**
16 **What do we learn from this slide and how does it**
17 **fit in?**

18 **A.** If I look at the top-left panel, and
19 this is looking -- the blue bar is, in essence,
20 Aetna revenue. The red bar is out of pocket costs
21 of enrollees with Aetna, the green bar is margins,
22 and the purple bars are premiums. And what each of
23 those bars shows is the number of insurers offering
24 Medicare Advantage plans in Missouri. So it's
25 looking at different counties and it's saying,

1 well, in counties with four competitors, say, or
2 five competitors, how do margins, revenue, out of
3 pocket costs differ?

4 And what you see is there's no
5 pattern that suggests that more competition is
6 producing results consistent with a view that
7 Medicare Advantage is its own market. In fact,
8 these kinds of similar effects would suggest that
9 traditional Medicare is a very significant
10 constraint. But I didn't just stop with that in
11 Missouri. I went to the econometrics again.
12 Said, let's do this holding all else constant. And
13 when I hold all else constant, we don't need to go
14 through each and every last example, but I tested
15 this with regard to per member per month revenue,
16 out of pocket costs, margins, medical expenses,
17 nonmedical expenses, and there's no economic --
18 economically significant relationship between those
19 factors and market structure consistent with what
20 Professor Gruber said should happen if traditional
21 Medicare is a competitive constraint on Medicare
22 Advantage.

23 **Q. So there's a lot of words on this**
24 **page and just, again, if you could highlight for**
25 **the us the bold, the bold parts for each the bullet**

1 points, what is exactly -- what are those bullet
2 points?

3 A. Yeah. So the actual detailed numbers
4 are probably more difficult to understand. They're
5 on pages 27 and 28 of the presentation, but they
6 present the econometrics. But what this shows is,
7 let's just take the first one, for example. The
8 correlation between per member per month revenue
9 and measures of market structure, however I measure
10 it, by the way, I tried multiple different ways,
11 that the relationship is economically small. That
12 is, changes in market structure have a very small
13 effect or statistically insignificant effect on per
14 month -- per member per month revenue. And I find
15 that same result on each of these categories.

16 Q. And again, tie that back to why does
17 that matter for the analysis we're talking about
18 here today?

19 A. Because it's -- it goes back to the
20 point that Professor Gruber made, which I agree
21 with. If you change the number of MA competitors
22 by say one or two, if traditional Medicare is the
23 big gorilla in the room, if it's there, you would
24 expect the increasing of one or two competitors not
25 to have much an effect on outcomes. That's exactly

1 what we see. That's exactly what we see in the
2 econometrics data. And if, in fact, traditional
3 Medicare weren't a significant constraint, changing
4 the number of competitors by one or two, one would
5 expect to have a very significant either economic
6 or statistically significant effect, and we just
7 don't see that the data.

8 **Q. You've gone through a lot. You've**
9 **covered a lot of topics. But I want to make sure I**
10 **don't take away your opportunity to address**
11 **something that I forgot to bring up. What did I**
12 **miss?**

13 **A.** I think if I could summarize, maybe
14 that's the simplest concept.

15 **Q. Please do.**

16 **A.** I read Dr. Gruber's report carefully,
17 and I've known Dr. Gruber for a long time. He's
18 done a lot of work in the health care space and a
19 lot of pioneering work on health care, but he
20 hasn't done competition economics. He hasn't
21 analyzed how firms compete. That's just not his
22 area of specialty, and he said it right here.

23 And his analysis doesn't meet the
24 appropriate standards for analyzing mergers, and
25 one has to look at the facts and circumstances of

1 the merger itself. We can't just look at decade
2 old data. And I looked at the actual data for the
3 last few years. I looked at the data for this
4 state, but I've also looked nationally. And my
5 conclusions rest on that data, not on some theory
6 or some old economic literature.

7 **Q. Have you reviewed the Florida**
8 **consent, the conclusions the Florida OIR reached**
9 **with respect to this matter?**

10 A. I read it when it came out, yes.

11 **Q. And generally do you agree with the**
12 **Florida OIR in how they do it?**

13 A. If you use the word generally, I'm
14 not going to -- as an economist, I like to think
15 about things differently than lawyers often do, but
16 I think the general conclusions are in line with
17 the economic conclusions that I've expressed here
18 and in Exhibit K that you presented to me earlier.

19 MR. WHITMER: Thank you very much. I
20 have no further questions at this time.

21 HEARING OFFICER ERICKSON: Before you
22 leave the stand, I do realize we are approaching
23 five o'clock. We have a lot of folks that are here
24 observing today, and I had previously advised
25 parties -- and I'm sorry it's in the middle of your

1 expert -- but is there anyone in the public who
2 would intend to offer public comment or written
3 comment that cannot stay for the remainder of this
4 hearing?

5 This hearing will go beyond
6 five o'clock. We will continue with the hearing
7 until completed. Be advised that the building does
8 close at 5:30. That means if you have exited the
9 building you cannot get back into the building.
10 There are floors that have snack machines and I
11 thank God that some of our folks here can tell you
12 where those are at. I don't personally do that.
13 But if you need sustenance, there is something here
14 in the building, but I would like to ask the public
15 members. Yes, sir.

16 MR. GRIMALDI: I would be one of
17 those, your Honor.

18 HEARING OFFICER ERICKSON: Okay. Is
19 there anyone else who would like to take the
20 advantage of the opportunity before the parties
21 finish their presentation of making oral or written
22 comments?

23 By leave the parties, I ask if you
24 would, Dr. Orszag, step down, you're still under
25 oath subject to cross-examination.

1 Sir, if you would please approach.
2 I will go through a little bit of -- if you just
3 take a seat for just a moment. I'm going to remind
4 everyone of what I said at the very beginning of
5 the hearing, in case some persons were not here
6 earlier.

7 Interested persons may also submit
8 written comments by no later than four p.m.,
9 Thursday, May 19th, as outlined in the amended
10 notice of hearing found on the Department's
11 webpage. Those are submitted electronically, and
12 as soon as those are received, I've tried to get
13 them on our website. If you got that down, I'll
14 turn off my monitor.

15 MR. GRIMALDI: My name is Gerard,
16 G-e-r-a-r-d, last name Grimaldi, G-r-i-m-a-l-d-i.

17 HEARING OFFICER ERICKSON: Thank you.
18 Are you commenting on your own behalf or on behalf
19 of an entity or organization?

20 MR. GRIMALDI: On behalf of Truman
21 Medical Centers in Kansas City, Missouri.

22 HEARING OFFICER ERICKSON: Thank you.
23 Do you wish to make an oral comment, submit a
24 written comment or both?

25 MR. GRIMALDI: Oral comments, and I

1 promise to talk fast.

2 HEARING OFFICER ERICKSON: I see you
3 have a document in your hand. Are you going to
4 literally read that into the record?

5 MR. GRIMALDI: Yes, very quickly.

6 HEARING OFFICER ERICKSON: Please
7 proceed.

8 MR. GRIMALDI: Thank you, your Honor.
9 Thank you for the opportunity to say a few words.

10 Truman Medical Centers is Kansas
11 City's essential hospital and serves two vital
12 purposes western Missouri: As the safety net
13 health system for the uninsured and underinsured,
14 and as western Missouri's academic medical center,
15 teaching those who will provide future care across
16 Missouri and beyond.

17 We serve more than 108,000 patients
18 of whom an overwhelming majority have at least one
19 chronic illness. In the last year Truman Medical
20 Centers cared for these patients in more than
21 338,000 outpatient visits, plus an additional
22 257,000 behavioral health visits. About half of
23 all the babies born in Kansas City are born at one
24 of our two hospitals.

25 In addition to serving as the health

1 home for many Kansas Citians with primary and
2 specialty outpatient care needs, Truman Medical
3 Centers cared for more 23,000 patients last year,
4 plus an additional 2,700 behavioral health
5 patients.

6 We also meet the specialty care needs
7 and with many specialty services that are broad and
8 wide ranging, and we are western Missouri's
9 premiere Level 1 trauma center. We are -- Truman
10 Medical Centers provide about 12 percent of all
11 uncompensated care in the entire state of Missouri
12 at two hospitals in Jackson County, Missouri.

13 In sum, Truman Medical Centers is one
14 of the very few Missouri health systems which
15 demonstrates through practice a total commitment to
16 caring for vulnerable populations. We also note
17 that, but for our existence and the essential role
18 we play in Kansas City, Missouri, we feel that the
19 cost of health care to individuals and families
20 would be significantly higher in the Kansas City
21 area.

22 We want the Department to be aware
23 that a significant number of our patients enrolled
24 in both Senior Advantage and commercial insurers
25 are racial and ethnic minorities. Our data

1 indicates that up to 40 percent of our patients of
2 Senior Advantage plans also are dual-eligible
3 enrollees.

4 We are concerned that narrow network
5 and pricing behavior by insurers after acquisitions
6 occur could have a significant impact on continuity
7 of care for Truman Medical Centers patients, many
8 of whom are low income.

9 The ability of Jackson Countians to
10 obtain medical care of one of Missouri's few
11 essential community provider health system could be
12 jeopardized, and we are concerned that
13 post-acquisition decisions and insurer behavior
14 could hinder options severely for the current TMC
15 patients who become Medicare eligible in the future
16 because of disability and/or age, or who come for
17 coverage in the health insurance exchange in the
18 future.

19 In sum, if plans narrow the networks
20 after consolidation, it could place Truman Medical
21 Centers in a downward spiral of limited network
22 access, hindering the ability of thousands of
23 patients to receive care from their preferred
24 physicians in a preferred setting. As such, we ask
25 the Department to consider as much as possible to

1 require health plans to include essential community
2 providers, such as Truman Medical Centers in
3 network at reasonable, fair and appropriate
4 reimbursement rates.

5 The rapid pace of change and
6 volatility of today's health insurance markets
7 presents increasingly more challenges for essential
8 providers of care like Truman Medical Centers.
9 Such action and consideration by the Department is
10 necessary to assure reasonable and timely access to
11 essential services in a culturally sensitive
12 setting for all patients, but especially the
13 low-income beneficiaries who rely on Truman Medical
14 Centers for care in Jackson County, Missouri.

15 Thank you.

16 HEARING OFFICER ERICKSON: You have a
17 written comment?

18 MR. GRIMALDI: Sure.

19 HEARING OFFICER ERICKSON: Thank you,
20 Mr. Grimaldi.

21 MR. GRIMALDI: Thank you.

22 HEARING OFFICER ERICKSON: Are there
23 any other interested parties at this time,
24 realizing that we are close to five o'clock, who
25 wish to offer a public comment at this time?

1 Seeing none, let's take a ten-minute
2 break, 15-minute break. We are off the record.

3 (A BREAK WAS TAKEN.)

4 CROSS-EXAMINATION BY MR. ANGOFF:

5 **Q. Good afternoon, Mr. Orszag.**

6 A. Good afternoon, sir. How are you?

7 **Q. I'd like to talk about one of your**
8 **favorite documents in the world. Do you remember**
9 **you were talking about one of your favorite**
10 **documents in the world?**

11 A. The Horizontal Merger Guidelines.

12 **Q. Now, in the Horizontal Merger**
13 **Guideline, you talked a lot about it. You refer --**
14 **they're guidelines, but you refer very SSNIP test.**

15 A. That is correct.

16 **Q. Okay. Could you tell us what the**
17 **SSNIP test is?**

18 A. Sure. As I -- it's S-S-N-I-P. It's
19 a small but significant nontransitory increase in
20 price.

21 **Q. Okay. And don't the Merger**
22 **Guidelines instruct that the way you define the**
23 **product market is to apply the SSNIP test?**

24 A. Not quite. So let's backtrack, if
25 you don't mind, and start with what you actually

1 do, which is you start with a candidate market.
2 You start with a market. You test first whether
3 that market is a relevant market. You assume that
4 there is hypothetical monopolist over all
5 production in that market. So you assume that the
6 monop-- there's a monopoly, say, supplier of all MA
7 plans, one single firm, all MA plans. And then you
8 assume that that hypothetical monopolist raises
9 prices by a SSNIP. The SSNIP in the guidelines
10 generally is 5 percent, but there are occasions
11 that it should be higher or it should be lower.

12 And then you ask the question of
13 whether that SSNIP is profitable. If that SSNIP is
14 unprofitable, then you expand the candidate market
15 to include other products, for example, traditional
16 Medicare. And if that SSNIP is profitable, then
17 you have a relevant product market.

18 **Q.** So let me refer you to page 12 of
19 your, I guess the presentation you put up here
20 that's got -- it's headed Traditional Medicare and
21 MA Plans Consumer Services. Do you see that?

22 A. Yes, sir.

23 **Q.** And then you see in the bottom right
24 column, right, that you say that the average cost
25 for an MA, an average premium for an MA plan which

1 includes Part D is \$38.56?

2 A. That includes Part D, yes.

3 Q. Okay. And so how much is 5 percent
4 of \$38.56?

5 A. 5 percent of that will be roughly a
6 \$1.50, give or take.

7 Q. Okay. \$1.50, \$1.90. Less than \$2.
8 So then the question is, could a hypothetical
9 monopolist of that product, of the MA product,
10 impose a small but significant nontransitory price
11 increase, which as you pointed out the guidelines
12 generally define as 5 percent, could the MA carrier
13 raise its prices by \$1.50 or \$1.90 without
14 having -- without too much -- too many people
15 leaving, without there being an adverse effect on
16 it?

17 A. I'm going to answer your question, if
18 you don't mind, in two parts, if that's okay with
19 you.

20 Q. Yes, it is.

21 A. First, we have to start -- you're
22 looking at an average price. When you apply the
23 SSNIP, you apply it on all prices ranging from up
24 to \$388 as I have in the bottom right-hand corner.
25 So it would be across all products, not just on the

1 average product. So you'd raise the price by
2 5 percent.

3 Given the margins that one observes
4 for these companies, given the diversion ratios
5 that I described in my presentation and applying
6 the standard methodology for the application of the
7 hypothetical monopolist test, this would be a paper
8 that Michael Katz and Carl Shapiro have that
9 describes the implementation of this.

10 That price increase would not be
11 profitable. That is, there would be a sufficient
12 number of people who would divert to traditional
13 Medicare, making that price increase that you
14 hypothesize unprofitable.

15 **Q. You're saying for -- well, you're not**
16 **saying, are you, that the \$388 MA plan that you**
17 **mention is purchased by a substantial number of**
18 **people? I mean --**

19 A. I'm saying that you increase -- when
20 you implement this hypothetical test, so you assume
21 that it's a monopolist over every single MA plan,
22 not just the average plan but also the more
23 expensive plans and the less expensive plans, the
24 \$38.56, they raise prices by 5 percent, and you ask
25 the question of, is that profitable? And according

1 to margin data, according to the diversion data,
2 that would be an unprofitable price increase
3 applying the standard models that one would use in
4 the economics literature for assessing that kind of
5 question.

6 Q. That's really not exactly what the
7 SSNIP test is, though, is it? Doesn't the SSNIP
8 test require that a hypothetical profit-maximizing
9 firm would impose the small but significant
10 nontransitory increase in price on just one of
11 those products?

12 A. Okay. So let's now -- it's the
13 product at issue, and the product at issue is there
14 a hypothetical monopolist over the MA plans. If
15 you want to start out with your candidate market
16 being low-cost MA plans --

17 A. Average. I said the average. I'm
18 asking you about the average.

19 A. That's not a candidate market. You
20 have to first define a candidate market. If you're
21 going to say that the candidate market is an
22 average plan, then that by definition is not going
23 to be profitable because there's going to be a plan
24 slightly above the average and a plan slightly
25 below the average that that hypothetical monopolist

1 would not control. When you raise a price from
2 38.56 to -- I'm going -- the math works out to
3 roughly \$40, just over \$40, that monopolist under
4 your hypothetical doesn't control that \$40 plan, so
5 people will just switch the \$40 plan. So that
6 would be unprofitable. And so then you'd keep
7 expanding the relevant market to include more
8 plans.

9 And when the Horizontal Merger
10 Guidelines describe the product, they're talking
11 about the product as the MA plans. That's all the
12 plans in the MA space, unless you're talking about
13 a candidate market that's much narrower than that.

14 **Q. Let's try to bring this down to a**
15 **very specific real-world example. Mr. Orszag, I**
16 **show you what's been marked as Exhibit 36 for**
17 **identification. It's not in evidence. Can you**
18 **tell me what that is?**

19 **A.** This looks like the plan options if
20 you go to the Humana website. I'm -- this is what
21 it looks like to me. I haven't done this myself.
22 And it shows in a particular area in Jackson,
23 Missouri, zip code 64101, what options are
24 available, and it shows nine Medicare Advantage
25 plans, three prescription drug plans and eight med

1 supp plans.

2 **Q.** **Okay. And are -- are you reasonably**
3 **comfortable that this is a -- that this is a**
4 **legitimate screen shot of the website? It hasn't**
5 **been doctored or anything?**

6 **A.** I have no reason to think that you've
7 doctored it at all. It looks like it is what it
8 is.

9 MR. ANGOFF: Okay. Your Honor, I
10 move the admission of Plaintiff's Exhibit 36 into
11 evidence.

12 MR. WHITMER: No objection.

13 HEARING OFFICER ERICKSON: Exhibit 36
14 is admitted.

15 (PETITIONER'S EXHIBIT 36 WAS RECEIVED
16 INTO EVIDENCE.)

17 BY MR. ANGOFF:

18 **Q.** **Okay. So, Mr. Orszag, can you take**
19 **however much time you need and just look at the**
20 **prices charged there for the different MA plans**
21 **that Humana offers?**

22 **A.** Yes, sir. They range from, there's
23 zero premium plans to, it looks like, \$118 per
24 month.

25 **Q.** **Okay. So --**

1 A. And this is ignoring PDP and med
2 supp.

3 Q. Right. So even a -- even let's take
4 the most expensive plan, a 5 percent price increase
5 would be about 6 bucks, right?

6 A. Give or take, that's about right.

7 Q. All right. And then when you're
8 talking about Medicare as an option, as I think you
9 said, and I think Professor Gruber said and I think
10 several other witnesses said, it's really -- the
11 comparison is not really between MA and traditional
12 Medicare but between MA and traditional Medicare
13 plus Part D plus Medigap?

14 A. For most consumers. Some consumers
15 will decide that they don't need Medigap because
16 they're choosing an MA plan without -- or they
17 don't need prescription drug coverage because
18 they'll decide what they want is an MA plan without
19 prescription drugs. And so they're going to
20 compare themselves to traditional Medicare without
21 Part D.

22 Q. Sure. Okay. So in the middle column
23 of your document, your chart there on page 12, you
24 set out there the average Medigap premium, which is
25 about \$101, right?

1 A. That is correct, sir.

2 Q. And then the average standalone
3 Part D premium is about 40 bucks?

4 A. That is correct.

5 Q. And then both -- whether you buy MA
6 or you buy traditional Medicare, you still have to
7 pay the traditional Medicare Part B premium, right?

8 A. That is correct.

9 Q. And how much is that now?

10 A. Sitting here today, I didn't commit
11 it to memory.

12 Q. Would you agree that it's -- if I
13 said it's \$104.90, does that seem reasonable to
14 you?

15 A. It seems reasonable, but I'm not --
16 sitting here today, I didn't commit it to memory,
17 so I don't know.

18 Q. Let's assume that the Part B premium
19 that everybody pays is about 100 bucks, and you've
20 got the average Medigap premium which is a little
21 over 100 and the standalone Part D premium which is
22 about 40. That's 240, right? That's on one side
23 of the scale. And on the other side of the scale,
24 you've got 5 percent of 118 at the most extreme.
25 That's about six bucks. Are you saying that for

1 that \$6 increase, there would be a substantial
2 number of people who would switch to Medicare plus
3 Medigap plus Part D?

4 A. Well, let's -- your hypothetical that
5 you've defined is -- we've used the term
6 incomplete -- is very incomplete for a variety of
7 reasons. If I may explain, I will. One, we know
8 today, given the choice between MA as you've
9 described with the premium of say zero to \$118
10 versus traditional Medicare with the costs that
11 you've described, the vast, vast majority of
12 consumers are picking traditional Medicare,
13 72 percent according to the data.

14 They're making a choice that they
15 prefer the traditional Medicare product with the
16 prices that you've described versus the MA product.
17 They've made that choice, and it's reflected in the
18 data, the consumer preference. Professor Gruber
19 talked about consumer welfare. I agree.

20 What they're describing, what they're
21 sort of saying to you, to me, to everyone here, to
22 your Honor, is that the value of the traditional
23 Medicare, the consumer surplus, the consumer
24 welfare that they receive from traditional Medicare
25 is great are than the value that they get from

1 Medicare Advantage for those 72 percent.

2 Q. But we're not talking about that
3 72 percent. We're talking about people who have
4 Medicare Advantage now and who have got to pay
5 another six bucks if they've got a \$118 plan or
6 another \$1.90 if they've got the average \$39 plan.
7 We're talking about them, and the question is, do
8 you think that for somebody who already has
9 Medicare Advantage, that \$6 or as little as \$1.90
10 increase in price would cause that person, how
11 likely is it that it would cause that person to go
12 over and buy traditional Medicare plus the other
13 two benefit packages?

14 A. And according to the data, the
15 switching data, the probability that in response to
16 a price increase they will switch from, say, the
17 Humana plan because we're using Humana to
18 traditional Medicare is higher than the probability
19 that they'll switch to any other MA plan.

20 So the data -- I'm not -- by the way,
21 I'm not making this up out of thin air as a matter
22 of theory. I'm just going to the data. The data
23 are telling me that's the answer, and that's why I
24 conclude that Medicare Advantage and traditional
25 Medicare are in the same market. If the data

1 produces different results, suggesting that
2 diversion, let's say, to traditional Medicare was 2
3 percent and diversion to MA plans was 98 percent,
4 I'd be sitting here saying it's an MA-only market.

5 **Q. I understand that there are different**
6 **ways of determining the product market. One way,**
7 **though, is to use the SSNIP test, isn't it?**

8 A. That is correct, and that's what I've
9 just described. You're not describing the SSNIP
10 test, though.

11 **Q. But how does what you said about**
12 **Aetna and Humana, how does that relate to the**
13 **question whether a 5 percent increase by a**
14 **hypothetical monopolist in the MA market would**
15 **cause the person with MA to switch to Medicare?**

16 A. Because you have to remember in the
17 hypothetical monopolist test that the \$5 -- the
18 \$118 plan goes up by roughly \$6, but the Aetna --
19 you've just described the Humana plan. The Aetna
20 \$118 plan or the \$110 plan or 120, whatever plan
21 they may -- we don't have the number there, would
22 also go up by 5 percent. So products would look
23 relatively similar.

24 And now consumers are saying, wait a
25 second, MA plans are more expensive. They're more

1 expensive. What am I going to do? I can stick
2 with MA. And by the way, there are a lot of people
3 who will stick with MA. I'm not saying that there
4 won't be. But a lot of people will say, you know
5 what -- and this is based on the empirical
6 evidence -- I'm going to go to traditional Medicare
7 because now traditional Medicare looks relatively
8 more cost effective for me. And so consumers will
9 then switch.

10 What I'm saying is, according to the
11 empirical data, and it lays itself out clearly, the
12 percentage of people who are going to go to
13 traditional Medicare are much greater than the
14 people who are going to stay inside of the MA space
15 and go to another MA plan. And that's precisely
16 the diversion rate calculation I did based on the
17 most recent paper by John Levin and the paper that
18 Professor Gruber himself cited from 2003 by Town
19 and his co-author.

20 **Q. But that diversion doesn't relate,**
21 **does it, to the \$6 increase in this case in the MA**
22 **plan, does it?**

23 A. Yes, it does. That's exactly what I
24 converted it to, because that measure in those
25 studies is -- is measuring based on a price

1 increase. So I am precisely doing the hypothetical
2 monopolist test and the SSNIP test in that
3 presentation that I made.

4 That's when, as you may have heard
5 during my direct, I switched -- I don't want to
6 use -- I changed from talking about switching rates
7 to the diversion ratio, and I described what the
8 diversion ratio was. And that's what that slide
9 where I got up and I talked about it, that's what
10 it did is it changed from talking about switching
11 rates to diversion ratios which would be based to
12 price increases, as you've just described, and what
13 it shows quite clearly is that diversion to
14 traditional Medicare is much higher than diversion
15 to other Medicare Advantage plans.

16 **Q. Can you show us the calculation you**
17 **did that shows that when Medicare Advantage raises**
18 **its rates by 5 percent, that a significant number**
19 **of people would then switch to traditional Medicare**
20 **plus Medigap plus Part D?**

21 A. Sure. So if we can go to slide 21 of
22 my presentation. May I stand up again, if that's
23 okay?

24 HEARING OFFICER ERICKSON: Please.

25 THE WITNESS: So what these two

1 models do, the John Levin paper and the Curto
2 paper, I like citing to John Levin because I know
3 him quite well and he's an old friend and he's very
4 talented, and the Town paper from 2003, which I
5 don't prefer because it's based on old data, is
6 it's using what's called a nested logit model.
7 And what the nested logit model does is it asks a
8 question that includes an outside good, which is
9 traditional Medicare, and then inside the nest -- I
10 often talk about these things as they're birds in
11 the nest, but the things in the nest are Medicare
12 Advantage plans.

13 And so what this sigma measures is,
14 in essence, the strength of the nest, how willing
15 customers are willing -- enrollees are willing to
16 choose just among MA plans or go outside of MA
17 plans. And so the strength of the nest is defined
18 by the magnitude of this, which will be between
19 zero and one.

20 Once you define the magnitude of the
21 strength of the nest, all of the calculations to
22 produce exactly what you just asked me to do, which
23 is what's the impact of a price increase, fall out
24 from the following information which I presented.
25 What's the share of MA penetration rate? What's

1 the share of Aetna within MA? What's the share of
2 Humana within MA? What's the share of all the
3 other plans within MA? And then the share of Aetna
4 relative to Medicare, traditional Medicare, Humana
5 relative to traditional Medicare and other relative
6 to original Medicare. The equation then just falls
7 out to produce these precise numbers. And I can
8 provide the backup material if you'd like, but
9 that's exactly how I calculated it.

10 **Q. I'll move on. But where is anything**
11 **on that chart showing the dollar amount of the**
12 **increase correlated with a certain percentage of**
13 **people switching?**

14 **A. Well, the diversion ratio by itself,**
15 **the sigma value, the diversion ratio is calculated**
16 **from the literature directly based on a**
17 **hypothetical price increase.**

18 **Q. We're talking now -- we're talking**
19 **about a specific price increase, a 5 percent of the**
20 **MA premium, and what I'd like to know is, where is**
21 **that dollar figure on that chart?**

22 **A. The dollar figure is undergirding**
23 **that sigma sign, the first line, the .32 and the**
24 **.58. Just so we're clear, the price increase is**
25 **actually done by a hypothetical monopolist. It's**

1 not done by Humana. It's not done by Aetna. It's
2 by an assumed monopolist that controls all the
3 products, and then you assume that it goes up
4 5 percent.

5 And that's exactly what those studies
6 have done, exactly the study that Professor Gruber
7 cites, which I don't like as much because it's
8 older. The newer study, it's estimating the
9 strength of competition between MA plans and MA and
10 traditional Medicare, asking the question of, if
11 there are price changes, how are -- how do people
12 move in response to that hypothetical price
13 increase, that SSNIP that you described.

14 **Q. So you're saying that the dollar**
15 **figure undergirds your sigma there, but it's not on**
16 **the chart?**

17 A. No, obviously not on the chart. It
18 doesn't say it on the chart, but that's how you
19 derive that figure is -- and I didn't measure that.
20 That's coming from the literature. That's
21 precisely how they've done it is they've measured
22 the degree of competition when there are price
23 changes between these products.

24 **Q. This is a model, though, right? This**
25 **is a model?**

1 A. No. It's based on actual data.

2 **Q. What is that based on?**

3 A. The Town data is based on 1993 to
4 2000 data. The Curto/Levin paper I believe is 2012
5 to 2014 data. I actually believe it's --

6 **Q. And do you know what it is? Again, I**
7 **apologize, but do you know what data they looked**
8 **at?**

9 A. Well, we can look it up if you like
10 because they're going to report their data right
11 here in the paper. I just -- I didn't commit to
12 memory the time frame, but it's -- you know, it's
13 more recent because it was published in 2015, and
14 they're using more recent information.

15 **Q. But to determine what a hypothetical**
16 **monopolist would do, you're saying they looked at**
17 **data, real-world data?**

18 A. That is correct. They have detailed,
19 detailed information on thousands of county and
20 year plans that they're getting from Medicare.

21 **Q. Detailed information on how much each**
22 **of these plans did what?**

23 A. How much -- what their premiums are
24 to consumers and what the costs and then the shares
25 and how many people are enrolling in those, and the

1 char-- the market characteristics of those
2 products.

3 **Q. Now, when we talk about whether one**
4 **firm constrains the pricing of another, what does**
5 **that mean?**

6 A. That if -- today if, you know -- I
7 have a Diet Coke next to me. If Diet Coke decided,
8 you know what, we're going to charge an extra 5 or
9 10 percent, there are marginal consumers --
10 remember, there's two types of consumers out there.
11 Economists would call them inframarginal and
12 marginal.

13 We could think about these as you
14 just read sticky consumers, people who have a
15 strong preference for Diet Coke, like me, and
16 people who are more willing to switch between Diet
17 Coke and Diet Pepsi.

18 **Q. So it's not a black and white issue;**
19 **some people will switch, some people won't?**

20 A. You could raise the price of Diet
21 Coke a lot before I'd consider switching because I
22 love it so much. My wife would never consider Diet
23 Coke because she's a Diet Pepsi person.

24 **Q. And at some point, depending on the**
25 **degree of substitutability, the products are in the**

1 same product market, right? That's what the SSNIP
2 test said? No? Okay.

3 A. You can run into what's called the
4 Cellophane fallacy. So if you raise the price --
5 if you raise the Diet Coke price to \$10 a can,
6 guess what, I'm not going to be drinking Diet Coke
7 because, given that I drink so many of them, it
8 would be too costly for me to drink it at \$10 a
9 can.

10 Q. Now, Whole Foods -- Whole Foods and
11 Safeway, they're not in the same market, are they,
12 same product market?

13 A. It's not an analysis that I've
14 conducted. It depends on the facts and
15 circumstances of that analysis.

16 Q. And what about big box superstores
17 like Home Depot and Staples, are they in the same
18 market as a mom and pop stationery store?

19 A. Given that I've analyzed that issue
20 more than anyone in this room and probably anyone
21 in the world, the answer is, from a retail
22 perspective, absolutely. They are in the same
23 relevant market.

24 I have done econometrics on this
25 issue. I could -- this could be great fun. But

1 the -- for me, not for anyone else.

2 But the answer is, in response to
3 that the prices for Office Max, Office Depot,
4 Staples are determined now competitively with --
5 because they face competition at the retail level
6 by tons of people. And that's why when Staples and
7 Office Depot, the last two office supply stores,
8 wanted to merge, the Federal Trade Commission did
9 not seek to block the merger on the retail side
10 because they concluded, as I had concluded, that
11 there would be no harm to retail customers because
12 of all the competition that's out there in the
13 market for office supplies.

14 **Q. But the court did conclude, didn't**
15 **it, that big box superstores were their own**
16 **markets?**

17 **A.** No, it did not. You're confusing
18 retail customers with big businesses. What the
19 court concluded is that there's a relevant market
20 for large customers. So this is customers --
21 Fortune 100 customers basically, customers who
22 spend more than a million dollars per year on
23 office supplies, or I'm sorry, more than \$500,000 a
24 year on consumable office supplies, and that the
25 market shares of Office Depot and Staples were

1 extremely high in that market.

2 They did not conclude that big box
3 stores -- or Judge Sullivan did not conclude that
4 big box stores were its own market because he did
5 not analyze the retail space, much to his chagrin.
6 He wanted to.

7 **Q. Was the merger consummated?**

8 A. No, but not because of the retail
9 side. It was not consummated because of the fact
10 that the judge concluded that they would control
11 too much space in the large customer market, not in
12 any other market.

13 **Q. Let's talk about another topic in one
14 of your favorite documents. Could you tell us what
15 the HHI is?**

16 A. Sure. And just because this is -- I
17 want to be technical, the representative from the
18 Insurance Division got it slightly wrong. I'm
19 being real technical here. It's actually the
20 market share times 100 squared for each market
21 participant.

22 And so we'll -- it will reflect a
23 value of essentially close to zero if the market is
24 very diverse and there's thousands and thousands of
25 competitors, and it will equal 10,000 if there's a

1 monopolist.

2 Q. And the merger guidelines say, don't
3 they, that the HHI is the way that you measure
4 concentration?

5 A. It includes the HHI guidance, but the
6 guidelines I would say have moved beyond just
7 solely basing any conclusions based on the HHI.

8 Q. Sure. It's not conclusive, right?
9 The HHI isn't conclusive?

10 A. The HHI provides guidance about which
11 mergers need further investigation, but you must
12 first calculate a market or determine a market in
13 order to accurately measure market shares. And so
14 all the evidence that I've discussed today and that
15 you and I have discussed shows quite clearly that
16 you have to include traditional Medicare in that
17 relevant product market.

18 Q. Okay. Well, let's assume that you
19 did conclude -- that you did include traditional
20 Medicare in the relevant market. Did you calculate
21 a HHI including traditional Medicare in the market?

22 A. No, but I can do that right now if
23 you'd like me to.

24 Q. Sure. Doesn't have to be exact.

25 A. Well, you'd have 72 -- traditional

1 Medicare would be you'd have 72 percent squared, so
2 it would be just around -- just under 5,000 for
3 traditional Medicare. And then you'd add 60 --
4 8 percent and 6 percent, so you'd add 36 and --
5 you'd have a number that's in the low 5,000s, and
6 the combined merger would be quite modest given the
7 size of the dominant player, which would be
8 traditional Medicare in the marketplace.

9 **Q. Well, can you agree, then, that under**
10 **the HHI, that even were the market to be defined as**
11 **traditional Medicare plus MA, that's a highly**
12 **concentrated market, correct?**

13 **A.** It's a highly concentrated market,
14 but it's precisely for these reasons that when you
15 strengthen the second and fourth strongest
16 competitors in the market, I think those are the
17 numbers here in Missouri, that allows them to more
18 effectively compete against the big player.

19 I don't think that anyone would worry
20 about a merger where the combined entity has
21 14 percent of the market. It's just not something
22 that as a matter of competition economics or a
23 matter of competition law as I know -- and I'm not
24 a lawyer, but as I understand it, that anyone would
25 ever worry about.

1 Q. Well, but don't the guidelines worry
2 about it? The guidelines say in a highly
3 concentrated market, and we agree that the market
4 even defined to include traditional Medicare is
5 highly concentrated, that if the merger would cause
6 an increase in the HHI of between 100 and 200
7 points, that it potentially raises -- and clearly
8 this would, right? Instead of squaring 6 and
9 squaring 8, you square 14.

10 A. But then you subtract the 6 and 8.

11 Q. Right. So it's not over 200, but
12 it's between 100 and 200, if you do the arithmetic.

13 A. I think it's actually less than 100.

14 Q. Well, if we assume --

15 A. 14 squared --

16 MR. WHITMER: Would you like a
17 calculator?

18 THE WITNESS: It's 64 plus 36, so
19 it's 100, and 14 squared is less than 200, so by
20 definition it's less than 100. You'd be in safe
21 harbor.

22 MR. WHITMER: Your Honor, may I
23 provide the witness with a calculator?

24 HEARING OFFICER ERICKSON: I'm sorry?

25 MR. WHITMER: May I provide the

1 witness with a calculator? He's being asked to do
2 some math.

3 THE WITNESS: I mean, it's less than
4 100. I can tell you it's less than 100 because the
5 market shares here are on page 18.

6 BY MR. ANGOFF:

7 Q. What about -- go back to page 21, if
8 you would, and let's use the numbers, your numbers
9 from there, a 9 percent share and a 6 percent
10 share.

11 A. That's not the overall shares. Those
12 are Aetna relative to Medicare, not Aetna as a
13 share of the total market. To do Aetna as a share
14 of the total market, you go to page 18, sir.

15 I can do the arithmetic real quickly.
16 So it's 103. So the pre-merger combination of the
17 two is 103, and the post-merger combination is 198.
18 So it would be less than 100. So then, as a
19 result, it would not meet the threshold, so it
20 would be in safe harbor and the merger should be
21 allowed in Missouri.

22 Q. If you --

23 A. And that's before any other
24 consideration that no one really ever worries about
25 a 14 percent market share.

1 Q. And that's if you consider the MA
2 plus Medicare market to be a statewide market,
3 right? We're talking about statewide data here?

4 A. That is correct.

5 Q. Okay. Did you conduct an HHI
6 analysis on county markets?

7 A. No.

8 Q. No?

9 A. No, I did not.

10 Q. Why not?

11 A. Because just in the interest of time.
12 There are, I think I heard, 115 counties, and one
13 would have to do it county by county.

14 Q. Well, you're not saying, are you,
15 that the geographic market for Medicare Advantage
16 is the state?

17 A. No. I'm saying -- well, there's two
18 elements to this, so let's be clear.

19 MR. WHITMER: I'm going to object to
20 the question to the extent it calls for a legal
21 conclusion. It's addressed in the statutes of this
22 state. But with that, I have no problem with
23 him --

24 HEARING OFFICER ERICKSON: I think
25 the witness was prepared to testify. You may

1 proceed.

2 THE WITNESS: I was going to say,
3 it's a little complicated here. So it's not a
4 precise calculation that I've done, so I -- let's
5 be clear about that.

6 There's -- as I understand the state
7 rules, if you provide insurance in the state, and I
8 was listening earlier, you have the ability,
9 according to your license, to enter anywhere else
10 in the state, and maybe I'm misguided, which would
11 suggest that entry is quite easy.

12 And that rapid entrant would be
13 assigned a market share, and when one -- according
14 to the guidelines, we can go to Section 9 of the
15 guidelines if you like, assuming a SSNIP in that
16 local area. And so once you did that, you would
17 include all the potential entrants in the market,
18 and there's -- you'd end up roughly back at these
19 market shares that are at the state level, so you'd
20 end up in the same safe harbor.

21 BY MR. ANGOFF:

22 Q. If you -- if it is the case that a
23 seller who's licensed in a county and only that
24 county can only sell in that county, and a buyer in
25 that county can only buy in that county, doesn't

1 the geographic market have to be the county?

2 A. If they're setting prices at that
3 level -- this is how much they like my testimony.

4 HEARING OFFICER ERICKSON: One
5 moment. Off the record.

6 BY MR. ANGOFF:

7 Q. Would you like me to repeat the
8 question?

9 A. Yes.

10 Q. If the seller legally can only sell
11 in the county and the buyer legally can only buy in
12 the county, doesn't the county have to be the
13 geographic market?

14 MR. WHITMER: Objection, again, to
15 the extent it calls for a legal conclusion,
16 addressed by the statute before your Honor.

17 BY MR. ANGOFF:

18 Q. According to the guidelines. We're
19 speaking about the guidelines.

20 A. According to the guidelines, it does
21 not have to be, no.

22 Q. Why not? Explain how in that
23 situation the market can be bigger than the county.

24 A. If the firms find efficiencies for
25 setting prices across counties harmoniously, then

1 that will -- that would suggest that the market is
2 broader because in that situation they're setting a
3 single price for a bigger area, and so the relevant
4 market covers that single area which has a single
5 price.

6 **Q. Even if the buyer can only buy in the**
7 **county?**

8 A. Even if buyer can only buy in the
9 county. So, for example, I can only -- like for
10 cable service, I can only buy cable from the cable
11 company that has wire into my house. I can't buy
12 any other cable company. Can't.

13 The relevant market isn't my house.
14 That doesn't make any sense, because they're not
15 setting prices to just my house. They're setting
16 prices on a more aggregate basis. So the relevant
17 geographic market in that circumstance will be the
18 scope of the geography over which prices are set,
19 and so that's why it can much broader than the
20 circumstance you just gave me.

21 **Q. But the cable guys, though, the law**
22 **doesn't prevent you from buying others?**

23 A. Yes, it does. There are cable
24 franchise areas.

25 **Q. But the law does not impose a duty on**

1 **you, does it?**

2 A. I can't -- I can only buy from the
3 entity that has a wire into my house. That's my
4 only choice.

5 **Q. I mean, that's a matter of practice,**
6 **but the law does not -- there's no law prohibiting**
7 **it?**

8 A. But there's a law -- I mean, we're
9 getting far afield, but I'll just do it for a
10 second. If Comcast has the cable franchise area,
11 Time Warner can't provide cable service without
12 getting a cable franchise in that area, and so they
13 can't have a wire into my home, so they're not a
14 competitive option.

15 But when one thinks about a
16 geographic area, if prices are set across the whole
17 MSA, the whole metropolitan standard area, and
18 Comcast has half the market and Time Warner has
19 half the market, the agencies will look at a much
20 broader market than my home.

21 **Q. So is your opinion that the market in**
22 **MA is broader than the county?**

23 A. That's not an analysis I've
24 conducted, so I don't have an opinion whether the
25 market is the county level or the state level or

1 somewhere in between.

2 Q. Okay. And you don't think, do you,
3 that people in St. Louis as a practical matter can
4 buy -- that it makes sense for them to buy coverage
5 from a carrier in Kansas City that has a network in
6 Kansas City, not in St. Louis?

7 A. That's not the relevant question for
8 determining the relevant geographic market.

9 Q. Could you please answer that
10 question?

11 A. I'm not saying that they -- no. I
12 agree with you. If I -- if I'm in St. Louis, I'm
13 not going to buy from a provider who's just serving
14 Kansas City. I agree with you that proposition, if
15 that provider is also not providing coverage in
16 St. Louis. But that again isn't the relevant
17 question for determining the relevant geographic
18 market.

19 Q. Now, you mentioned earlier that
20 you've done some work on efficiencies, correct?

21 A. Not with regard to this merger. I've
22 done --

23 Q. No. Right.

24 A. -- efficiencies generally.

25 Q. Did you say that you were -- that

1 **you'd written an article about efficiencies?**

2 A. I have one that's coming out very
3 soon, yes.

4 **Q. And what does that concern?**

5 A. Two issues. One is there's a
6 footnote in the merger guidelines that talks about
7 whether you can count so-called out-of-market
8 efficiencies if they're inextricably linked. And
9 the way the footnote is written is it describes it
10 in the context of supply side efficiency, so let's
11 assume a network effect.

12 So this is like an airline. You get
13 to count the efficiencies on a route from, say,
14 St. Louis to San Francisco. Even if there's harm
15 potentially on another route, you get to offset.

16 The paper talks about that it should
17 also be broadened to include demand-side
18 complementarities, and that definition of
19 inextricably linked should be broader than is
20 outlined in the guidelines. That's number one.

21 The second part is, the guidelines
22 talk about the standard of likely. And when you
23 get to litigation, it's not clear as a matter of
24 economics that there should be a bright line test,
25 that if the probability of efficiency is 51

1 percent, it gets counted fully at 100 percent, and
2 if the probability that efficiency will occur with
3 the merger is 49 percent, it doesn't get counted at
4 all.

5 And so what I discuss is, in the
6 context of litigation, the standard should go to
7 what economists would like, which is an expected
8 value concept. And so the paper covers those two
9 topics.

10 **Q. So you believe that the standard in**
11 **the guidelines with respect to efficiencies is too**
12 **strict as a matter of economics?**

13 A. No. The guidelines -- remember, the
14 guidelines are from the Department of Justice and
15 the Federal Trade Commission. I'm not suggesting
16 as part of that paper that they should change their
17 regulatory review process. I think it's
18 appropriate that the burden remain on the parties.
19 The Department of Justice and the Federal Trade
20 Commission have a hard enough job as it is to
21 review mergers and do quickly, to shift burden to
22 them.

23 What I'm saying is if you get the
24 litigation process where there's more discovery,
25 more time spent, that a more thorough estimate of

1 efficiencies based on expected values should be
2 used, and that could have -- efficiencies could go
3 up or down depending upon the expected value. So
4 it's not an unambiguous answer. Whether the
5 guidelines are too strict or too lenient will
6 depend on the facts and circumstances of the
7 situation, but it's outside the guidelines and more
8 towards a litigation circumstance.

9 **Q. So you're suggesting that the courts**
10 **should be more thoughtful with respect to whether**
11 **they accept an efficiencies defense?**

12 A. Courts are very thoughtful. I'm not
13 going to use that terminology. What I'm going to
14 say is they should use a more economics-based
15 measure instead of a bright line test.

16 **Q. Now, in doing your research about**
17 **Missouri for this -- for this report, did you find**
18 **in Missouri that there were Missouri counties in**
19 **Missouri where a competitor would be eliminated in**
20 **the MA market than in any other state in the**
21 **country?**

22 A. I didn't count counties that way, so
23 I can't tell you one way or the other.

24 **Q. Did you look at the counties with**
25 **respect to which the Justice Department has issued**

1 a second request?

2 A. Yes. I've examined that closely.

3 Q. Okay. Did you count those?

4 A. I just haven't counted them in the
5 way that you described.

6 Q. But you don't know deny, do you, that
7 in Missouri there are a great many counties that
8 are that way, that the merger would eliminate a
9 competitor?

10 MR. WHITMER: Objection. Can we have
11 a sidebar?

12 HEARING OFFICER ERICKSON: Actually,
13 I'd like the question answered. The witness
14 indicated that he was familiar with the material
15 generally, and the question is a very general
16 question. Please answer.

17 MR. WHITMER: Ms. Erickson, could we
18 have the question read back? There's a
19 confidentiality issue. I'm not trying to be
20 difficult. It deals with confidential -- if we
21 could have the question read back, I'd appreciate
22 it, and I'm requesting a sidebar.

23 HEARING OFFICER ERICKSON: Let's have
24 the question read back and then approach.

25 (THE REQUESTED TESTIMONY WAS READ BY

1 THE REPORTER.)

2 MR. WHITMER: If we could have a
3 short sidebar.

4 HEARING OFFICER ERICKSON: We're off
5 the record. Please approach.

6 (AN OFF-THE-RECORD DISCUSSION WAS
7 HELD.)

8 HEARING OFFICER ERICKSON: We're back
9 on the record. Mr. Angoff, please proceed.

10 BY MR. ANGOFF:

11 Q. Mr. Orszag, you agree that the
12 Aetna/Humana merger would have differing impact in
13 different states, correct?

14 A. That's correct.

15 Q. And you've done enough analysis of
16 the merger, haven't you, to know that Missouri is
17 one of the states in which it would have a very
18 substantial impact?

19 A. Well, with the qualification is a
20 substantial impact, I think the right way to say it
21 is it's a merger where they're both overlapping
22 today, where there's some states where they don't
23 overlap.

24 Q. So you would agree that there are
25 many more counties in Missouri in which Humana and

1 **Aetna overlap with respect to Medicare Advantage**
2 **than in most other states?**

3 A. It's, A, not an analysis that I've
4 conducted counting up counties. And, B, I wouldn't
5 do it that way. I think the right way to think
6 about it as a percentage of Medicare-eligible
7 beneficiaries because each state defines counties
8 differently. So you could have one state that just
9 has a bunch of big counties and one state that has
10 a bunch of small counties geographically and, as a
11 result, you could have more counties in one state
12 than in another. And so you're defining a county
13 as I would define it in terms of people.

14 Q. Fine. Let's define it your way.
15 Would you agree that defined as a -- using the
16 metric percentage of Medicare beneficiaries,
17 Missouri is a state where more are affected than in
18 most other states?

19 A. With the caveat that it's not an
20 analysis that I've done, I'm not going to -- I have
21 no basis to agree or disagree with your
22 proposition.

23 Q. Well, you really do, though, don't
24 you, because in your -- in your report, which is
25 not public, there are lots and lots of maps, aren't

1 **there, showing a substantial impact in Missouri?**

2 A. With the caveat that those -- I,
3 A, didn't commit them to memory; but B, I also
4 don't know as a share of the number of
5 beneficiaries, I don't rank order states. And so I
6 have no way to give you an answer one way or the
7 other.

8 The concept that there are a number
9 of counties in Missouri and there are some states
10 where there's overlaps in other states isn't
11 something that I will disagree with.

12 **Q. Well, let's see if we can refresh**
13 **your recollection. My apologies, Mr. Orszag.**
14 **We'll come back to that if we can. Let's move on.**

15 A. Okay. Sure.

16 **Q. And let's talk about some things that**
17 **I think you will agree with Professor Gruber about.**
18 **One, you do agree, don't you, that the health**
19 **status of those who enroll in Medicare Advantage is**
20 **better than the health status of those in**
21 **traditional Medicare?**

22 A. With the caveat that when we're
23 talking about on average. In terms of marginal
24 customers, I do not agree with him.

25 **Q. Okay. But on average, you do?**

1 A. On average, I have no basis to
2 disagree with him, no.

3 Q. And you also agree, don't you, that
4 when he makes the point he made in his fourth -- he
5 made it in his fourth point, I think you said that
6 his third and fourth are pretty much the same, but
7 the concept that applies in both cases is, isn't
8 it, that because in more highly concentrated
9 markets consumers get less benefit or another -- or
10 insurers raise their prices, there's either case
11 there's less consumer welfare.

12 Professor Gruber's point is, isn't
13 it, that that shows that Medicare Advantage is the
14 market because if traditional Medicare were in the
15 market, the traditional Medicare share would dwarf
16 the shares of MA and, therefore, there wouldn't be
17 a correlation, a substantial correlation based on
18 the concentration among MA carriers, correct? And
19 I apologize for the long-windedness and
20 convolutedness.

21 A. I think I understand your question,
22 and if I may recharacterize it very quickly, which
23 is that you're saying, according to Professor
24 Gruber, if market structure -- he's saying market
25 structure has an effect on market outcomes, and

1 that's evidence that MA is its own product market.

2 And what I described, I hope clearly,
3 but I'll try again right now, is that he bases that
4 conclusion on very old data, prior to Obamacare,
5 some of the data prior to the introduction of even
6 Med-- some time periods are before even Medicare
7 was more formalized with Part C or Part D was
8 introduced. And I have no basis to disagree with
9 that conclusion from long ago, and I don't know if
10 they controlled for costs appropriately.

11 What I'm saying is, based on my
12 analysis for not only national but also Missouri
13 for the last several years, the evidence is
14 unambiguous that there is no correlation, no
15 relationship between market structure of MA and
16 outcomes, which is strong evidence, strong
17 empirical evidence that traditional Medicare and
18 Medicare Advantage are in the same product market.

19 **Q. But you don't disagree with -- I**
20 **understand your objection to the age of the data.**
21 **But you don't disagree with the concept that if**
22 **concentration within the Medicare Advantage market**
23 **affects benefits or prices, that is an indication**
24 **that Medicare Advantage is an antitrust product**
25 **market?**

1 A. With -- there are a number of caveats
2 around that, but I think I can agree to the general
3 proposition. But empirically I've tested that and
4 it doesn't prove -- it doesn't come out
5 empirically.

6 Q. So it's a -- you can agree that it's
7 a general proposition, but it doesn't come out
8 empirically. Can you explain that?

9 A. Yes. So if -- there are
10 circumstances where the introduction of a market
11 structure of MA can have an effect on outcomes and
12 traditional Medicare is still in the relevant
13 product market. That -- so that's why I said --
14 you said if a change in the market structure of MA
15 has an effect on market outcomes, that suggests MA
16 is its own market. I said I can come up with
17 theoretical models where that's not the case, where
18 you'd still have traditional Medicare in the
19 market. That's why I agreed with you. Generally,
20 your proposition is correct.

21 I have tested that question
22 empirically. That was all the slides after
23 slide 21, and it shows overwhelmingly there's no
24 empirical effect relationship between market
25 structure and outcomes.

1 If we turn to slide, for example, 24
2 in my presentation, that shows that there's
3 relationship between the number of competitors,
4 two, three, four, five, and --

5 **Q. Wait a minute. When you're saying**
6 **you tested things empirically, that means, doesn't**
7 **it, that you're relying on articles?**

8 A. No.

9 **Q. It means -- did you do your own**
10 **independent research?**

11 A. This is all my own independent
12 research. This is all data directly from CMS,
13 supplemented by data from the companies and
14 additional third-party data. These are all my own
15 empirical -- and I hope that was clear during my
16 direct, but I'll say it again.

17 Starting on slide No. 18, everything
18 that I did, except for that estimate of sigma where
19 I described that came from the papers, everything
20 is my open empirical analysis. So, for example,
21 not to bore everybody, but I do like this kind of
22 stuff. If we turn to slide 27, we have all kinds
23 of econometric results right here. These are all
24 my own analyses with my colleague, Bryan Keating.

25 **Q. And the sigma, what did you say about**

1 **the sigma?**

2 A. When I was up there before and I
3 described I got that parameter value from two
4 papers in the literature, that's the only piece of
5 that entire back half of my analysis that was
6 derived by somebody else.

7 **Q. I got it.**

8 A. Everything else that I did are my
9 econometric analysis involving thousands of data
10 points and observations.

11 **Q. I would like to refresh your**
12 **recollection. I found the document I was looking**
13 **for. Do you have Exhibit K in front of you?**

14 A. Yes, I do.

15 **Q. Could you turn, please, to page 69.**

16 HEARING OFFICER ERICKSON: I'd advise
17 counsel to be cautious. Thank you.

18 MR. ANGOFF: I'm sorry, your Honor?

19 HEARING OFFICER ERICKSON: I would
20 advise counsel to be cautious in proceeding as this
21 is a closed record. Thank you.

22 MR. ANGOFF: And I will, your Honor.

23 BY MR. ANGOFF:

24 **Q. Does that reflect your -- does that**
25 **refresh your recollection as to whether or not the**

1 **Aetna/humana merger would have a more substantial**
2 **effect in Missouri than in most other states?**

3 A. I'm going to have -- I'll agree in
4 part and disagree in part. These are based on
5 counties as defined by the U.S. Department of
6 Justice. They haven't obviously completed their
7 investigation.

8 MR. WHITMER: Objection.

9 HEARING OFFICER ERICKSON: I instruct
10 the witness to stop. I don't think that was the
11 question asked. I think that there is a very
12 straightforward answer here, and if we are starting
13 to get into areas that we should not, then we need
14 to approach. But I think the question was very
15 straightforward, and the witness can either answer
16 it based on observing the document now that the --
17 it is in the record, what exact exhibit and page
18 number. Can you answer the question?

19 THE WITNESS: With the caveat this is
20 based on counties, not people, I would do this on
21 people, so I can't answer the question precisely.

22 HEARING OFFICER ERICKSON: And is
23 there something else that you need to pursue? If
24 so, then please approach.

25 MR. ANGOFF: Yes.

1 (AN OFF-THE-RECORD DISCUSSION WAS
2 HELD.)

3 HEARING OFFICER ERICKSON: We're back
4 on the record.

5 BY MR. ANGOFF:

6 Q. Mr. Orszag, you've been very patient.
7 I've only got a few more questions.

8 A. Thank you.

9 Q. Your -- are you affiliated with the
10 Center for American Progress in any way?

11 A. Yes, I am.

12 Q. And you're a fellow?

13 A. I think I'm actually a senior fellow.

14 Q. Okay. And you know, don't you, that
15 CAP put out a paper on this merger, correct?

16 A. Yes, I do know that.

17 Q. I take it you disagree with their
18 conclusion?

19 A. To say the least, the econometrics in
20 there -- and I'm going to try to be nice, but it's
21 actually hard given how poor the econometrics are
22 in that paper. They don't control for cost, which
23 I described earlier as a critical measure, and
24 they -- the paper suffers from so many flaws that
25 it's -- it's really shoddy work.

1 Q. Well, I guess --

2 A. Let me finish. I mean, I had a long
3 talk with relevant folks about how bad it was and
4 why it was bad, and so I can just say that it's not
5 the type of literature that equates to, say, the
6 papers that were published that I described
7 earlier.

8 Q. You're not going to resign from your
9 position as senior fellow with CAP over it, though?

10 A. I don't do health care stuff with
11 them, so there's no reason that I can -- I do
12 believe that you can disagree with some people. I
13 don't agree with all my partners all the time. I'm
14 sure John Gruber doesn't agree with all of his
15 colleagues at MIT all the time. You can reasonably
16 disagree in a thoughtful world and still be
17 colleagues.

18 Q. You referred in Exhibit K on page 41
19 to the A. Dunn paper. Do you see that?

20 A. Yes, I do. I know the paper quite
21 well.

22 Q. Okay. And what -- in the top
23 right-hand corner there, what do you conclude about
24 these? How do you characterize the A. Dunn paper?

25 A. Is that if you actually studied the

1 results, it's consistent with substantial
2 competition between Medicare Advantage and
3 traditional Medicare.

4 Q. But didn't the A. Dunn -- really
5 isn't that not true? Didn't the A. Dunn paper, in
6 fact, say that competition among private insurers
7 in a county may lead to more affordable and
8 generous benefits beyond what is covered under
9 traditional Medicare?

10 A. The answer is he has that line, but
11 if you actually go to his results, it's -- the
12 results are -- what happens -- and this is going to
13 take a second to describe. What he describes as a
14 market when you have a new product that comes out,
15 a new MA product, customers --you see that MA plan
16 gain market share. And he takes that as evidence
17 that it's an MA-only market.

18 But if you actually think through the
19 economics, and this is something that we will
20 engage the Department of Justice at the appropriate
21 time, the --

22 MR. WHITMER: Objection.

23 THE WITNESS: The economics is clear
24 here that -- that the shift, some of that shift,
25 according to his own paper, comes from traditional

1 Medicare. And so it's just people who prefer that
2 new option moving from traditional Medicare to
3 Medicare Advantage, which is entirely consistent
4 with the kind of competitive forces that I was
5 describing.

6 BY MR. ANGOFF:

7 Q. So when A. Dunn says, For antitrust
8 investigators, evidence of competition among MA
9 insurers demonstrates that the relevant product
10 market may be as narrow as MA insurance, you
11 disagree with that conclusion?

12 A. Two caveats. One, it's based on
13 older data, but with the caveat that if you
14 actually look at his conclusion, he's drawing a
15 conclusion based on share shifts, not on -- on
16 share gains, not on share shifts.

17 Q. Before you go, I'd like you to
18 explain once again why -- I thought maybe I didn't
19 ask you this exact question. Aetna and Humana are
20 both Medicare Advantage carriers, right?

21 A. That is correct.

22 Q. Okay. But you said, didn't you, that
23 traditional Medicare, which has different benefits,
24 is a closer substitute to the Medicare Advantage
25 plan than another Medicare Advantage plan, right?

1 A. According to the data, I'm letting
2 the data -- I'm not drawing this based on theory.
3 The empirical evidence is saying that consumers
4 would move -- are more likely to move from Aetna MA
5 plan to traditional Medicare than to another -- or
6 to Humana's MA plan.

7 **Q. That's not the question. The MA --**
8 **the MA plan -- Humana and Aetna MA plans have**
9 **benefits, don't they, that are closer to each other**
10 **than Medicare benefits are to either, correct?**

11 A. As a general proposition, I'm not
12 going to disagree with as -- if the look at the
13 products that they line up that way --

14 MR. ANGOFF: Okay. No more
15 questions, your Honor.

16 MR. WHITMER: May we do redirect,
17 your Honor?

18 HEARING OFFICER ERICKSON: One
19 moment.

20 QUESTIONS BY HEARING OFFICER ERICKSON:

21 **Q. Mr. Orszag, in preparation for today,**
22 **did you consider -- well, you've mentioned the**
23 **Horizontal Merger Guidelines; is that correct, sir?**

24 A. Yes, ma'am.

25 **Q. And who puts those forth?**

1 A. The U.S. Department of Justice and
2 Federal Trade Commission, and they're updated every
3 10 to 15 years. I mean, it was 1992, 1997, and
4 then 2010 was the last update.

5 **Q. And have you reviewed or sought to**
6 **review any guidelines or definitions, white paper,**
7 **anything from the National Association of Insurance**
8 **Commissioners?**

9 A. I've been exposed to the varies
10 documents from, I believe the acronym is NAIC.

11 **Q. That's correct.**

12 A. But I didn't commit those to memory.

13 **Q. Did you use any definitions,**
14 **guidelines, white paper, other information from the**
15 **NAIC in reaching -- in your analysis?**

16 A. No. I'm basing my analysis on the
17 data from Medicare, from the parties, and the
18 economic literature.

19 **Q. I'm going to reflect a few words that**
20 **you've said, that the government competes**
21 **vigorously in this market.**

22 A. Traditional Medicare does. That
23 product is a vigorous competitor to the MA products
24 in the sense that consumers choose it
25 significantly.

1 Q. And so I just want to make sure I
2 understand. Does the government vigorously
3 advertise and market, such as a private insurer
4 would?

5 A. The government's a little different,
6 so the answer is not really. I mean, what the
7 government does is it makes information available.
8 And one way to think about it from an economic
9 perspective is it's the outside good, it's the --
10 it's the default for a lot of people. So they go
11 to the government website, and Medicare.gov, as we
12 saw, gives that choice. And the way I think you
13 should think about it, that we all should from an
14 economic perspective is if the parties try to raise
15 price or decrease quality, fewer people when they
16 go to that Medicare.gov site are going to pick the
17 Medicare Advantage option. Relatively more people
18 pick that traditional Medicare option, and that
19 will unprofitable for Medicare Advantage.

20 Q. In your econometrics analysis, did
21 you consider any other factors that may lead to the
22 diversion or the shift of consumers from an MA
23 product to a traditional Medicare product?

24 A. Yes. I looked at -- made a number --
25 I did a number of different econometric analyses.

1 So let's just be clear about this. In terms of the
2 market structure, an impact on outcomes that I
3 described, the controls are -- I'm sorry that it's
4 so small -- are listed right here. So it includes
5 a number of competitors, medical costs, non-medical
6 costs, the CMS benchmark rate, whether the plan is
7 a local PPO, whether it's a regional PPO, whether
8 it's a private fee for service plan, the number of
9 Medicare eligibles available in the area, the year
10 and what's called county fixed effects. It allows
11 for different controls. In certain specifications
12 I did that. So I had a number of controls, and
13 this is embodied in page 27 and page 28.

14 Q. Thank you. I was just going to let
15 the record reflect you're referring to for your
16 demonstrative page 27 and 28. I see a lot of
17 numbers. I want to talk people.

18 A. Yeah.

19 Q. Individual consumers choosing from
20 this array of products. You're an economist. You
21 understand consumer behavior. Tell me what are
22 some of the factors the consumers may be thinking
23 about discussing with their husband, their wife,
24 their loved ones, regarding what should they do.

25 A. Obviously price is an important one.

1 I mean, we -- price is going to be -- to a lot of
2 people who are budget constrained, that will maybe
3 define the decision for them. To some people it
4 may be they love their doctor and so it's whether
5 they get access to their doctor or not, and that
6 will define the issue for them. To some it will be
7 a combination of the two. To some it may be they
8 expect to have high drug costs, for example, and so
9 they want a plan that delivers those drug costs at
10 a low rate.

11 I think we all experience this. I
12 don't know, obviously, the plan that you have for
13 the State of Missouri, not Medicare but just your
14 health care plan today. But since fortunately,
15 despite my diet, I'm relative healthy, I choose a
16 plan that has a high deductible and relatively low
17 premiums and take some of that risk myself
18 personally.

19 But there are many people who go the
20 opposite direction, that they want to choose plans
21 that have low premium -- I mean they're willing to
22 pay higher premiums because they don't want to be
23 out of pocket if they get sick.

24 So it's a combination of, in essence,
25 the factors that are outlined on page 12 of my

1 presentation where you look at -- people are
2 looking at each of these products. Some people
3 want vision. Some people -- personally, I'm
4 personalizing this because it's easy to do that. I
5 false find that my dental is never covered. So I'm
6 always like, why am I paying for dental when every
7 dentist I've ever gone to doesn't seem to take it
8 or I get paid back like \$10, and I feel like I'm
9 out of pocket more than the premium. So I don't
10 bother with that.

11 So even person's making a decision
12 based on factors that are right here, and those
13 factors are, there's an economic concept called
14 revealed preference. Paul Samuelson won the Nobel
15 Prize for it. And what consumers are doing is
16 they're revealing their preferences between the
17 competing plans with the vast majority of consumers
18 deciding that traditional Medicare is the option
19 for them.

20 But we also see customers move -- I
21 mean enrollees moving back and forth, every year
22 deciding which one they think is better for them
23 than the other one. And that's what's defining the
24 ability of Aetna and Humana to price, because if
25 they, say, price too aggressively, they got it

1 wrong, more customers are going to stay with
2 traditional Medicare and they're going to lose that
3 opportunity to serve those people, and that's
4 what's driving their decisions today, more so than
5 losing a customer to each other.

6 And so there's not an easy answer to
7 your question because everyone's different, and
8 we're all making decisions based on factors that
9 are very personal to us and our own health
10 situations. So those are then going to be
11 reflected in how people sort themselves across the
12 products.

13 **Q. Have you done any analysis regarding**
14 **consumer -- the correlation of consumer ability to**
15 **pay and decline of consumer health as they age**
16 **leading them to maybe move into traditional**
17 **Medicare?**

18 A. No, I have not.

19 **Q. Is that a consideration?**

20 A. It is a potential consideration. I
21 am not sure if there's data -- I need to think
22 about whether there's data available to analyze at
23 that level of detail, but it's not something I'm
24 familiar with.

25 HEARING OFFICER ERICKSON: Thank you

1 for your indulgence. Would you like to do any
2 redirect?

3 MR. WHITMER: I would, your Honor.

4 HEARING OFFICER ERICKSON: Will it
5 take a while?

6 MR. WHITMER: Not too long.

7 HEARING OFFICER ERICKSON: How long
8 can you go?

9 THE WITNESS: I'm fine if everyone
10 else is.

11 MR. WHITMER: I think we can proceed.

12 HEARING OFFICER ERICKSON: Proceed.

13 REDIRECT EXAMINATION BY MR. WHITMER:

14 Q. Thank you, Mr. Orszag. At the very
15 end of your cross-examination, you were in the
16 middle of answering a question and you didn't get
17 to finish the answer. Do you remember the question
18 and do you remember what you wanted to say you
19 didn't have a chance to say?

20 A. I think the question was something,
21 are there differences in the plans or are the MA
22 plans of Aetna and Humana more similar than the
23 benefits offered by traditional Medicare. And I
24 was saying yes; however, in the data we observe
25 that customers are viewing traditional Medicare as

1 a closer substitute than -- than each plan.

2 I've seen this before. In a merger
3 of the satellite TV providers, a proposed merger of
4 DirecTV and AquaStar, one observed that people
5 viewed going to cable as a closer substitute than
6 moving between the satellite providers. So even
7 though the entities look alike, sometimes they're
8 not as close substitutes as the bigger player in
9 the market because people's minds, the way they
10 think about it is the choice is between traditional
11 Medicare and Medicare Advantage, not between the
12 Medicare Advantage plans for some people.

13 Q. So you have Exhibit K in front of
14 you. If you could turn to page 27. You were asked
15 questions about the differences between traditional
16 Medicare and Medicare Advantage as it pertains to
17 age, for example. Does this document, this page
18 reference that issue?

19 A. This has averages for different
20 demographic characteristics, yes.

21 Q. And where did you get the data that's
22 set forth on this specific page?

23 A. It's from a survey conducted by AHIP.

24 HEARING OFFICER ERICKSON: Could you
25 explain what AHIP is, please?

1 THE WITNESS: It's the Association of
2 Health Insurance Plans, I believe is the full
3 acronym.

4 BY MR. WHITMER:

5 Q. Is this publicly available data, sir?

6 A. Yes, it is.

7 Q. Then with respect to this page, what
8 can you tell -- what does it tell us about the
9 differences between Medicare Advantage and
10 traditional Medicare with respect to age groups?

11 A. With regard to age and female/male,
12 you see relative similarities. These are averages.
13 Just so I make it clear on the question that your
14 Honor asked was with regard to you would need
15 microdata to do econometric analysis that was asked
16 of me. This is averages from a survey. So the
17 averages look -- each of the type of plans look
18 relatively similar. There's some modest
19 differences, but they're relatively similar.

20 Q. So as we're considering the
21 demographic differences between Medicare Advantage
22 on one hand and traditional Medicare on the other,
23 the data that's set forth on this page doesn't
24 suggest any significant differences?

25 A. Nothing that's wildly significant.

1 There's obviously some modest differences.

2 Q. There appeared to be some confusion
3 on your cross-examination about what you actually
4 did, and I think you did a nice job of trying to
5 clear up the confusion, but I want to make sure
6 that we make it crystal clear.

7 When you did your empirical analysis,
8 the one that you've been talking about here today,
9 what categories of data did you review?

10 A. So for the switching analysis,
11 there's a daily report that it's DRR -- I forget
12 the actual acronym. I have it in my -- in
13 Exhibit K. There's a daily -- it's a Daily
14 Transaction Reply Report, DTRR, that CMS provides
15 to the insurers. And what that has is it has data
16 on where individual enrollees are going. Do they
17 switch from traditional Medicare to MA? Do they
18 switch from MA to MA or MA to traditional Medicare?

19 So I have detailed analyses based on
20 that actual data for folks in Missouri, and I based
21 my analysis on that. I also have data on plans by
22 county, by year, over time, and that's part of my
23 econometrics looking at outcomes that I described
24 in lots of detail.

25 Q. So to be clear, with respect to your

1 analysis of Missouri, what we're talking about here
2 today, what categories -- because you just provided
3 some information for us. Were you describing
4 Missouri only?

5 A. Well, I do it both nationally but
6 also for Missouri, and the data that I described in
7 this presentation, the 28-page one, I believe it
8 is, was all based on data for Missouri.

9 Q. Now, with respect to the data for
10 Missouri, your office was requested to provide that
11 data as part of this proceeding?

12 A. That is correct.

13 Q. And did you do it?

14 A. Yes.

15 Q. Okay. If you could turn --

16 A. Let me be clear. I gave it to
17 counsel. How you transmitted it, I --

18 Q. Fair enough. Fair enough. Good
19 point. Go ahead and take a look at binder 3,
20 Exhibit N.

21 A. Okay.

22 Q. You'll see there that this is a
23 confidential enclosed exhibit. Says this data is
24 on a hard drive that is being provided with
25 respondent's exhibit binders. Sir, I'll represent

1 to you that that is reflective of the data you
2 provided to us.

3 But can you clarify now for the
4 hearing officer, did you provide data that matches
5 up with the information that's been presented on
6 the board today?

7 A. Yes, ma'am. Yes, sir.

8 Q. And all of the backup data that
9 anyone would need to evaluate and fully consider
10 all of the Missouri data that you presented, the
11 empirical evidence you presented here today is all
12 on Exhibit N?

13 A. That is correct.

14 Q. Now, the hearing officer asked you
15 some questions about the differences between
16 markets defined by the NAIC and the DOJ, FTC. I
17 want to go into that just a bit.

18 HEARING OFFICER ERICKSON: I'm going
19 to object that that mischaracterizes the hearing
20 officer's questions.

21 MR. WHITMER: I apologize. I'll just
22 ask it differently, directly.

23 HEARING OFFICER ERICKSON: I'd
24 appreciate it. Thank you.

25 BY MR. WHITMER:

1 Q. Let's assume, Mr. Orszag, that
2 Missouri statute at issue here, specifically
3 382.095, states that the relevant geographical
4 market is assumed to be the state. That would be
5 different than the presumption of what the relevant
6 geographical market would be from the viewpoint of
7 the DOJ; would you agree?

8 A. It could be. I'm an economist. I
9 look at these things from an economic perspective.
10 How lawyers look at it, I let lawyers do that.

11 Q. If one were to look at the question
12 you've been asked about whether you were looking at
13 it statewide or whether you were looking at it at
14 more local community, would it have any impact on
15 the conclusion that you reached today, which is
16 that traditional Medicare and Medicare Advantage
17 do, in fact, compete with each other?

18 A. I have no basis to believe that it
19 would be different, the conclusion.

20 MR. WHITMER: I have no further
21 questions.

22 HEARING OFFICER ERICKSON: Recross?

23 MR. ANGOFF: Yes, your Honor.

24 RE CROSS-EXAMINATION BY MR. ANGOFF:

25 Q. Mr. Orszag, could you take a look

1 again at page 27 of Exhibit K. Counsel was
2 referring, I believe, to the -- counsel asked you
3 whether there were any significant differences
4 shown on that chart. The most significant is,
5 isn't it, the difference between the 12.9 percent
6 for MA and 18.1 for Medicare fee for service for
7 those who are younger than 65 years, correct?

8 A. That is correct.

9 Q. And those who are younger than 65
10 years qualify for Medicare obviously not based on
11 age but based on what?

12 A. There's a few criteria. It's
13 basically due to disability and other factors.

14 Q. Okay. So wouldn't that difference
15 then showing that many fewer people in that
16 category enroll in Medicare Advantage than enroll
17 in Medicare fee for service, doesn't that buttress
18 Professor's Gruber's conclusion, which I believe
19 you agreed with, that the health status of
20 Medicare, traditional Medicare enrollees is lesser
21 than the health status of those in Medicare
22 Advantage?

23 A. I have no -- this is based on age
24 right here?

25 Q. This is based on the 12.9 percent, on

1 a much lower percentage of those who are younger
2 than 65 who you just characterized as being, among
3 other things, disabled, a much lower percentage of
4 those people is MA than is in Medicare fee for
5 service. You would agree with me, wouldn't you,
6 that people who are disabled, all other things
7 equal, would have higher medical expenses than
8 those who aren't disabled?

9 A. I have no reason to disagree with
10 you. It's not an analysis I've conducted one way
11 or the other, but I have no reason to disagree.

12 Q. Okay. And then could you turn to
13 page 38 of that Exhibit K, and you see there where
14 it says --

15 HEARING OFFICER ERICKSON: One
16 moment. Is there any danger of crossing into an
17 area of confidentiality, counsel?

18 MR. WHITMER: I'm not sure what the
19 question's --

20 MR. ANGOFF: I was going to read him
21 the first -- the sentence before the colon, the
22 language before the colon in the third bullet.

23 MR. WHITMER: No objection to that.

24 HEARING OFFICER ERICKSON: Proceed.

25 BY MR. ANGOFF:

1 Q. And then you see there on page 38,
2 the third bullet, the language before the colon,
3 can you read that?

4 A. Sure. Switchers from fee for service
5 Medicare or traditional Medicare to MA tend to be
6 younger than overall Medicare-eligible population.

7 Q. That would also support Professor
8 Gruber's view, wouldn't it, that the health status
9 of MA enrollees is greater, better than that of TM
10 enrollees?

11 A. Just so we're clear, chart on 27 was
12 just about demographics. You're now changing it to
13 health. And when you raised it about health, I
14 didn't disagree. It's not an analysis that I've
15 conducted, but as somebody who spent time in the
16 industry and read the literature, that's a finding
17 that I have observed on average. But again, the
18 relevant question for competition analysis is what
19 happens on the margin.

20 Q. You were asked by counsel about the
21 Missouri statute which counsel stated provides that
22 the relevant product market is assumed to be -- I'm
23 sorry, the relevant geographic market is assumed to
24 be the state. Do you remember that?

25 A. Yes, I do.

1 Q. Okay. But the statute also says --
2 I'll represent to you the statute also says, in the
3 absence of information to the contrary, the market
4 is presumed to be the state. Do you -- I take it
5 based on your testimony that you know of no
6 information to the contrary which would undercut
7 the presumption that the geographic market should
8 be the state with respect to Medicare Advantage?

9 A. It's not an analysis that I've
10 conducted one way or the other, so I don't have
11 the -- I haven't taken a view on that issue.

12 MR. ANGOFF: I have no other
13 questions.

14 MR. WHITMER: Your Honor, I have no
15 further questions.

16 HEARING OFFICER ERICKSON: Thank you,
17 Mr. Orszag.

18 THE WITNESS: Thank you very much.

19 HEARING OFFICER ERICKSON: You may
20 step down. May he be excused?

21 MR. WHITMER: He may. Thank you,
22 your Honor. I would respectfully request on behalf
23 of myself and perhaps many in the room a short
24 break.

25 HEARING OFFICER ERICKSON: That

1 request will be granted. It is 13 till 7. Let's
2 reconvene at 7.

3 (A BREAK WAS TAKEN.)

4 HEARING OFFICER ERICKSON: We are
5 back on the record. Mr. Whitmer, please proceed.
6 THOMAS MCCARTHY, being sworn, testified as follows:

7 DIRECT EXAMINATION BY MR. WHITMER:

8 Q. Good evening, Dr. McCarthy.

9 A. Good evening.

10 Q. Could you tell us where you work and
11 what your title is?

12 A. I'm a senior vice president with NERA
13 Economic Consulting. That's a consulting firm
14 that's based in the New York area, but I work in
15 our L.A. office.

16 Q. Approximately how many economists
17 work for NERA?

18 A. Around the world, we probably have
19 400 economists and another 100-plus support people.

20 Q. And what types of projects generally
21 does NERA handle?

22 A. We do economic analysis for
23 regulatory matters, for strategy, for advisory, for
24 litigation, for mergers and acquisitions. Pretty
25 much the full range of economic consulting.

1 Q. And you've been with NERA for more
2 than 30 years?

3 A. Yes, 32 years.

4 Q. Let's talk briefly about your
5 education. Where did you go to college?

6 A. I graduated from a small Catholic
7 school in Worcester, Massachusetts called
8 Assumption College with a BA in economics.

9 Q. Did you get any education beyond
10 that?

11 A. Yes. I got a master's and a Ph.D. in
12 economics, both from the University of Maryland.

13 Q. Dr. McCarthy, I would like to talk
14 briefly about your college teaching positions.
15 Tell us a little bit about that.

16 A. Well, while I was at Maryland, I was
17 an instructor while I was writing my dissertation.
18 So I taught mostly microeconomics there. Then I
19 took a job -- just as I was finishing up my
20 dissertation, I took a job with Oakland University,
21 which is oddly in Rochester, Michigan. So it's all
22 very confused geography. But Oakland University,
23 I taught MBA students, undergraduates, but it also
24 included health economics.

25 Q. I'd like to talk briefly about your

1 professional background. Tell us a little bit
2 about your work at the Federal Trade Commission.

3 A. I worked at the Federal Trade
4 Commission for a while after teaching at Oakland
5 University, and then I was recruited to my current
6 company, NERA Economic Consulting. At the Federal
7 Trade Commission, I analyzed regulations in the
8 health care industry. In particular I did a study
9 of certificate of need. I did a study of the DRG
10 system, what is commonly known as the DRG system
11 and some home health care.

12 Q. Over the past 30-plus years, what has
13 your focus been?

14 A. For at least the past 25 years of
15 that, I've been the head of NERA's health care
16 practice, and probably 75, 80 percent at least of
17 my work is strictly in the health care industry.

18 Q. Now, this is not the first health
19 plan merger that you've been involved in; is that
20 right?

21 A. That's correct.

22 Q. Tell me about other ones that you've
23 been involved over the years.

24 Q. Well, I've done -- I've represented
25 the antitrust side along with various counsel in

1 Cigna-HealthSpring, that merger, United Health
2 Care/Pacific Care. Blue Cross Blue Shield of
3 Michigan bought the University of Michigan's
4 insurance plan called M-CARE. Aetna/Prudential. I
5 did the Aetna/Coventry transaction. Blue Cross of
6 New Mexico bought the Lovelace Health Plan in
7 Albuquerque. I did that. Cigna bought Great West.
8 I represented them in that one. And then the last
9 one I have on my list is HCSC, which is a company
10 that owns five Blue Cross plans. HCSC bought the
11 Montana Blue Cross plan several years ago.

12 Q. So by my count, this is your ninth
13 health care merger that you're providing consulting
14 on?

15 A. I think there are probably some small
16 ones in between, but yes, at least for significant
17 transactions.

18 Q. So you're also co-editor of a book on
19 health care reform around the world titled
20 Financing Health Care?

21 A. Yes. An author of some of the
22 chapters, but yes.

23 Q. Talk briefly about your prior
24 testimony. What kind of testimony have you
25 provided with respect to state departments of

1 **insurance?**

2 A. In this particular transaction, I
3 testified both by affidavit and in person to the
4 Florida OIR. Also, we submitted materials to
5 Texas. We've submitted materials to Indiana. And
6 I suspect there may be others, but that's what
7 we've done so far in this matter.

8 Q. So you also testified live before the
9 Florida Office of Insurance Regulation for what
10 ended up being about a three-hour hearing?

11 A. Yes, back in December.

12 Q. And with respect to other
13 transactions, you've also appeared in person before
14 other departments of insurance?

15 A. Yes, I have.

16 Q. And which states are those?

17 A. I testified before the DOIs of
18 Alaska, Colorado, Delaware, Montana, twice in
19 New Mexico, and in Washington state.

20 Q. In addition, Dr. McCarthy, you've
21 also provided testimony before the Department of
22 Justice and Federal Trade Commission hearings?

23 A. Yes. They held what they call the
24 dose of competition hearings, which is the
25 importance of competition in the health care

1 industry, and they held hearings. I testified at
2 three different sessions of those hearings.

3 Q. Have you also provided testimony in
4 state and federal court matters?

5 A. I have.

6 Q. And what's the general nature of
7 those federal court matters?

8 A. Pretty much the gamut. Some are
9 maybe damages cases, but health care liability
10 cases, contract damages, antitrust litigations, a
11 variety.

12 Q. What was your assignment in this case
13 that we're here to talk about today?

14 A. It was essentially to assess the
15 potential competitive impact of the merger in
16 Missouri. And the question, the standard that I
17 held out was whether this would tend to create a
18 monopoly or lessen competition in any line of
19 business in the state of Missouri.

20 Q. So that standard you just referred
21 to, lessening of competition or tend to create a
22 monopoly in any line of insurance in the state of
23 Missouri, is that similar to the standard that the
24 Department of Justice uses?

25 A. Yes. Yeah. They're both -- I think

1 that language is in perhaps the Clayton Act. I'm
2 not quite sure where, but both the federal approach
3 and the NAIC standard I understand to be roughly
4 the same.

5 **Q. I'd like to walk through the process**
6 **that you undertook for this assignment, starting**
7 **with what information did you review?**

8 A. Well, you'll see we're going to look
9 at a lot of share data. So we had to collect the
10 data. There's premium and enrollment data that we
11 obtained from several sources. In some cases it
12 was the Missouri DOI data. We'll see that. The
13 federal data from the CMS, much like what John
14 Orszag used, the parties' data.

15 And then, of course, there's -- there
16 are third-party datas, data sources like
17 InterStudy, what's called HealthLeaders-InterStudy.
18 They collect data on commercial insurance, and we
19 looked at some of their numbers.

20 **Q. What else did you review?**

21 A. Well, I think we went through a lot
22 of -- a lot of different things. We interviewed
23 Aetna and Humana management, both nationally and
24 locally. We looked at websites to identify who was
25 who and what their products were. We -- there are

1 a number of submissions that have been made to the
2 Department of Justice that have been shared with
3 the DOI, with the Missouri DOI. We've looked at
4 those. Those are the various white papers.

5 I also reviewed Dr. Gruber's report
6 to the DOI and the Florida Consent Order and just
7 various articles that -- some of which were sent by
8 Ms. Doggett.

9 Q. Did you also have the opportunity to
10 conduct any interviews?

11 A. Yes.

12 Q. Tell us a little bit about that.

13 A. Well, the Aetna and Humana management
14 folks who are responsible for Missouri and some who
15 have more of a national responsibility who could
16 talk a little bit about Medicare and some other
17 broader topics, but the Missouri people, too.

18 Q. The documents you reviewed, the
19 interviews you conducted, the information that you
20 considered, was it sufficient to perform the
21 analysis you're about to talk about today?

22 A. Yes, I believe it is.

23 Q. So before we get into the details,
24 can you tell us, what was your overall conclusion?

25 A. That, in my opinion, based on what I

1 will show you, that there will be no substantial
2 lessening of competition or tendency to create a
3 monopoly in any line of business in Missouri as a
4 result of this transaction.

5 Q. If you take a look at Binder 2, which
6 is I believe right in front of you.

7 A. It is.

8 Q. And turn to Exhibit C. That's the
9 affidavit that you've submitted with respect to
10 this matter; is that right?

11 A. Yes, it is.

12 Q. Okay. And if you briefly take a look
13 at Exhibit D, that's your CV?

14 A. It is my CV.

15 Q. I'd like to start by talking about
16 four key facts, and I understand that your
17 conclusion is based on these four facts. Let's
18 take one at a time. The first one that you
19 identify in this report we just looked at is that
20 Aetna and Humana have complementary strengths?

21 A. That's right.

22 Q. What do you mean by?

23 A. Well, I think you heard some of this
24 from Mr. Martino earlier today, but it's basically
25 that Aetna focuses on group and particularly large

1 group and on national accounts. They tend to have
2 a different competitive strength and a different
3 competitive focus. You've heard this before.
4 Humana tends to focus on Medicare and the smaller
5 groups, individual products and small group
6 business. When they get into the large group, it
7 tends to be on the smaller end of the group size.

8 **Q. What does this have -- does this have**
9 **any impact on, for example, having a diversified**
10 **portfolio?**

11 A. Yes. I mean, one of the goals is
12 to -- since both have these relative strengths, one
13 of the goals is to get the membership mix to be a
14 full and balanced membership mix.

15 **Q. Let's jump forward to your second key**
16 **fact that you identify in your affidavit, and this**
17 **is that the proposed transaction will lower costs**
18 **and provide greater competitive opportunities for**
19 **both companies. Can you explain that and perhaps**
20 **provide some examples as well?**

21 A. Well, I think again we've heard from
22 Mr. Martino earlier that -- and I touch upon this
23 in my affidavit, but that there's expected to be
24 \$1.25 billion worth of synergies coming out of this
25 transaction.

1 I would point out, though, there's
2 also a white paper done by another economic
3 consulting firm, CRA, and that white paper talks
4 about the success that Aetna has had from its
5 Coventry merger in terms of achieving not just the
6 amount of savings they said they would but
7 exceeding those savings and at the same time
8 increasing the quality of care.

9 Q. Right in front of you, Dr. McCarthy,
10 is Binder 4.

11 A. Yes.

12 Q. You were just referring to a white
13 paper. I'd like to take you there. Take a look at
14 Exhibit P.

15 A. Yes, I have it.

16 Q. I'm just going to remind you that
17 this is a document that's marked confidential. It
18 has been identified as confidential and closed.
19 But what I'd like for you to do is just describe
20 generally, without going into any confidential
21 information, what is it that this article, this
22 white paper states?

23 A. What it spends a fair amount of time
24 doing is demonstrating that the promises made about
25 cost savings in the Coventry transaction were

1 actually realized and, in fact, were exceeded. And
2 it also talks about how they have been able --
3 Aetna has been able in absorbing Coventry, and
4 Coventry certainly assisting in this, they've been
5 able to increase the quality, meaning their star
6 ratings, their quality ratings improved as they
7 were saving money. So it's higher quality, lower
8 cost, and that's a lot of what this white paper
9 demonstrates.

10 **Q. So with respect to the Coventry**
11 **transaction, when Aetna goes to state insurance**
12 **departments back then, several years ago, and state**
13 **that there's going to be hundreds of millions of**
14 **dollars of synergies, that actually did happen?**

15 **A. Yes. As a matter of fact, we've**
16 **talked a little bit about the merger guidelines.**
17 **The merger guidelines actually talk about**
18 **demonstrating efficiencies become more credible,**
19 **let's say, when you can demonstrate that you've**
20 **actually done it in the past, and that's why I**
21 **think it's important.**

22 **Q. So let's bring it back to this deal**
23 **now. You talked about the \$1.2 billion per year in**
24 **efficiencies. That's as of 2018?**

25 **A. Yes. That's when it will reach that**

1 level of annual savings.

2 **Q. Will consumers benefit from those**
3 **synergy savings?**

4 A. I think if you take the first opinion
5 I expressed, which is that there won't be a
6 competitive problem in Missouri, then the answer is
7 that the competition that results will assure that
8 these costs are passed on, these cost savings are
9 passed on.

10 **Q. Let's move forward to the third key**
11 **fact that you identify in your affidavit, and**
12 **that's that post-merger shares for the relevant**
13 **products will generally remain below 30 percent.**

14 A. Yes.

15 **Q. I understand you took a two-step**
16 **approach to this analysis, but I'd like you to**
17 **explain the first step and the relevance of the**
18 **30 percent number.**

19 A. Partly due to a lot of experience,
20 partly due to economic logic, partly due to some of
21 the thresholds and standards we see both in the
22 regulations and in the case law, it's certainly
23 been my experience that if the share doesn't
24 reach -- in a reasonably defined market, if the
25 share doesn't reach 30 percent, then it really

1 doesn't trigger much of a competitive concern.

2 So it's a fuzzy number to some
3 degree, but it's pretty solid that that's a
4 threshold where competitive interest begins.

5 **Q. Just to be clear, when you say**
6 **30 percent, you're talking about adding up the**
7 **shares of A and B?**

8 A. Yes. I'm sorry. The post-merger
9 shares.

10 **Q. Okay. So that's the first step.**
11 **What I'd like you to do now is address the second**
12 **step.**

13 A. Well, and we'll look at some of these
14 examples. In some cases you end up with a share
15 that exceeds 30 percent and, therefore, what that
16 triggers for me in my experience, and I think in my
17 experience with the antitrust agencies, that
18 triggers a little deeper look.

19 And so what we have done is we've
20 pursued that and looked at what I think is
21 ultimately the most important thing about a
22 competitive analysis, and that's the competitive
23 process. That is what you really care about is
24 that competition not be threatened, and what I mean
25 by competition is that the competitive process not

1 be threatened.

2 Q. Now, you're not a lawyer, right, sir?

3 A. I am not.

4 Q. But you've been in front of a lot of
5 courts, and you just explained that to us. Do you
6 have any understanding based on your 30-plus years
7 in the industry how courts evaluate market shares
8 and where they see lines being drawn?

9 A. Courts -- in terms of finding market
10 power, courts generally -- and this is in some of
11 the lawyer books actually. Courts generally do not
12 find market power unless there's about a 50 percent
13 share or more. That's certainly been the more
14 recent experience.

15 Q. So if the market shares for A plus B
16 are less than 50 percent, generally courts will say
17 that that doesn't present a competition problem?

18 A. Well, I would -- yes, but I would
19 also say in broader context, too, if there's an
20 antitrust litigation and they're looking at market
21 share, then the same sort of principle.

22 Q. Let's take you to your fourth key
23 fact, and that is that additional factors further
24 establish why the transaction we're talking about
25 here today does not present any competitive

1 concerns. What additional factors are you
2 referring to?

3 A. This takes me back to I'm really
4 talking about the competitive process. You can
5 think of the competitive process as being made up
6 of two responses. One is the response by
7 consumers. They have these options. They choose
8 among those options based on price and networks and
9 quality and all that sort of thing. That's -- we
10 look at shares, and that tells us what the
11 alternatives are.

12 But also, the competitive process and
13 probably the more important part of the competitive
14 process in my view is the supply response side. So
15 the argument goes that if there's a market
16 opportunity that comes up based on consumers
17 expressing their preference of what they like and
18 what they want more of, there are suppliers who
19 will respond to that by serving that need.

20 So what we're really talking about
21 competitive process is suppliers being able to
22 shift resources, reposition their product, expand
23 graphically, change the benefits, change the
24 pricing, all sorts of responses that would allow a
25 firm to reposition itself to be a better

1 competitor. So the key is the supply response.

2 Q. And that would include, for example,
3 creating new products?

4 A. Yes.

5 Q. Let's -- are there any other
6 opportunities in Missouri that you'd like to
7 reference?

8 A. Well, these are part of the supply
9 response, but there are opportunities to expand,
10 there are opportunities to enter, and as you say,
11 even more particularly than expand, we could call
12 it, as it's often called, their opportunities to
13 reposition. You may -- you may want to enter --
14 maybe you're a Medicaid -- we talked a little bit
15 about this. You're a Medicaid provider and you may
16 decide that there's a logical connection between
17 Medicaid and the Exchanges, the public Exchanges.
18 So that would be a repositioning of a firm doing
19 Medicaid to start offering Exchange products.

20 Q. So as you're considering these
21 additional factors and you're looking at other
22 opportunities, how does the willingness of a
23 customer to switch factor in?

24 A. Well, they need the information.
25 They need the -- they have to have an incentive.

1 You have offer -- I mean, there are plenty of
2 people who have opened some, let's say, restaurant
3 and not very many people came. So you have to --
4 in order for this competitive process to work, the
5 supplier has to be satisfying the preferences of
6 the consumer.

7 **Q. So you've identified several**
8 **additional factors that need to be considered.**
9 **Before we talk more about it, I just want --why**
10 **does it matter? Why does all this matter for what**
11 **we're talking about here today?**

12 **A.** I'm going to use the same phrase, I
13 guess, but because of the competitive process. In
14 other words, we have -- we have an economy where
15 there's a lot that's automatic, where a lot of
16 preferences are expressed. Suppliers decide what
17 to do about it. People are unhappy with the
18 product, they shift to another product. There's a
19 trend product or a trend away from a product.

20 The fact that we have the movement of
21 resources to satisfy these consumer preferences is
22 really the heart of the competitive process.

23 **Q. So let's assume we see a supply**
24 **response. You've been talking about this. Is that**
25 **suggesting that there's some competitive problem**

1 that triggered the response?

2 A. No. No. I mean, somebody can just
3 come up with a better idea. Somebody can come up
4 with a product that they want to try. It may or
5 may not be successful. But just the threat of
6 entry is part of the competitive process. It
7 doesn't have to be a monopoly pricing problem
8 before somebody enters. It's somebody has a better
9 idea, it's a better mousetrap, they're going to try
10 it.

11 Q. So are there other reasons that entry
12 and expansion would matter in this context,
13 anything else you can tell us about that?

14 A. Well, yeah. It moves resources into
15 the area. It provides more choices. It provides a
16 competitive alternative, and it's what makes
17 markets work.

18 Q. So, Dr. McCarty, now that we've
19 established the four factors, four facts that led
20 to your conclusions, I'd like to turn our attention
21 to the lines of insurance that you've analyzed.
22 Take a look at the board. We've been looking at it
23 all day. You'll see lines of insurance at issue,
24 No. 1, No. 2 and No. 3. Are those the three lines
25 that you reviewed?

1 A. We reviewed the fourth, too, but it's
2 taken out of the review right now. Yes, those are
3 the three we looked at.

4 Q. And we talked about this a little bit
5 this morning. Just in a nutshell, why is it that
6 these three lines were selected as opposed to the
7 other dozen or so we talked about this morning?

8 A. These lines were reflected in the
9 letter from Mr. Hopper as lines of business that
10 exceeded the NAIC's safe harbors or thresholds.
11 So they -- the way I understand the NAIC guidelines
12 is to say that if you don't have that safe harbor
13 kind of protection, then you have this prima facie
14 case that there may be a competitive problem. It's
15 a little like the 30 percent trigger I talked
16 about, that it warrants a further look. So my
17 understanding is these are the three lines of
18 business that remain and require a further look.

19 Q. So take a look at the board, if you
20 will. These are the three lines, and as you look,
21 there's Aetna and Humana and there's share
22 information there. And then actually look at the
23 very bottom of the page and it says Hopper letter.
24 That's the data. Do you know where that data came
25 from?

1 A. Yes. That's the NAIC premium data as
2 to what the shares would be under the NAIC
3 analysis.

4 Q. This is the information that came
5 from the SNL data that was provided to the Division
6 with respect to this matter?

7 A. Yes.

8 Q. And the Division then in turn sent a
9 letter back to Aetna and said, here's the -- here
10 are three of the lines I want you to look at?

11 A. That's my understanding, yes.

12 Q. I'd like to move forward to the next
13 slide. Take a look at Figure 1. Aetna on the
14 left. Humana on the right. What does this slide
15 tell us?

16 A. I think there are two takeaways from
17 this slide. I think they reflect this
18 complementarity that we've been talking about. You
19 can see that on the commercial, which is the blue
20 large wedge, roughly two-thirds of Aetna's business
21 is in the commercial group and individual, and only
22 about a third is in Humana's commercial
23 membership.

24 On the other hand, if we look at the
25 red slice, that's the Medicare amounts, and we see

1 that the remaining two-thirds of Humana's business
2 is in the Medicare, Medicare Advantage space, and a
3 much smaller percentage is for Aetna. Now,
4 that's -- that's the first thing you notice. It
5 reflects that complementarity. Part of it is true
6 nationally. This is what it is in Missouri.

7 **Q. Well, you said it's two things.**
8 **You've given us one. What's the second.**

9 A. Well, Aetna's substantially larger
10 than Humana in Missouri. Roughly Aetna's I guess
11 almost ten years bigger than Humana in terms of
12 total membership in Missouri.

13 **Q. Okay. So why does it matter? Why is**
14 **that relevant here?**

15 A. Well, it's relevant because --
16 there's sort of two levels of which it's relevant.
17 One of it is that the complementarity matters and
18 is part of what drives this transaction and why
19 there may not be that much overlapping competition
20 if the mix is different.

21 But the other part is that what we're
22 going to see is that in many of the segments,
23 Humana does not have a lot of membership. So most
24 of the membership that's causing whatever the share
25 is, the post-merger share, comes from the Aetna

1 side, not the Humana side.

2 Q. Let's move forward to Figure 2.

3 A. Yes.

4 Q. So some different colors, different
5 facts and information. A lot going on on that
6 slide. What can we learn from it?

7 A. These are all the commercial members,
8 and we break them into three slices: Individual,
9 small group, which is the 2 to 50 -- or on this
10 graph it's 2 to 100, I'm sorry, and the large
11 group. The large group is the darkest blue slice,
12 and we can see that Humana has whatever that
13 percentage is. It's maybe 30, 35 percent, maybe a
14 third is in the large group, but half of their
15 business is in small group. The remainder is in
16 the individual segment.

17 On the other hand, Aetna is mostly
18 large group. It has individual. We'll talk about
19 the individual segment, and it has a relatively
20 smaller percentage -- again, it's larger, but has a
21 relatively smaller percentage in small group.

22 Q. And I want to get to your analysis in
23 a minute. Just a few more background slides I'd
24 like to have you take a look at. Figure 3 is the
25 next one. This slide takes a look at the Medicare

1 have that, Division?

2 MR. ANGOFF: No.

3 MR. WHITMER: I apologize.

4 HEARING EXAMINER ERICKSON: I was
5 feeling lost.

6 MR. WHITMER: I should have started
7 there. Thank you for pointing that out.

8 BY MR. WHITMER:

9 Q. Dr. McCarthy, we're -- now, the
10 slides we're looking at, you've prepared an
11 affidavit. There's a lot of slides in your
12 affidavit that correspond to the ones on our
13 screen. But for ease of our discussion today,
14 we're going to be focusing more on the screen
15 instead of walking through your report. Is that
16 okay with you?

17 A. That's fine.

18 Q. Let's turn to your competitive
19 analysis. I'd like to talk first about the
20 commercial segment. Now, earlier you mentioned
21 that you looked at the commercial group. And when
22 I say commercial group, does this correspond to
23 what the NAIC refers to as comprehensive group,
24 which is up is there as line 1?

25 A. And there's a bit of a yes and no

1 here. It does correspond very closely to the
2 comprehensive group, but what we do, as you'll see
3 in one side, is we add the self-insured business to
4 the fully insured. NAIC collects premium data, and
5 they omit collecting any self-insured data.
6 However, particularly for large group, self-insured
7 is a big part of the substitution possibility that
8 a large group has. So they can -- they can go with
9 a fully insured product or they can be
10 self-insured.

11 Q. So as we're talking about
12 comprehensive group or commercial group, this is
13 one of the three lines that the State has asked us
14 to respond to?

15 A. Yes.

16 Q. Okay. So what I'd like to take at
17 is, what are the shares for line 1 as reported in
18 the Form E?

19 A. The post-merger share, as I recall,
20 is 27 percent, with Humana being 3 percent of that.

21 Q. Okay. So you talk about a combined
22 share in that first line, comprehensive group. You
23 look at the NAIC data. You've going to see a
24 combined share of 27 percent for post-merger
25 shares?

1 A. That's my recollection, yes.

2 Q. Okay. And earlier you talked about a
3 30 percent marker. Tell us how those factored in.

4 A. Well, I mean, the way I would look
5 at -- even using the NAIC data, the way way I would
6 look at that is to say that's below the 30 percent,
7 that's -- there's no obvious reason to trigger any
8 antitrust concern, and, therefore, I'd put that
9 aside and look at other segments to see if there
10 are problems there. But we did go a little
11 further.

12 Q. So if we wanted to, if we wanted to
13 stop right there and we'd all go home on
14 comprehensive group --

15 A. I think under the NAIC numbers, we
16 could go home on commercial.

17 Q. Because we're under that 30 percent
18 number?

19 A. Yes.

20 Q. And of the 30 percent, only 3 percent
21 is Humana?

22 A. That's right. That again reflects
23 the difference in size.

24 Q. Okay. Now, you didn't pack your
25 bags. You kept looking at more information. I

1 want to take a look. What is it you looked at to
2 get a deeper value?

3 A. Well, I think from an antitrust point
4 of view, from a competition point of view, you
5 really have to include self-insured. So we looked
6 at commercial including self-insured. So we looked
7 at all of the commercial business collectively.

8 This chart you're looking at now is
9 based on what's called HealthLeaders-InterStudy
10 data. They are probably the best collector of the
11 insurance enrollment data that's available as a
12 third party.

13 Q. You talked about self-insurance a
14 couple times, and you explained briefly why you
15 included it. Is self-insurance a constraint on
16 fully insured products?

17 A. Yes, very much so. Self-insurance is
18 the individual -- the company, the employer can
19 decide that they are big enough. You don't see a
20 lot of self-insurance under 100 employees. You see
21 some, though. But the employer can decide that
22 they're willing to take the risk of what the health
23 care expenses are going to be rather than pay an
24 insurance company to actually bear the risk.

25 So there are a number of strategies

1 they can do, like self-insure but have reinsurance
2 at some point. The point being, though, that if
3 you have enough employees that you can pool the
4 health care costs over them, you can be your own
5 little insurance company and pay for their expenses
6 while somebody else manages the administrative side
7 of it. So self-insurance is also called ASO,
8 administrative services only.

9 Q. So we have on Table 1 is looking at
10 statewide data for the state of Missouri. I think
11 I got the date up there is 2015 information.

12 A. Correct.

13 Q. And this includes all commercial
14 insurance, including, as you just mentioned,
15 self-insured groups?

16 A. That's right.

17 Q. And if you look there, just tell us
18 what -- the number. You've got Aetna at
19 22.7 percent, Humana at 1.4 percent. You put them
20 together in the bottom right-hand corner and you
21 have 24.1 percent. What's our takeaway from this
22 information?

23 A. I suppose the obvious, that using
24 self -- looking at self-insured plus fully insured,
25 we're still well below the 30 percent threshold.

1 Q. Again, not only well below the
2 30 percent threshold, but you're looking at Humana
3 at less than 2 percent?

4 A. Right. This is again another
5 reflection of the fact that Humana is substantially
6 smaller in Missouri than is Aetna.

7 Q. Take look at United, we heard about
8 United this morning, and Anthem, the top two. Is
9 there anything relevant or pertinent about those
10 two?

11 A. Well, they're pretty substantial
12 players, and even post merger at 24.1, if you add
13 that small amount of Humana, they're all pretty
14 much the same size.

15 Q. Dr. McCarthy, have you also looked
16 specifically at small group? This is all
17 commercial insurance, small group, large group,
18 self-insured. Did you also focus specifically on
19 small group?

20 A. Yes.

21 Q. Okay. And tell us what you looked at
22 there.

23 A. We used the Missouri DOI data on
24 small group. In this case it's 2 to 50 because
25 that's the way the data are collected by the

1 Department. And when you combine the -- both the
2 Aetna and the Humana and look at the post-merger
3 share, it's about 20 percent. Slightly less than
4 20 percent.

5 So once again, looking at small
6 group, if you think it's a separate segment, a
7 separate line of business, then there's still no
8 obvious concern about the post-merger share.

9 Q. So again, you're looking at a lot of
10 different things, trying to do a deeper dive,
11 trying to get a sense of looking at different
12 pieces. This is the small group piece. You have
13 13.9 percents plus 5.9 percent, total of under
14 20 percent?

15 A. Yes. Rounding off, 20 percent.

16 Q. Okay. You know, if you take a look
17 at this again with Anthem and some of those at the
18 top of the page, does that tell you anything more?
19 Is there anything relevant there?

20 A. Well, there's still two that are
21 strong.

22 Q. Well, yeah. If you combine Aetna and
23 Humana, where do they fit?

24 A. They would be third, I think. I
25 can't quite see from here. Looks to me like

1 they're third. I can't quite see what Blue Cross
2 of Kansas City of.

3 Q. The first one's 33.4, second 27.4.
4 Basically, you add up Aetna and Humana, you're
5 still below the top two?

6 A. Right. That's right.

7 Q. And what does this tell us about
8 whether there will be any competitive problem in
9 small group post merger?

10 A. I don't -- I don't see a basis for
11 that worry. I see that the share is well under
12 30 percent.

13 Q. Let's move forward to Table 3, then.
14 Now, the data on Table 3, this also comes from the
15 Missouri DOI?

16 A. That's correct.

17 Q. And what's different about this
18 table?

19 A. This we thought we'd look at fully
20 insured as again I think I have argued and would
21 argue that competition includes both fully insured
22 and self-insured, but we looked at fully insured
23 separately.

24 Q. Okay. What did we learn here? What
25 did it tell us?

1 A. It tells us the same pattern, that
2 we're -- that Aetna is in sort of the low
3 20 percent share level and a small amount of --
4 Humana is added and they end up with a share that's
5 well below the 30 percent threshold.

6 Q. And, sir, we've been looking at some
7 tables. We've been looking at some figures. These
8 all come right out of your affidavit?

9 A. Yes.

10 Q. So if we wanted to, we could go
11 through your affidavit that's already been admitted
12 into evidence and look at all these? Again, I'm
13 just trying to --

14 A. Yes. I tried to draw a little easier
15 picture to look at from the affidavit. That's what
16 these slides represent.

17 Q. Sir, did you also look at the
18 commercial group segment more narrowly than
19 statewide?

20 A. Yes, we did. We looked at the MSA,
21 and when I say MSA, I sort of mean two different
22 kinds of cities. There's the metropolitan
23 statistical area, sometimes called a CBSA, but
24 nonetheless they're the big cities, and then
25 there's something called micropolitan statistical

1 areas, which are just smaller cities.

2 In Missouri there are 27 metropolitan
3 and micropolitan statistical areas. Let's call
4 them together MSAs. And so we looked at shares in
5 those MSAs.

6 A. So you've been giving us this
7 30 percent benchmark, and Dr. McCarty, how many of
8 those 27 MSAs or micropolitan areas had shares
9 above 30 percent?

10 A. Three of them.

11 Q. And which three?

12 A. Branson, Lebanon and Springfield.

13 Q. So we have Table 4 up in front of us
14 now. A lot of information on one slide. Just walk
15 us through this a little bit, if you will.

16 A. Well, what you can see in each of
17 these three areas is that Humana is contributing a
18 relatively small amount to the post-merger share.
19 The post-merger share in each of these instances
20 exceeds 30 percent. And in every instance Humana
21 is less than 5 percent of that addition.

22 Q. So how is it that Humana performs in
23 these three counties?

24 A. How is they what? I'm sorry.

25 Q. Yeah. Sure. I mean, all three of

1 them -- let's look at some specific numbers up
2 here. In the three that are above 30 percent, for
3 Branson, Humana's at 3.6 percent?

4 A. Yes.

5 Q. For Lebanon, Humana's at 4.5 percent?

6 A. Yes.

7 Q. And for Springfield, Humana's at
8 2.1 percent?

9 A. That's right.

10 Q. And why does that matter? Why is it
11 relevant?

12 A. Well, the small addition, a small
13 share being added to larger share is not likely to
14 change, at least materially change the market
15 structure very much. And these don't look to be
16 substantial increments to me that would cause an
17 additional problem compared to what Aetna had.
18 Aetna has a reasonable share already.

19 Q. And again, just --

20 A. And there are other players that
21 are -- have a substantial presence.

22 Q. And again, just to clarify, this --
23 you're only looking at three here out of the 27,
24 and that's because these are the only three over
25 30?

1 A. Correct.

2 Q. All the other 24 were under 30?

3 A. That's right.

4 Q. Okay.

5 A. And so if you -- if you acknowledge
6 that there are other players in each of these
7 markets and if you add to that sort of the
8 complementary focus where Humana is more focused on
9 the smaller groups and Aetna's focused on the
10 larger groups, then it doesn't seem like there's a
11 material shift in the market structure.

12 Q. Well, what is the likelihood that
13 Aetna will obtain market power post merger in these
14 three areas?

15 A. Very small.

16 Q. Dr. McCarthy, did you also look at
17 the commercial individual segment?

18 A. I did.

19 Q. Is this the comprehensive individual
20 business line up on the chart, the second one?

21 A. That's right.

22 Q. And let's go back to the Form E data.
23 The Form E data that was presented to the
24 Department we've been talking about shows a
25 combined share of what?

1 A. 42 percent, where Humana has less
2 than 1 percent of that share.

3 Q. So the aggregate number's 42 percent,
4 but Humana's piece of it is less than 1 percent?

5 A. That's right. Very small.

6 Q. And given those -- that information,
7 is that likely to cause concern?

8 A. No. It -- this is 2014 data. So
9 we'll talk a little more about this, but that size
10 share would not really change the balance of
11 competition in the individual market at all.

12 Q. Would it be likely to substantially
13 lessen competition?

14 A. No, not at all.

15 Q. Sir, did you look any deeper?

16 A. Yes.

17 Q. What did you do?

18 A. Well, this was 2014. Humana had not
19 entered the individual exchange, health care
20 exchanges until 2015. So we wanted to look and see
21 whether --

22 Q. Let's hold on for one second,
23 Dr. McCarthy.

24 (AN OFF-THE-RECORD DISCUSSION WAS
25 HELD.)

1 HEARING OFFICER ERICKSON: We are
2 back on the record.

3 BY MR. WHITMER:

4 Q. You were just describing before we
5 lost your lights about a deeper dive you took.
6 Could you just pick back up there?

7 A. Yes. Because that less than 1 percent
8 was in 2014 when these important changes began and
9 Humana had not yet jumped into the health exchange
10 market, we wanted to look beyond 2014.

11 Q. Why is it you were looking at the
12 public exchanges?

13 A. Because they've become -- the
14 estimate go -- I think the Aetna estimates were
15 between 70 and 80 percent of all individual plans
16 now come through the exchange.

17 Q. So when we're looking at the
18 exchange, we're looking at the lion's share?

19 A. You're looking at the individual
20 insurance products that you're -- both on exchange
21 and off exchange. Most of it's on exchange.

22 Q. Before we discuss the specific
23 components of competition on the exchange, is there
24 some overarching thing you can provide?

25 A. Well, yeah. I think there are two.

1 And John Orszag talked about this, I thought, very
2 well. Obamacare has changed a lot of things, and
3 with respect to just the narrowness of the health
4 exchanges, there's an individual mandate that says
5 under most circumstances, a lot of circumstances,
6 you must buy health insurance. These are people
7 who either have not had the income or are young and
8 healthy and don't want -- haven't wanted to have
9 insurance prior to this. So many of the people on
10 the health exchanges want to buy the cheapest
11 policy they can buy.

12 The other part of the exchanges
13 that's been set up is that there's a bidding
14 process by which companies submit bids and are
15 placed at a certain premium on an exchange, and
16 these go county by county by county.

17 The goal of that bidding process is
18 to be among the first two lowest priced plans. And
19 the reason is, this is an extremely price-sensitive
20 group, and they will -- what's called the second
21 silver plan, and I can explain that in a moment,
22 but the second lowest price silver plan becomes
23 what's called the benchmark price. That benchmark
24 price is the one that the subsidies are tied to.

25 The reason many people have shifted

1 to being on the exchange is that their income is
2 sufficiently low that they can warrant a subsidy.
3 You cannot get the subsidy unless you're on the
4 exchange. And the subsidy is tied to whatever that
5 second lowest silver plan is.

6 And just as a footnote, the way the
7 exchanges are organized is they have four levels of
8 metal tiers. They have bronze, silver, gold and
9 platinum. As you go from bronze to platinum,
10 they're richer benefits. They cover a higher
11 percentage of the actuarial value of the health
12 care costs. So bronze plans cover 60 percent of
13 the actuarial value and platinum plans cover
14 90 percent.

15 So that tedium aside, the one that
16 drives the subsidy is the second lowest silver
17 plan. The bidding process is to try to become one
18 of those two lowest plans.

19 Q. You say second lowest silver plan.
20 Second lowest what?

21 A. Priced premium.

22 Q. Second lowest price silver, that's
23 what we're looking for?

24 A. Yes.

25 Q. Let's take a look at Figure 4 going

1 up on the screen in a second here. What does this
2 chart tell us?

3 A. This chart is sort of the clear
4 impression of the price sensitivity. What we have
5 here, these are Aetna data, and what we have is we
6 have -- on the vertical axis we have Aetna's share.
7 So those blue dots way up at the top, that means
8 they have a very high share. And as we go to the
9 right-hand side, those blue dots mean they have a
10 low share.

11 But along the X axis or the
12 horizontal axis, what we're looking at is how far
13 is Aetna's premium from the benchmark price in that
14 county. So every one of those dots represent two
15 years of county data. That is all of the counties.
16 I say there are 115, but I can call it 114 plus
17 St. Louis. Each of those counties that Aetna was
18 in has an Aetna premium, and we want to measure how
19 far away that Aetna premium was from the benchmark.

20 So one other thought about this
21 graph. If you go to where the zero horizontal --
22 zero is on the horizontal axis, that means you're
23 exactly at the benchmark price. There's no
24 difference. If you go to the left, that means your
25 price is lower than the benchmark price. It's

1 going to be very attractive.

2 And that's why you see this negative
3 slope, which is that you have high share when
4 you're at at below the benchmark, and the share
5 quickly falls off as you get further away from the
6 benchmark. That's the measure of the price
7 sensitivity of the consumers in the exchange
8 markets.

9 **Q. Now, we talked about how most of**
10 **these figures are actually in your affidavit. This**
11 **one actually is not in your affidavit; is that**
12 **right, sir?**

13 A. That's right.

14 **Q. And some of this information was made**
15 **available to you after your affidavit was**
16 **submitted?**

17 A. That's right.

18 **Q. With respect to this graph and what**
19 **you just testified to, I'm trying to bring it back**
20 **to why it matters. What is the big theme here that**
21 **this information is telling us?**

22 A. Well, think about sort of the normal
23 competitive standards. The normal competitive
24 standard is I see a high share, I think they must
25 have market power. This is exactly the opposite.

1 I see a high share, they must have a really low
2 price relative to the benchmark. And how do you
3 keep your high share? You only keep your high
4 share by staying low, either at or below the
5 benchmark, and we'll see some other numbers about
6 that.

7 Q. If someone wanted to get a lot of
8 share, a lot of share, given what you just
9 explained to us, what would they have to do?

10 A. Well, they have to bid low. There's
11 a danger in bidding low, of course. That's one
12 reason -- there are a lot of reasons -- why we have
13 so much financial stress in the exchange markets.

14 Q. So I understand there's some reasons
15 why you don't want to bid low, but if your only
16 goal is to get as much share as possible, you've
17 got some ability to do it?

18 A. Yes. You have control through the
19 bid.

20 Q. So let's talk -- let's talk a little
21 bit about -- how have companies done on the
22 exchange?

23 A. Companies have not -- many companies
24 have not done well. Some have done reasonably
25 well. And it's really easy to be a major player

1 and then with next year's bid to be an also ran.

2 Q. Would you say Obamacare is designed
3 to highlight price competition; is that fair?

4 A. Yes. I think the structure of this
5 market is to promote price competition.

6 Q. How about let's be concrete. Give us
7 some specific examples about how some companies are
8 doing on these exchanges.

9 A. Well, I think we've -- we've all
10 heard that United has lost, what, \$650 million on
11 the exchanges and is pulling out of most exchanges,
12 if not all exchanges. That's been, you know, a
13 large story.

14 With respect to the two parties,
15 Humana has issued a press release -- actually, it
16 was in Bloomberg. It wasn't their press release.
17 But Humana is reported to have lost about
18 \$200 million last year, and it's likewise trying to
19 figure out what to do about its national strategy
20 moving forward.

21 The public information I've seen,
22 though, suggests very clearly -- again, it was in
23 this Bloomberg article -- suggests clearly that
24 they're planning to raise prices, that they're --
25 meaning premiums, they're going to reduce the

1 product offerings and they're going to leave, pull
2 out of some markets.

3 Q. So I think you've made this point
4 already, but a lot of share doesn't necessarily
5 lead to financial success in the world of
6 Obamacare?

7 A. That's true.

8 Q. You've talked about United. You
9 talked about Humana. Let's talk about Aetna.

10 A. Well, Aetna, my understanding for
11 Aetna is that they, like everybody, are always
12 assessing what's working and what's not working,
13 but that they're generally committed to staying in
14 the exchanges with maybe some changes at the
15 margin, but they're generally committed to the
16 exchanges.

17 Q. Let's move forward to Table 5. This
18 table's titled Individual ACA Public Exchange
19 Enrollment in Shares, and this is for this state of
20 Missouri 2015-2016. What is this information and
21 why does it matter?

22 A. This is to show you the sort of
23 volatility that I've been describing. If you look
24 at the enrollment side of it, the second column,
25 you can see that Humana has zero. They were not in

1 the exchanges in 2014.

2 Q. So we're starting in the left column?

3 A. Starting in the left column.

4 Q. Final 2014 you have Aetna at 85,000
5 or so and Humana at zero?

6 A. Right. They're not in the exchanges
7 yet. That's what triggered -- that's back in the
8 year when they had 1 percent of the individual
9 market because it was the off exchange that they
10 had 1 percent of the individual market.

11 Q. Let's move --

12 A. We started here from 2014.

13 Q. Well, so you're talking about
14 exchanges started in 2014?

15 A. No. I've confused you. I'm sorry.
16 When we first looked at the NAIC data, we started
17 with 2014 and they had less than 1 percent. None
18 of it came from the ACA exchanges.

19 Q. Got it. Okay. Thanks for the
20 clarification. As we're moving from left to right,
21 I'd like you to take a look at final 2015 and tell
22 us what we're seeing happening there.

23 A. Well, what you're seeing is Humana
24 enters. They get a modest amount of individual
25 business. Next year they get more individual

1 business. And if you do this in terms of shares,
2 what you see is that Aetna's shares falling
3 precipitously, Humana's shares growing modestly.
4 So the question -- and then you can look at what
5 the combined share would be, and it's, what,
6 38 percent or so in 2016. Whereas, back in 2014,
7 just two short years before that, Aetna itself had
8 72 percent share.

9 How do you lose that amount of share
10 in two years? The answer is the bids that were
11 submitted to the -- to the exchanges. They were in
12 a worse and worse and worse position each of those
13 three years.

14 **Q. Is this in your view a picture of**
15 **volatility?**

16 A. Absolutely.

17 **Q. And what does the volatility mean**
18 **specific to this transaction in this state?**

19 A. It means that -- it means a couple of
20 things. One, you cannot look at a share and say
21 that you're looking at market power. The share
22 does not predict or represent market power. It
23 represents a low bid. You only get that share
24 because of the price sensitivity of the exchange
25 members.

1 And it also says that -- really, it's
2 the flip side of the same coin, that your share can
3 fall off quite rapidly if you fall out of the
4 mainstream of being at the benchmark.

5 **Q. So tell me more about what this means**
6 **for Missouri and how you see it factor in to this**
7 **transaction.**

8 A. Well, we'll look at a little bit more
9 on the exchanges, but it means that the competition
10 can change very, very quickly, and that shares and
11 concentration measures really have no relevance to
12 assessing this market.

13 **Q. And at 38.3 percent, that's Aetna and**
14 **Humana combined as of 2016, does that signal to you**
15 **that there's going to substantially lessen**
16 **competition problem?**

17 A. No, it will not substantially lessen
18 competition in this line of business. It's quite
19 the opposite.

20 **Q. Let's move forward. I'd like to take**
21 **a look at Table 6. Now we're looking at a slide**
22 **titled Health Exchange Silver Plan Rankings in**
23 **Missouri, obviously 2015 and 2016. What do we**
24 **learn from this slide?**

25 A. This is again for Missouri, two

1 years, 2015 and 2016, and what we're looking at is
2 how times did Aetna have the number one rank, that
3 is the lowest price, and the number two rank. And
4 you can see that in 2015 in 49 counties they had
5 the lowest price, and they had the second lowest
6 price in, I think it's 51. I should probably have
7 one of those if you have one.

8 But what ended up happening as a
9 result of the bids in 2016 is they only had the
10 number one rank in 26 counties and the number two
11 rank, the second benchmark rank in 16 counties.
12 You'd say not that bad, but if we then go to the
13 next slide -- I'm sorry. This is Aetna and Humana
14 combined. That's what I couldn't really read.

15 Q. Yeah. We're going to keep it on
16 Table 6 here, if you could get on Table 6 there. I
17 apologize. But what I really want you to do is, as
18 we're looking at all the ranks, Rank 1, Rank 2,
19 jumping around, and you talk about volatility on
20 the other slide, this demonstrates further
21 volatility?

22 A. Yes. I mean, you can see the shifts
23 that have gone on just for the combined Aetna and
24 Humana ranks, and we also saw what happened to
25 their share. Aetna's went from 72 down to, I think

1 it was 59 on the table before, 59.7, down to 32 in
2 2016. So here they are, they have the top rank
3 and the second rank in 26 plus 16 counties, and
4 they've still dropped just in one year whatever
5 that would be, 27 percentage points. That's
6 volatility.

7 Q. It's volatility, but it also goes
8 back to your theme, which is connecting shares and
9 market power. And just remind us again, what does
10 this tell us on that point?

11 A. This tells us that it's hard to keep
12 your share when -- when the bids can take it away
13 given the price sensitivity of these mandated
14 exchange members.

15 Q. Now, we heard this morning that
16 United will likely drop out of the market for 2017,
17 and in the seven counties that Aetna and Humana are
18 both present, that would mean that the market's
19 losing another competitor. Fair enough?

20 A. For those seven counties.

21 Q. Should we be concerned, then, that
22 prices are going to rise based on that set of
23 facts?

24 A. No. Two reasons. One, it's fairly
25 quick that one can make a bid and win share. So

1 it's an attractive opportunity if you know how to
2 serve this exchange membership. Some do better
3 than others at that.

4 But also, what we see, if we look at
5 Table 7, what we see there is something to me was
6 fairly remarkable for Missouri, which is back in
7 2014, there was no county that had more than two,
8 two carriers, two insurers in that county.

9 Now, remember, just to make it clear,
10 each insurer doesn't just bid one plan. They can
11 bid as many plans as they want. So you could
12 actually have the first and the second lowest bid
13 if you wanted to do so. We saw that with Centene
14 in Florida.

15 But in 2014 on this graph, you can
16 see there was no county -- this is the startup of
17 Obamacare -- in which there were more than two. By
18 2016 you see the exact flip. There were only two
19 counties that had two or fewer carriers.

20 So you've -- so there are a couple of
21 things going on here. One of them is you can see
22 that there's rapid -- and it's called ready entry
23 in the merger guidelines, but you can see a rapid
24 response, you can see aggressive bidding, and you
25 can see that the shares move around quickly from

1 the data we've already looked at.

2 Q. Sir, so you looked at whether the
3 number of competitors makes a difference on
4 year-over-year prices; is that right?

5 A. Yes. This is one measure of that.

6 Q. Dr. McCarthy, are there any other
7 factors you want to discuss on this particular
8 point?

9 A. Well, yeah. I mean, the barrier to
10 entry point I think I just made, but I want to
11 understand that, that the Obamacare exchanges are
12 also set up to minimize some of the marketing costs
13 of a new entrant, because you're listed on the
14 exchange. If you bid a low price, you're actually
15 listed at the front of the exchange. The lowest
16 prices are revealed first. So the barriers to
17 entry are relatively low.

18 Also, what we've seen in other states
19 is we've seen a company, the one that tends to be
20 most active we've seen so far is Centene. Who's
21 Centene? Centene is an important Medicaid managed
22 care company. Centene recently bought Health Net,
23 at least their California and Arizona operations,
24 and they bought Health Net because Health Net, at
25 least they say in their press release, that Health

1 Net has a good Medicare Advantage -- I'm shifting
2 slightly here -- have Medicare Advantage product,
3 and they want to put that on their platform as they
4 expand in other states. But they're also expanding
5 from Medicaid to the exchanges because they're very
6 good at getting low prices from the Medicaid side.
7 So they get good provider prices, and they're very
8 good at handling patients who are on the exchange,
9 patients who are willing to accept a narrow
10 network, which helps them to keep costs down.

11 And they've done reasonably well on
12 the exchanges and are moving in more exchanges.
13 They are not in Missouri at this time. And this
14 tells me there's rapid response. Companies like
15 Centene, perhaps Molina, WellCare, they're
16 positioned to make the same kind of move.

17 Q. I'm going to move forward to Table 8.
18 Table 8 is titled Health Insurance Enrollment in
19 Shares, Aetna/Humana Overlap Counties, and this is
20 2014 to 2016 data. Now, go to the very left-hand
21 column. These are counties. How is it that we
22 selected these counties?

23 A. These are the seven counties in which
24 the two companies overlap.

25 Q. And what do we learn from this table?

1 A. Well, again, you can see in 2014
2 Humana does not have a presence, but these are the
3 shares that they have in each of these years.
4 Again, you could compare roughly the columns, say
5 2015 and 2016, and you'll see that there's quite a
6 bit of volatility in these shares. So this is
7 another measure of the volatility of shares.

8 Q. So we've looked at a lot of tables,
9 talking about a lot of volatility, but I want to
10 come actually back to Dr. Gruber for a second.
11 Did you have a chance to review Dr. Gruber's report
12 about the exchanges?

13 A. Yes.

14 Q. Let's just start, what did you
15 generally think about it?

16 A. I mean, I'd sort of sum it up a lot
17 like John Orszag did about all of the studies, that
18 those -- that study relied on 2011 being the
19 benchmark of what shares would have been. It's
20 sort of like if I imagine the individual market in
21 2011 going forward and United was in it, all the
22 insurers were in it, then what would I see?

23 That's not at all -- that's not at
24 all the way to approach this, because the changes
25 from Obamacare were dramatic. You've got a totally

1 different population. Those are buying individual
2 insurance in 2011 are a different group than those
3 who are now mandated to buy on the exchanges.

4 The rules of the exchange cause
5 companies to have a totally different bidding
6 strategy, have a -- they're not just sort of
7 putting their price out there and, you know,
8 they'll catch a few people in the individual market
9 or not. They're looking to bid for those low
10 spots. And so it just -- it just doesn't fit as a
11 predictor.

12 We also have the fact that many of
13 the plans have lost a lot of money. So to say
14 United doesn't come in when they came in and now
15 they're exiting doesn't really match the assumption
16 that he would be making that had they come in and
17 stayed.

18 **Q. Let's connect this to this**
19 **transaction. Whether Professor Gruber actually**
20 **said it or whether he was implying it wasn't**
21 **exactly clear perhaps, but let's assume he was**
22 **suggesting that Humana leaving the marketplace**
23 **through a merger would somehow lead to higher**
24 **prices. If Dr. Gruber were saying that, what would**
25 **your response be, given what we just talked about?**

1 A. That would be the implication of his
2 finding, but I would say look at the volatility,
3 look at the readiness of others to come into the
4 market, look at the availability of, I think, a
5 couple of sensible possible entrants. I don't
6 know. It's probably known now in many states who
7 is planning to enter, at least exploring to enter,
8 but I would predict that there are going to be
9 expansions by companies like Centene at least in
10 some states.

11 Q. Dr. McCarthy, to summarize, after all
12 the commercial data we've looked at, all the
13 tables, all the graphs, do you have any concerns
14 with respect to the commercial, which is
15 comprehensive group or comprehensive individual,
16 that the result of this transaction would be to
17 substantially lessen competition in this state?

18 A. No, certainly not in this line of
19 business.

20 Q. Let's move forward then to Medicare.
21 I want to talk to you again about the Form E data,
22 and again, not the confidential parts of the
23 Form E, but I want to talk about the shares, which
24 has already been put up on the board, that part
25 that we've all agreed can be shared today. What

1 are the Form E shares on Medicare?

2 A. I believe the number was 55 percent
3 or so based on the Medicare Advantage premiums.

4 Q. And that 55 percent number we've been
5 seeing on the board assumes that traditional
6 Medicare should not be factored in to the analysis
7 when considering the segment; is that right?

8 A. That's correct. And I'll give you
9 some reasons, too, but I thought John Orszag gave a
10 fairly ringing defense as to why they should be in
11 the same market. When you do that, the post-merger
12 share of the two companies is 14.1 percent.

13 Q. In your affidavit, Dr. McCarthy, you
14 mentioned that the Florida Office of Insurance
15 Regulation concluded that TM and MA do compete,
16 correct?

17 A. Yes.

18 Q. And let's go ahead and turn to
19 Exhibit E, which is in Binder 2.

20 HEARING OFFICER ERICKSON: I'm sorry.
21 What exhibit letter?

22 MR. WHITMER: Exhibit E, Binder 2.

23 HEARING OFFICER ERICKSON: E?

24 MR. WHITMER: E as in Edward.

25 HEARING OFFICER ERICKSON: Thank you

1 very much.

2 BY MR. WHITMER:

3 Q. Exhibit E is not a confidential
4 document. It is admitted into the record, and this
5 is the Consent Order issued by the Florida Office
6 of Insurance Regulation that you referenced in your
7 affidavit, correct?

8 A. That's correct.

9 Q. And in your report, you talk about
10 some of the conclusions that the Florida OIR
11 reached, and I'd like to actually walk through it.
12 Now, if you could go ahead and take a look --
13 again, we're still in Exhibit E, and if you could
14 take a look at page 6 of 25, the very top of the
15 page, and read it -- I'll read it. You tell me if
16 I read it correctly.

17 In reaching its conclusion that
18 Medicare Advantage competes directly with
19 traditional Medicare, the office analyzed a number
20 of factors and market conditions, including but not
21 limited to the following. Do you see that?

22 A. I do.

23 Q. And then the Florida OIR proceeds to
24 identify five specific factors that it considered
25 when reaching its conclusion that TM and MA, in

1 fact, do compete and that that competition should
2 be considered as part of the analysis?

3 A. That's correct.

4 Q. Okay. Have you also had the
5 opportunity to take a look at those same five
6 factors and reach your own conclusions?

7 A. Yes, and we can go through each of
8 them if you'd like.

9 Q. Yeah. Let's do it. Let's take a
10 look at the screen. Point 1, consumer experience.
11 This is one of the five factors that we just talked
12 about. Go ahead and explain this one.

13 A. And this one you've heard quite a bit
14 about. I've got a few slides that would support
15 this. But this has to do with the shopping
16 process. The consumer experience is the consumer
17 is presented with this side-by-side choice. The
18 consumers I presented with a lot of information
19 about them. They can choose different variations,
20 and I think they were broadly discussed already.

21 But the shopping experience is such
22 that it facilitates competition by the fact that
23 there's good information out there, that the
24 products are presented side by side, that there's
25 the aging in moment when the choice is made, and

1 there's also the annual enrollment period. And
2 just what the Florida DOI OIR said that this
3 shopping process itself was something that
4 facilitated competition.

5 Q. So again, Mr. Orszag already talked
6 about this, and so I don't want to go into it too
7 much, but can you give us an example of how this
8 might factor in, a real life example that
9 articulates this point?

10 A. If I can have the next slide, I think
11 it's quite similar to what you saw. This slide is
12 sort of the opening screen. It shows you the
13 alternatives that you have. So if we look at --
14 you can get prescription drug plans. There are 26
15 of those. I'm reading the middle and right-hand
16 column. You can get Medicare Advantage health
17 plans with drug coverage. That's called MAPD, and
18 there are eight such plans. And there are two
19 plans that offer Medicare Advantage without drug
20 plans.

21 So we're starting from the beginning
22 here as to the things that are available to you,
23 and what we're going to see is that you can also
24 get traditional Medicare. That would be on the
25 next slide.

1 **Q. Let's go ahead and go to the next**
2 **slide.**

3 A. What you see at the top of that slide
4 is you see original, which is the same thing as TM,
5 traditional Medicare, as the first option. And
6 then we've only pulled up, you know, a screen shot
7 of the first one in line, but then the next one
8 right below is the Medicare Advantage. So these
9 are presented right next to each other as options
10 with various links to click and to understand and
11 price things out for yourself.

12 **Q. Let's jump forward to the next of the**
13 **five factors, and this is going to be up on the**
14 **screen in a second.**

15 HEARING OFFICER ERICKSON: Before you
16 proceed, I do have a quick question for
17 clarification. Figure 5 that we were just looking
18 at and then Figure 6 that goes into more detail,
19 can you tell me what website or where is this from?

20 THE WITNESS: It's from the
21 Medicare.gov.

22 HEARING OFFICER ERICKSON: And why
23 does this one look different from one of the
24 earlier ones we saw? I just don't understand.

25 MR. WHITMER: I think they're just

1 different screen shots from different portions of
2 the website.

3 THE WITNESS: Yeah. I think it's
4 maybe -- that's right.

5 HEARING OFFICER ERICKSON: So this
6 is -- it's the CMS website?

7 THE WITNESS: Yes. Medicare.gov.

8 HEARING OFFICER ERICKSON: If I went
9 there today and I decided I'm of age, it's time for
10 me to get my Medicare, this is what I might see?

11 THE WITNESS: This is where you might
12 start. You can see even on that first page, which
13 I jumped over a little too quickly, it says there
14 are a total of 37 plans available in your area,
15 including original Medicare. And then you go to
16 the next page and they present you original
17 Medicare plus. If you scrolled down, which of
18 course you can't do on hard copy, but if you
19 scrolled down, you would see the other plans that
20 are available.

21 MR. WHITMER: Your Honor, if we could
22 just go to the side for a second, because you asked
23 and it's a good question, if you take a look at
24 John Orszag's slides which we provided to you
25 earlier, if you want to do a compare and contrast

1 we can look at Slide 10.

2 HEARING OFFICER ERICKSON: As long as
3 you mention it, I believe it. It's over here
4 somewhere. I just wanted to confirm the origin of
5 the screen shot. Thank you. So you mentioned it
6 was Slide 10 of Dr. Orszag?

7 MR. WHITMER: Yes. So Mr. Orszag's
8 Slide 10, the screen shot matches up with what you
9 see on Figure 6 here.

10 HEARING OFFICER ERICKSON: Thank you.

11 BY MR. WHITMER:

12 Q. So, Dr. McCarthy, I'm going to move
13 forward, keep us moving to the second of the five
14 factors, and this titled The Future of Medicare.

15 A. Yes.

16 Q. What did we learn from this?

17 A. Well, this is pretty interesting
18 actually. What is also going on, and is largely
19 driven by the Obamacare law, is that traditional
20 Medicare is actually moving toward Medicare
21 Advantage, and it's mostly done in terms of -- the
22 trigger for this is something called ACOs,
23 accountable care organizations.

24 What ACOs are is they're collections
25 of usually a -- they can be physician groups that

1 start them. They can be a hospital system. They
2 can be an integrated hospital system. There are
3 lots -- we'll look at this. There are lots of
4 ACOs.

5 And what the ACOs do is they take on
6 more and more risk. Even when they're serving
7 traditional Medicare patients, they're bearing more
8 and more risk. And there are a number of other
9 things going on in Medicare that are facilitating
10 this move toward greater risk bearing.

11 So we will see more and more -- there
12 are bundled payment initiatives going on. There
13 are payments for quality going on. There are --
14 we'll see some of these models here in Figure 7.
15 We can look at that and give you a better sense.

16 Figure 7 shows what is a payment
17 taxonomy framework. And so what -- Category 1 is
18 basically traditional Medicare. There's fee for
19 service. There's no link to quality.

20 The second category is a move to a
21 greater proportion of the payment being based on
22 how well you do, what -- and there are quality
23 measures that Medicare is collecting already.

24 Category 3 is an alternative payment
25 mechanism, and that's where you see in the bottom,

1 accountable care, medical homes, bundled payments,
2 which is a big one. Comprehensive VSRD, that's the
3 end stage renal disease program. Making Medicare
4 and Medicaid work better together. Category 3
5 you've got alternative payment mechanisms that
6 cause greater risk bearing.

7 And then finally Category 4 is
8 population-based payment. What population-based
9 payment means is, it's an awful lot like getting a
10 chunk of money to manage the health care of a given
11 population, and that population are traditional
12 Medicare patients who have, in effect, been
13 assigned to -- they're not locked in, but have been
14 assigned to a particular group of physicians or a
15 hospital system.

16 So more and more Medicare is moving
17 the traditional Medicare into risk sharing by
18 providers. Well, that's exactly the hallmark of
19 Medicare Advantage. We used to think of Medicare
20 Advantage as being run by an HMO where they have to
21 bear all the risk. So these models are moving
22 closer together.

23 **Q. Let's jump to the next slide. It**
24 **talks about ACO incentives. Briefly, what can you**
25 **tell us about that?**

1 A. What this slide is meant to show,
2 where we say MAOs, those are Medicare Advantage
3 organizations, and where we say Medicare ACOs,
4 those are traditional Medicare patients. And if
5 you look at the characteristics, there are, what,
6 seven of them listed here, you can see that there's
7 very much a parallel function, a parallel structure
8 that's being used in the Medicare ACOs.

9 So just take the first one. A
10 network of doctors in a hospital with a financial
11 and clinical responsibility for a set of patients.
12 That sounds an awful lot like a Medicare Advantage
13 plan, which we've labeled as -- this is from a
14 colleague economics firm, Bates White, you'll see
15 at the bottom.

16 But under MAOs it's labeled as an
17 insurer with financial responsibility for a set of
18 patients, shared clinical responsibility. I don't
19 want to go through all of these for you.

20 **Q. This is helpful, Dr. McCarthy, but**
21 **you just mentioned something. You mentioned Bates**
22 **White. I'd like to take you to a document. It's**
23 **actually in Binder 4. Should be sitting to the**
24 **left of you, I think.**

25 A. Yes, it is.

1 Q. And if you take a look at Exhibit O.

2 A. Yes.

3 Q. I'm just going to remind you, sir,
4 this is a document that's been marked confidential.
5 It's a closed document,

6 A. Correct.

7 Q. I'm asking you not to refer to or
8 mention any of the confidential portions in this
9 white paper. What I'd like for you to do, though,
10 is just to tell us generally what is this white
11 paper and what is it we can learn from this?

12 A. This white paper is an analysis of
13 entry, including an econometric model that helps to
14 predict entry, and there's a section on Missouri in
15 this -- in this white paper about entry in
16 Missouri.

17 Q. And when you say entry in Missouri,
18 why does that matter and how does it pertain to
19 this transaction?

20 A. Well, it's -- it's a measure of what
21 the likely entry could be and how the -- that, of
22 course, is one of the big supply responses that
23 would lead to --

24 Q. I'm going to --

25 A. I'm sorry. That would lead to

1 greater competition.

2 Q. I'm going to jump forward to Point 3.
3 I'm going to go a few slides ahead. And you see
4 Point 3, it says market fluidity?

5 A. Yes.

6 Q. And I'm going to read what's on the
7 screen. Point 3 is, switching between traditional
8 Medicare and Medicare Advantage demonstrates
9 competition. This again is one of the five points
10 that the Florida OIR identified as being important
11 to its conclusion. What can you tell us generally
12 about this?

13 A. Well, again, I think you've heard
14 quite an exchange between, well, both yourself and
15 John Orszag as well as Mr. Angoff. This really has
16 to do with a relatively consistent pattern of
17 switching, that traditional Medicare is moved to
18 Medicare Advantage, Medicare Advantage moves to
19 traditional Medicare, Medicare Advantage move among
20 Medicare Advantage plans.

21 So I think you've heard a lot about
22 this analysis, and what the Florida OIR is saying
23 here is, they look at this market fluidity and it
24 gives them comfort in concluding that the two
25 products TM and MA compete.

1 Q. Let's turn to the next point, Point 4
2 out of 5 talks about market dynamics. This is that
3 benefit design changes as premiums change. What do
4 we take from this point?

5 A. Well, this -- this is almost sort of
6 a long-run look at it all. That is that there have
7 been changes in the premiums, changes in the
8 subsidies that have gone on, and what has been
9 demonstrated is that people, enrollees care a lot
10 about the mix of things. This goes to sort of the
11 differentiated product point that was already
12 discussed as well.

13 That is, in 1997 there was a big
14 cutback in benefits. Actually, I've jumped ahead
15 to the value proposition. I should -- they're very
16 closely related.

17 Q. You can describe them both Point 4
18 and Point 5 together. In fact, while you're doing
19 that, I'm going to go one slide ahead, value
20 proposition. And why don't you just go ahead and
21 describe generally both of those points together,
22 what the main issue is there.

23 A. Yeah. This is more the longer-term
24 point, which is that the fact that we see changes
25 in Medicare Advantage penetration over time when in

1 1997 the -- there were cuts in the subsidy that the
2 federal government paid to Medicare Advantage
3 companies, that caused quite a dropoff in
4 penetration rates.

5 Then in the early 2000s the premium
6 amounts were increased. That caused a big increase
7 in penetration over the -- particularly over the
8 last ten years or so.

9 So what Florida found valuable about
10 that is that clearly the amount of benefits that
11 came out of those higher or lower subsidies were
12 something that something that consumers responded
13 to and switched to and from traditional Medicare.

14 Q. Now, you heard John Orszag's
15 testimony about how MA and TM compete. You've now
16 walked us through the five points that the Florida
17 OIR focused on in reaching its conclusion that TM
18 and MA compete. What I'd like to do now is take
19 you forward to the next slide, which is Table 9,
20 and now tell us if Mr. Orszag is correct and if you
21 are correct, Dr. McCarthy, and if the Florida OIR
22 is correct, if you're all correct, then what
23 numbers do we get as part of this analysis?

24 A. Well, you can see that the total
25 combined post-merger share, if you include

1 traditional Medicare in the market as that group
2 you just mentioned believes is warranted, the share
3 is 14.1 percent.

4 Q. Aetna at 8.6 percent, Humana at
5 5.5 percent, aggregate of 14.1 percent, and that's
6 obviously less than half that 30 percent number
7 that we were talking about?

8 A. Yes.

9 Q. And given that, sir, do you have any
10 concerns that this transaction that's proposed
11 would substantially lessen competition in light of
12 Medicare?

13 A. No, I don't. I think that this is a
14 clear picture of the competition.

15 Q. Let's move forward to Figure 9. Tell
16 us what we see here and why it matters.

17 A. Well, what you see here is the
18 results of a Towers Watson survey. Who's Towers
19 Watson? They're a big benefits consulting sort of
20 firm, and they arrange for big companies and small
21 companies alike, they arrange health care benefits,
22 among many other things they do.

23 And they did a survey as to who was
24 going to -- which employers were going to shift
25 their retiree benefits for health care from what's

1 called a group Medicare Advantage plan to something
2 else, something called private exchanges, and
3 Towers Watson runs one of these exchanges. There
4 are others that do as well.

5 And what they found was that
6 40 percent, I think was the number, that in the
7 next year -- yes. In the next year have either
8 converted already or will convert to a private
9 exchange.

10 So what's a private exchange? A
11 private exchange basically is that health care
12 consultant takes an employer group and they offer a
13 wide variety of Medicare Advantage programs around
14 the country as to where the retirees may go, or
15 maybe not around the country. Maybe they'll stay
16 mostly local.

17 But they will arrange for each
18 Medicare beneficiary who's retiring with that
19 company to choose either traditional Medicare or
20 some Medicare Advantage plan. So it's basically
21 taking a group plan and breaking it up into its
22 parts.

23 HEARING OFFICER ERICKSON: Regarding
24 this Figure 9 from Towers Watson, is this based on
25 national numbers, sir?

1 THE WITNESS: That's my
2 understanding, this is their survey of national
3 employers.

4 HEARING OFFICER ERICKSON: Have you
5 dug any deeper with regards to the use of this new
6 alternative within the state of Missouri?

7 THE WITNESS: Yes. We -- we looked
8 at that. What we find is there are large employers
9 which I think have some employees here, but I don't
10 know that the Missouri employers themselves were
11 headquartered here. For instance --

12 HEARING OFFICER ERICKSON: That's
13 fine. I don't want to take you astray. I just
14 wanted to make sure Figure 9 was based on national
15 data. Let's keep moving. Thank you.

16 THE WITNESS: The examples we have
17 are IBM and UPS and big companies like that.

18 BY MR. WHITMER:

19 Q. Dr. McCarthy, you've been focusing on
20 statewide data, statewide information, and you
21 provided all sorts of information to us, and we've
22 looked at that. But I want to sort of switch gears
23 on you now and ask, have you had the opportunity to
24 look more narrowly at local competition in
25 Medicare?

1 A. Yes, we did. We did something
2 similar as we looked at it MSA by MSA.

3 Q. Okay. So let's take a look at the
4 next slide. On Table 10, again, there's a lot of
5 information on Table 10. Let's unpack this
6 together. It's titled Medicare Enrollment and
7 Shares.

8 A. Yes.

9 Q. Okay. So before we talk about this,
10 when you looked more narrowly at a local
11 competition in Medicare, what broadly did you find?
12 Just give me your conclusion first.

13 A. Local -- that most MSAs did not have
14 a share greater than 30 percent and, therefore,
15 there was no immediate concern.

16 Q. And, sir, there's four counties that
17 are identified on Table 10, Dallas, Polk, Webster,
18 and I'm not sure I'm going to pronounce it
19 correctly, but Laclede?

20 A. Laclede.

21 Q. Four counties where the combined
22 share is above 30 percent; is that right?

23 A. That's right.

24 Q. And is that how you selected the four
25 counties that are set forth on Table 10?

1 A. Yes.

2 Q. Let's take some time looking at the
3 four counties on Table 10 where the combined share
4 is above that 30 percent threshold. What can you
5 tell us about these four counties?

6 A. Well, three of the four are counties
7 as part of the Springfield MSA. We know a couple
8 of things. One, Essence who's a player in Medicare
9 Advantage, has entered and expanded into
10 Springfield. So their presence there should
11 increase.

12 Also, Anthem is in all three
13 counties, so they could expand their offering. We
14 understand, in fact, I think some of this is
15 covered in that entry white paper, that Anthem's
16 entry plans and expansions, they've gone further
17 into the SSNIPs, the special needs plans. So
18 they're expected to become much more active in
19 Medicare Advantage.

20 And then the third thing is a rumor
21 that we learned from Aetna management that Mercy
22 may be considering entering. Mercy is the
23 hospital, one of the two hospital systems in
24 Springfield. The other is the Cox hospital system,
25 which already has insurance products.

1 Q. So that leaves Lebanon. Let's take a
2 look up here. Let's come back in a second. Why
3 don't you give us a conclusion, then, about what
4 is -- on Table 10, what is our global takeaway?

5 A. That these -- first of all, the
6 levels of shares are not -- are not particularly
7 threatening. We're barely over 30 percent in most
8 of these.

9 And the second takeaway is that there
10 are things going on in Springfield that I think
11 give us some assurance that a supply response is
12 going to happen.

13 And the other thing I guess I would
14 say is that these markets are much more resilient
15 than I think people give them credit for. We've
16 seen -- certainly in the ACA exchanges we've seen
17 how quickly things can change there. Medicare
18 Advantage is another opportunity that insurers will
19 look to, and I suspect expansion and entry are
20 easily predicted.

21 Q. So as you've looked statewide and
22 you've looked locally, can you summarize for us
23 either way, is from your perspective the effect of
24 this transaction likely to substantially lessen
25 competition from either approach with respect to

1 Medicare?

2 A. No, I don't believe it will.

3 Q. Dr. McCarthy, I want to give you an
4 opportunity both to summarize your testimony and to
5 provide any additional points that you think we
6 ought to consider as we're evaluating this
7 transaction.

8 A. First, with respect to the
9 fundamental question I was asked to answer, I do
10 not believe that the transaction will lessen
11 competition or tend to create a monopoly in any
12 line of business in Missouri.

13 And if I had to say what's the reason
14 I believe that, it's because of the resilience of
15 the competitive market process, and that there are
16 entities that can change the shares quickly in at
17 least the areas we've been talking about,
18 comprehensive group, individual and Medicare. And
19 I think these markets, the supply responses in
20 these markets are going to be sufficient to keep
21 prices low.

22 Q. I'm going to go back to slide 1 for
23 just a second. It's a long trip back to slide 1,
24 but we'll get there. So we're back where we
25 started. We started with three lines. I want to

1 end with three lines. Just to summarize what we've
2 talked about, on comprehensive group, that first
3 line, you've explained to us that if you just look
4 at it through the Form E lens, you're well below
5 the 30 percent threshold, right?

6 A. You're well below under NAIC measures
7 and under even the broader measure of self-insured
8 plus fully insured.

9 Q. And you dug deeper and you dug deeper
10 and you dug deeper and you've given us many, many
11 different ways of looking at it beyond what the
12 approach is that's set forth through the lens of
13 the statute at issue here and the Form E lens, and
14 they all -- you reached the same conclusion for us
15 in all respects?

16 A. I think that's right, yes.

17 Q. And comprehensive individual where we
18 see Humana with less than a 1 percent share, you
19 talked about it and said that in and of itself
20 doesn't cause you concern because you're only
21 adding less than 1 percent?

22 A. Yeah. We then -- that was 2014 data.
23 They're simply limited by the data that were
24 available at that time. I think 2015 is available,
25 but we also dug deeper on that one.

1 Q. And you dug deeper by talking about
2 exchanges and about the volatility of those
3 exchanges, and you also talked with us about how
4 the share isn't connected to market power?

5 A. Correct.

6 Q. And then you went into Medicare, and
7 you looked at the numbers that were up there on the
8 Form E data, correct?

9 A. Yes.

10 Q. And you explained to us how that
11 actually is when you're ignoring traditional
12 Medicare, that information up on the screen?

13 A. That's correct.

14 Q. And then you and Mr. Orszag and the
15 Florida OIR explained looking through the lens of
16 including traditional Medicare, you gave us new
17 data, which would be the new Form E data. You
18 probably saw that we walked through that this
19 morning with one of the witnesses, and you just
20 walked through it as well, and that gets you data
21 that's less than approximately half the 30 percent
22 threshold?

23 A. That's correct.

24 Q. In summary, based on whatever
25 viewpoint you look at --

1 MR. ANGOFF: Your Honor, I don't mind
2 counsel doing his closing, but shouldn't he wait
3 until closing.

4 HEARING OFFICER ERICKSON: Finish
5 your question.

6 BY MR. WHITMER:

7 Q. Whatever viewpoint you look at, sir,
8 do you have any concern whatsoever that this
9 transaction will substantially lessen competition
10 in the state of Missouri?

11 A. No. I think the markets are
12 resilient.

13 MR. WHITMER: Thank you. I have no
14 further questions at this time.

15 MR. ANGOFF: Dr. McCarthy --

16 HEARING OFFICER ERICKSON: Mr.
17 Angoff, we're going to go off the record.

18 (A BREAK WAS TAKEN.)

19 HEARING OFFICER ERICKSON: We are
20 back on the record. Mr. Angoff, please proceed
21 with cross-examination.

22 CROSS-EXAMINATION BY MR. ANGOFF:

23 Q. Dr. McCarthy, you mentioned several
24 times this threshold of 30 percent below which you
25 didn't see any competitive problems in connection

1 with the merger, right?

2 A. That's right.

3 Q. Okay. And this 30 percent threshold,
4 that's not based on the Missouri Insurance Holding
5 Company Act, right?

6 A. No. My reading of the statutes and
7 NAIC is that once you reach a threshold, it is a
8 safe harbor. And there's several federal
9 regulations that read this way, too. Once you
10 reach that threshold, then there's more analysis to
11 be done.

12 I believe, in my experience, that
13 whenever I've done a health insurance merger with
14 the agencies, that 30 percent is where that
15 threshold is.

16 Q. But there's no 30 percent figure in
17 the Missouri statute, is there?

18 A. Not that I know of, no.

19 Q. And, in fact, the figures in the
20 Missouri statute are 4 percent plus 4 percent,
21 10 percent plus 2 percent, and 15 percent plus
22 1 percent, correct?

23 A. For a prima facie case.

24 Q. That's correct.

25 A. And then there is the opportunity to

1 discuss that case, and that's what I'm doing.

2 Q. Right. But you're using this -- this
3 30 percent threshold, which is counter to the
4 threshold that establishes a prima facie case in
5 Missouri, right?

6 A. It's not counter. It's supplementing
7 the triggering finding of a safe harbor.

8 Q. Well, the 4 percent and 4 percent,
9 10 and 2 and 15 and 1, those aren't safe harbors,
10 are they?

11 A. If you're below them, they are.

12 Q. Doesn't the statute allow someone --
13 doesn't the statute allow the Department to
14 demonstrate by other evidence even if the merger
15 would result in more market shares below that
16 threshold that it's still anti-competitive?

17 A. That opportunity is open as well.

18 Q. Then that's not a safe harbor, is it?

19 A. Well, I think in practice it is, but
20 I suppose literally it's not.

21 Q. Okay. And the 30 percent that you
22 used, that's not based on any other law in
23 Missouri, right?

24 A. My role was to analyze the
25 competitive effect of a merger, and I'm analyzing

1 it the way an economist would generally go about
2 analyzing it. And I am saying that whatever the --
3 whatever the threshold is in the Missouri statute,
4 there is, in effect, an invitation to discuss that
5 threshold, and that's what I'm doing with you.

6 Q. So you're not -- you're not opining
7 on whether this merger violates the Missouri
8 Insurance Holding Company Act?

9 A. That's not for me. I'm not the
10 finder of fact.

11 Q. You also cited a couple of Federal
12 District Court decisions where the court said --
13 found market shares in around the 30 percent area
14 not to be anti-competitive, correct?

15 A. That -- the general -- yes,
16 generally.

17 Q. And you cited, by the way, even
18 though you're not a lawyer, you cited those cases
19 in beautiful Blue Book form.

20 A. I'm not sure what you're saying.

21 Q. There are, though, aren't there,
22 Supreme Court cases where the merger has resulted
23 in much, much lower shares than 30 percent, and
24 those mergers have been disapproved by the Supreme
25 Court, right?

1 A. My understanding, and I'm not -- I
2 don't read the law the way you would read the law,
3 and I don't read the precedence necessarily the way
4 you would read the precedence. But if you look at
5 the developments in antitrust law kind of
6 journal -- not journals, but books, volumes, this
7 is what you'll find. You'll find what I've
8 written, and I believe I've cited to those.

9 **Q. But you're -- and you're also not**
10 **opining on what the federal antitrust law is?**

11 A. I'm not -- no, I'm not opining on --
12 I'm not trying to make any legal conclusions here.
13 That is for the finder of fact and it is -- it is
14 simply meant to be put into a context.

15 **Q. You showed us a chart that listed**
16 **four counties in Missouri and showed in those four**
17 **counties what the shares, the combined shares of**
18 **the MA market would be on Aetna and Humana, right?**

19 A. Yes, I did.

20 **Q. But there are 111 other counties in**
21 **Missouri, right?**

22 A. Yes, if you count St. Louis as a
23 county.

24 **Q. I'd like to show you Exhibit 20,**
25 **which is in evidence, which is the Department's**

1 market share statistics for MA by county starting
2 with the year 2007. The last three pages are the
3 market share statistics by county for each of the
4 115 counties or 114 counties plus St. Louis City.
5 They're market share statistics for each of those
6 counties. Could you -- could you go to the third
7 to the last page and look at that column labeled --
8 headed Aetna plus Humana. Do you see that?

9 A. I do now, yes.

10 Q. Okay. You see there's -- in that
11 column, Aetna plus Humana, there are several
12 numbers opposite counties which are highlighted,
13 right --

14 A. Yes.

15 Q. -- in pink?

16 Okay. And the ones in pink, just
17 reading some of them, Jackson County's Kansas City.
18 Could you read what Jackson County's combined
19 market share is?

20 A. It is listed as 85 percent, 85.36.

21 Q. Okay. And if you count these
22 counties up, I'll represent to you, and feel free
23 to count them up if you disagree, but there are
24 33 counties where the combined market shares are
25 70 percent and greater. Does that give you any

1 pause? Doesn't that make you at least a little bit
2 concerned that this merger could have an
3 anti-competitive effect?

4 A. No. We're talking here, at least
5 what this is labeled is 2016 individual share.
6 Okay. I don't think there's any clear
7 demonstration about the volatility of share in any
8 county. It changes with the bid from any carrier.
9 So if somebody has an 86 percent share, it's
10 because they're pricing low right now. It does not
11 represent market power.

12 Q. Okay. So let me make sure I
13 understand your volatility argument. I thought you
14 were making your volatility argument only in
15 connection with the individual market, but you're
16 making it also in connection with the MA market?

17 MR. WHITMER: Objection.

18 THE WITNESS: This says market share
19 individual.

20 BY MR. ANGOFF:

21 Q. Sorry. Market share individual MA.

22 A. Well, let's reask the questions,
23 then.

24 Q. Okay. Are you making the argument
25 that volatility makes a -- volatility in the market

1 shares makes what would otherwise be an
2 anti-competitive merger not anti-competitive? Are
3 you making that argument in connection with the
4 Medicare Advantage market?

5 A. I have not studied volatility so much
6 in the MA individual market, but that's not the
7 argument I'm making to you. I'm making the
8 argument that traditional Medicare makes this not a
9 problem.

10 Q. Okay. In your analysis, did you do
11 any analysis using the HHI index?

12 A. No.

13 Q. Why not?

14 A. Two reasons really. One, I think we
15 would disagree on what that HHI number is because I
16 can see here that there's an HHI calculation on
17 these tables. I disagree with these shares. I
18 would disagree with these HHIs.

19 The other is that -- and you had a
20 bit of this discussion earlier. The other is what
21 has to do -- what it has to do with is the change
22 in share -- I'm sorry, the change in HHI. That's a
23 second point.

24 A third point is that I have not
25 found the agencies at all to be wedded to the HHI.

1 There are many hospital mergers, many insurance
2 mergers that would -- that have an HHI that's
3 higher. So, for instance, in this transaction,
4 under the individual exchange market, you can have
5 very high HHIs. They don't have any meaning.

6 **Q. The very high HHI would be what?**

7 A. Well, any -- pick any number. I'm
8 telling you that the only way you get a high HHI is
9 a high share. The only way you'll get a high share
10 is to be one of those first two silver plan bids.
11 And, therefore, both the share -- the high share
12 and the high HHI do not reflect market power.

13 **Q. You agree, though, that under the**
14 **guidelines an HHI -- the pre-merger HHI is at least**
15 **2,500 and the post-merger HHI increases by at least**
16 **200 percent, then the merger is presumptively**
17 **anti-competitive?**

18 A. I understand what the guidelines say.
19 I guess I'm --

20 **Q. And do you agree with that? I mean,**
21 **first you agree that is the standard in the**
22 **guidelines?**

23 A. I understand that's what the
24 guidelines say. There are two things to say. One,
25 do I agree with how you would be calculating them

1 as represented by this or by what you might ask me
2 about the exchanges. And I -- I don't agree that
3 we have the right shares or the right HHIs. But
4 I'm also suggesting to you that the HHIs are not as
5 slavishly followed as appears in the guidelines.

6 Q. Okay. And when you say you disagree
7 with these market shares, do you mean that you
8 think that they're calculated wrong?

9 A. Yes.

10 Q. You think there are arithmetical
11 mistakes?

12 A. Are we talking about these right
13 here?

14 Q. Yes.

15 A. No, I don't think they're
16 arithmetical mistakes. I think they're market
17 definition mistakes.

18 Q. You think that Medicare and MA should
19 be the same, are the same market?

20 A. Traditional Medicare, yes.

21 Q. But you don't disagree that if --
22 you're not saying, are you, that if Medicare
23 Advantage is the market, that these shares, that
24 these numbers here are inaccurate?

25 A. Well, either way I haven't tested

1 them, whether they're right or wrong. I'm saying
2 conceptually I'm telling you at this point they're
3 wrong. If it's just an MA market, are these
4 calculations right, I'll have to take your word for
5 it. I don't know.

6 **Q. You've worked on a lot of mergers,**
7 **right, Dr. McCarthy?**

8 A. I have, yes.

9 **Q. And so you're familiar obviously with**
10 **the concept of the relevant market?**

11 A. Yes.

12 **Q. And you know that there are two**
13 **components of the relevant market, the product**
14 **market and the geographic market?**

15 A. Yes.

16 **Q. Okay. And when you're analyzing**
17 **mergers, how do you go about determining the**
18 **correct product market?**

19 A. You look -- what you're looking for
20 is the degree of substitution among different
21 products, and one fairly standard way is to analyze
22 what Mr. Orszag talked to you about, too, which is
23 diversion ratios. How much diversion -- if a price
24 goes up or if a hospital is excluded from a
25 network, what is the diversion to arrive at?

1 Q. And how do you determine that?

2 A. Usually statistically. Sometimes you
3 don't have the data. Sometimes you have the data.
4 But you look at the diversion, and that's what
5 Mr. Orszag did with respect to Humana and Aetna and
6 their diversion both to each other and to other MA
7 plans and to traditional Medicare.

8 Q. Okay. You haven't done that in this
9 case?

10 A. No. That's -- that's a task left to
11 Compass Lexecon and Mr. Orszag.

12 Q. And have you heard -- have you heard
13 of the term brown shoe criteria? Do you know what
14 they are?

15 A. I don't know the criteria. I've
16 heard of certainly brown shoe, but I don't know of
17 the specific criteria.

18 Q. Have you ever determined the product
19 market based on your analysis of the brown shoe
20 criteria?

21 A. You'll have to tell me what I'm
22 answering specifically about the brown shoe
23 criteria.

24 Q. Fair enough. Are you familiar with
25 the SSNIP test under the merger guidelines?

1 A. Yes.

2 Q. And have you ever determined a
3 product market based on the SSNIP test?

4 A. Not specifically, because what you do
5 is you make inferences from the diversion ratios,
6 you make inferences about whether that leads to
7 certain upward pricing pressure. And so mostly
8 what is done is not the actual SSNIP estimate.
9 There are some models that do that.

10 Q. And by the SSNIP estimate -- I'm
11 sorry. Go ahead.

12 A. Well, don't make the SSNIP estimate,
13 but what you do is you look to see if, given the
14 diversion ratios, given the companies involved, is
15 it likely that there's substantial incentive to
16 raise price.

17 Q. And by SSNIP estimate, I assume you
18 mean what Mr. Orszag and I were discussing earlier
19 about whether that 5 percent increase in price by a
20 hypothetical monopolist would be a small but --
21 whether that would be enough to enable that
22 hypothetical monopolist to remain profitable?

23 A. That's the goal. It's a -- it's a
24 hypothetical. I think of it as a thought
25 experiment. You try to think your way through what

1 would -- what product market or geographic market
2 could lead to a profitable price increase, but I --
3 the SSNIP itself is usually, I would say, more
4 often inferred than estimated. There are models to
5 estimate it, and the question then becomes is that
6 model appropriate to use in estimating for that
7 industry or that situation.

8 **Q. So there are models to estimate it.**
9 **So are you saying, then, there's no real-world data**
10 **you can rely on?**

11 A. Well, no. There are -- yes, there
12 are real-world data that you rely on to estimate
13 diversion ratios, and there are formulas you rely
14 on to, including margin data and the like, that you
15 can use to see what the upward pricing pressure is,
16 what it's sometimes called, can be, and you can try
17 to infer some things. But again, you know, it's --
18 it's more of an inference than it is a specific
19 estimate.

20 **Q. And how do you go about determining**
21 **the geographic market?**

22 A. It really depends an awful lot on the
23 industry. We're talking about insurance here.
24 Hospitals, you can use patient origin data and you
25 can -- you can use diversion ratios. In insurance,

1 we've seen you can use diversion ratios. The --
2 you go about it by looking again for the
3 substitutes, for the most likely substitutes.

4 Let me say one other thing.

5 Geographic markets in health insurance matters are
6 a little tricky because when you -- when you
7 operate in the state and you're licensed in a
8 state -- depends a little on the product, but when
9 you're licensed in a state, often what you have to
10 do in order to expand your geography is you simply
11 have to make a filing and say that you have access
12 to the relevant types and numbers of providers.

13 So it's fairly easy -- under the
14 guidelines this is called ready entry. It's fairly
15 easy to expand or enter another county. That's one
16 thing to keep in mind. If you take that to heart,
17 that means that state is a relevant geographic
18 market. It's not often handled that way by the
19 antitrust agencies, but that's what the inference
20 would be.

21 The second thing to say is that --
22 and again, Mr. Orszag talked about this as well.
23 When you go to price, you don't usually just price
24 Jackson County. You price all, you know, 25 or 30
25 counties that make up Kansas City. So you --

1 you're basically setting a price on the theory
2 that -- depends on the product again, but let's say
3 you're doing group insurance. Well, they're
4 employers. They have employees coming from all
5 parts of town, all directions. So what are you
6 really serving? You're serving a whole MSA, and
7 maybe it's, quote, unquote, a greater MSA, not just
8 sort of the core city. And so the prices can be
9 efficiently set for the whole city all at once.
10 Well, Kansas City that's a lot of -- that's a lot
11 of counties.

12 **Q. If you're only licensed, though, in**
13 **Jackson County, you base your prices on Jackson**
14 **County, though, right?**

15 A. If you choose -- you've got to -- I
16 mean, yeah, you can make up anything, but I'm
17 trying to tell you, what you want -- the key to
18 understanding all of this right is how are prices
19 set, what's the competitive process by which prices
20 are set.

21 Okay. Well, if they're set across a
22 whole MSA, it doesn't make a lot of sense to talk
23 about counties, single counties, unless, of course,
24 that MSA is made up of one county, which is what
25 micropolitan is.

1 Q. Well, it does make sense to talk
2 about single counties if the sellers can only --
3 the seller can only sell in that county and the
4 buyer can only buy in that county, right?

5 A. But the seller will rarely choose to
6 serve only one county if it's efficient to serve
7 many counties in that area at once. You have
8 that -- you have this in Lebanon and Springfield.
9 You have this -- they're close by. The hospital in
10 Lebanon is I think 72 beds, and it's a Mercy
11 hospital. Well, United's above it and the
12 Cox-related hospitals like United and Anthem are
13 strong in Springfield, but a lot of the people from
14 Lebanon go from Laclede down to the Springfield
15 hospitals.

16 Q. Have you heard -- I'm sorry. Go
17 ahead.

18 A. Well, I was just going to say that
19 that gives the opportunity to substitute a
20 Lebanon -- to substitute a Springfield provider for
21 a Lebanon provider if you can be close enough to
22 the edges of -- with, you know, the physician
23 providers.

24 Q. You've heard the term regulatory
25 entry barrier, right?

1 A. Sure.

2 Q. And do you have any idea how long it
3 takes CMS to license a new MA provider?

4 A. Roughly. I can't tell you all the
5 tick marks.

6 Q. Is it more than a year, as far as you
7 know?

8 A. Well, it depends on when you apply,
9 but it can be less than a year.

10 Q. And do you happen to remember what
11 the application date is, what the application
12 deadline is?

13 A. I don't recall.

14 Q. Okay. And do you happen to know how
15 long it takes CMS to license a new carrier to write
16 on the exchange?

17 A. I think it's a similar process.
18 There's a bid, and it depends partly on when you
19 put in that bid.

20 Q. Okay. As far as the product market
21 is concerned in this case, you found the individual
22 market to be a relevant product market, right?

23 A. I think I would find the exchanges to
24 be a relevant product market. I would find --
25 again, there's less and less off-exchange business,

1 but I think -- I think they do collapse into each
2 other. I haven't thought fully about that.

3 Q. You made the point that there's
4 extreme price sensitivity of the consumers on the
5 exchange. Wouldn't you agree, though, that that
6 price sensitivity has to be dull to some extent
7 because so many people on the exchange get
8 subsidies and, therefore, they're not feeling the
9 full effect of a price increase?

10 A. No, not at all.

11 Q. You don't agree with that?

12 A. No.

13 Q. You think they --sorry.

14 A. The less income you have, the greater
15 your subsidy. If you -- you're talking now about,
16 you know, 100 percent of the poverty line, down to
17 100 percent of the poverty line if there hasn't
18 been Medicaid expansion. So you're still going to
19 be pretty sensitive to any premium that you have to
20 pay, and -- but more importantly than just sort of
21 why that may happen is it doesn't happen. We see
22 the volatility. We see that when you're at the
23 benchmark, you win. We see when you're far --
24 when you move away from the benchmark, you suddenly
25 lose large amounts of your share.

1 Q. So you don't agree that the fact that
2 people are subsidized and many heavily subsidized
3 on the exchange dulls their sensitivity to price at
4 all?

5 A. No, I don't.

6 Q. Is the small group market a relevant
7 product market in this case?

8 A. Not to me. In many health insurance
9 mergers, I don't think of it as a separate market
10 because --

11 Q. Why?

12 A. Because it is almost always true.
13 This has to do with the productive efficiency of
14 you build a network for your large group, then what
15 you want to do in order to get the best provider
16 prices is you want to fill that network. You want
17 to push volume through that network. You very well
18 may say, okay, I'm going to enter the -- I use
19 enter loosely. I'm going to extend my products
20 into the small group.

21 And so the ones who -- there are very
22 few companies that just do small group. They do
23 groups above 2 to 50 is what it is in Missouri.
24 Under Obamacare it's generally thought of as 2 to
25 100. But if you're a commercial producer of group

1 business, you're going to generally shift into
2 small group. It's not always true, but it's
3 productive efficiency to do that.

4 Q. You've agreed, though, that small
5 group employees can't legally buy a large group
6 benefit package, right?

7 A. That's why I'm telling you it's from
8 the supply side that the market is broadened to be
9 commercial insurance. That's not to say there
10 aren't others who claim small group is a separate
11 market for the reason you're stating, but I don't
12 think the demand side is the only side to look at
13 when you're looking at defining a market.

14 Q. And you'd include in the group
15 market, you'd include self-insured arrangements?

16 A. Yes. Yes.

17 Q. But you said earlier that there's --
18 I believe you said there's very little
19 self-insurance among groups of 100 or fewer. Do
20 you remember that?

21 A. There tends to be much fewer because
22 the employee base isn't enough to be bearing risk.
23 You could have one preemie baby or one AIDS case
24 that could really cost you a lot of money.

25 Q. And you believe, don't you, that

1 self-insured arrangements can strain the price of
2 insured coverage, right?

3 A. Yes.

4 Q. And how can you tell that?

5 A. Oh, because -- because talk to any
6 CFO of any medium to large sized company and that's
7 a calculation they have to make.

8 Q. You have -- sorry. I'm sorry,
9 Dr. McCarthy. Everybody wants to go home. I
10 apologize. Go ahead.

11 A. But I promised not to talk too fast.
12 The -- start again.

13 Q. Okay. You believe that self-insured
14 arrangements constrain the price of group coverage,
15 right?

16 A. I do.

17 Q. Okay. And why do you think that is?

18 A. Because it's an alternative. I mean,
19 it's like the alternative is any other calculation
20 that, again, if you're a CFO, you're minding the
21 store and trying to keep costs under control, you
22 have to look at your benefits costs, and of the
23 benefits costs you have to look at your health care
24 costs. And you say, look, what kind of risk are we
25 taking if we self insure, if we just hire an

1 insurance company to administer, you know, give our
2 member cards and build a network and rent us a
3 network and credential that network and process our
4 claims, just the administrative stuff. That's all
5 I want. I'm going to pay for the health care costs
6 that come my way because I'm a big enough company
7 and I can afford that risk.

8 Q. Have you done any calculations that
9 lead you to conclude that the self-insured
10 arrangement constrains the price of insured
11 coverage?

12 A. I've not done calculations, but I
13 would -- I would say of my 30-plus years in health
14 care, that's a very consistent phenomenon, a very
15 consistent behavior of medium and large firms.

16 Q. Do you know whether the Missouri
17 Insurance Department has any authority to regulate
18 self-insured arrangements?

19 A. I would guess not, but I don't know.

20 Q. Okay. And do you know whether the
21 Missouri Insurance Department has any authority to
22 consider self-insured arrangements in calculating
23 market shares in this case?

24 MR. WHITMER: Objection. Calls for a
25 legal conclusion. Wait. There's an objection.

1 HEARING OFFICER ERICKSON: Would you
2 like to rephrase? Maybe lay a foundation question
3 and then proceed.

4 BY MR. ANGOFF:

5 Q. Are you familiar with the -- you are,
6 aren't you, because you cited it? You're familiar
7 with the Missouri Insurance Holding Company Act,
8 right?

9 A. Generally, yes. I'm not sure I can
10 answer any question on it, but yeah.

11 Q. So you don't know one way or the
12 other whether that act allows the Missouri
13 Insurance Department to consider self-insured
14 arrangements in calculating market shares?

15 A. I guess I would say two things. One
16 is the calculations that were made based on the
17 NAIC data I assume are accurately done according to
18 what the Missouri statute would be.

19 But the second thing to say is that I
20 have not really been asked to come in and interpret
21 in any way and calculate in any way data that are
22 just the same as the Missouri act would call for.
23 I'm -- my role I understand to be talking about the
24 competitive significance of this merger to
25 Missouri. That has to be mindful certainly of what

1 the Missouri calculations will be, but that's why
2 we've been comparing different types of
3 calculations to what the NAIC has said now base
4 calculations are.

5 Q. In the -- in your statement you
6 mention that 84 percent of those who switched from
7 Aetna switched -- over a three-year period switched
8 to another MA plan, right?

9 A. I'm sorry. 84 percent?

10 Q. 84 percent -- I'm sorry. You say
11 16 percent of those who switched from Aetna
12 switched to traditional Medicare?

13 A. Right.

14 Q. Okay. And that means necessarily,
15 doesn't it, that 84 percent of the people who
16 switched from Aetna switched to another MA plan?

17 A. In that instance, in that -- if you
18 remember, Mr. Orszag put up some numbers that were,
19 I think, 19 and 17. That corresponds to our 16 and
20 21, reverse, 21 and 16.

21 Q. Fine.

22 A. Those are the numbers that you saw
23 earlier based on updated data.

24 Q. Right. I just want to make sure that
25 we agree that one's the inverse of the other. If

1 16 percent of those who switched switched to
2 traditional Medicare, then 84 percent switched to
3 another MA plan. If 17 percent switched to
4 traditional Medicare, 83 percent switched to
5 another MA plan, right?

6 A. I believe that's right. I have to
7 think about whether terminations are included in
8 that.

9 Q. Those statistics, though, don't
10 include everyone who enrolls with Aetna and then
11 stays with Aetna in the next year, right?

12 A. No. These are only what are called
13 the switchers.

14 Q. Okay. And the people -- about half
15 the people every year -- well, do you know -- do
16 you know how many people, what percentage of people
17 stay with Aetna in a given year?

18 A. I don't know stay with Aetna. The
19 general number I think is between 20 and 25 percent
20 switch. I don't know if that applies strictly to
21 Aetna.

22 Q. 20 to 25 percent switch, so that 75
23 or 80 percent stay with the company?

24 A. On average, across all companies.

25 Q. Sure. You point out in your

1 statement that one of the differences between MA
2 and traditional Medicare is that MA carriers use
3 agents and brokers and traditional Medicare
4 obviously doesn't, right? The government doesn't
5 pay agents or brokers to sell Medicare?

6 A. Well, not -- not all people shop with
7 agents and brokers for Medicare Advantage or for
8 Medicare to decide. Some go to the Medicare.gov.
9 So just because some may use it, they certainly can
10 use it, but I don't remember any statistics that I
11 included that said even a majority use agents and
12 brokers. I don't know what that answer is.

13 Q. I thought you said that, if you'll
14 turn to your paragraph 51 in your statement, that
15 there's a difference between Aetna's distribution
16 model and Humana's. Say Aetna uses a broker model
17 and Humana uses agents. What's the difference?

18 A. Brokers versus agents?

19 Q. Yes, sir.

20 A. Brokers would -- I don't remember
21 that statement. I have to find where it is, but --

22 Q. Paragraph 51.

23 A. May I ask what number mine is? Is it
24 C?

25 Q. Page 27.

1 HEARING OFFICER ERICKSON: Yes, the
2 exhibit is C in Binder 2.

3 THE WITNESS: Thank you. I'm sorry.
4 Where are you pointing me?

5 BY MR. ANGOFF:

6 Q. Paragraph 51 in the middle of the
7 page, the second two paragraphs you're just talking
8 about, Missouri Aetna and then Humana.

9 A. Okay. Yes, I've read it. And that
10 does -- that's for Missouri, specific to Missouri.

11 Q. And so when you say Aetna uses a
12 broker model and Aetna -- Humana primarily employs
13 sales agents, what's the difference?

14 A. Well, brokers means there's a broker
15 community out there that will advise and place
16 people and get commissions. Whereas, a sales agent
17 model, when it says employs sales agents, that
18 means that they have their own sales force to some
19 degree.

20 Q. So that a Humana sales agent is
21 compensated only by Humana, works exclusively for
22 Humana, right?

23 A. I believe that's the way it's set up.
24 I didn't -- I believe they're employees of Humana.

25 Q. Okay. And when -- and can brokers

1 represent more than one company? Can they get paid
2 by more than one company?

3 A. They can. They don't always, but
4 they can.

5 Q. Okay. And in the footnote on that
6 page, Footnote 45, you say that the agents or
7 brokers doesn't necessarily push one product over
8 another. Do you mean one MA seller, the person
9 selling an MA plan doesn't push his plan over
10 another MA plan, or are you saying there that they
11 don't push MA over traditional Medicare?

12 A. I think it would vary by whether it's
13 an employed agent. There are also agents that
14 aren't necessarily employed sales agents. But what
15 it says is they're going to offer choice if they're
16 asked to offer choice by the client.

17 Q. Okay. But you agree the government
18 doesn't pay agents or brokers to sell the
19 traditional Medicare program?

20 A. First of all, I don't think the
21 government has to. I think they've got
22 Medicare.gov. I don't know if you've ever seen it.
23 Around the open enrollment times, the government
24 will have public service announcements about that
25 open enrollment is beginning, and it will mention

1 Medicare.Gov. It's not advertising in maybe the
2 traditional sense, but it's public service
3 announcements.

4 Q. Let me ask you this way: You agree,
5 don't you, that if somebody's compensated by a
6 private carrier and is not compensated by the
7 government, that that person is going to push the
8 product that he or she is compensated by?

9 A. I think that -- I don't disagree with
10 that. I'm saying that if, however, the client
11 says, no, I think I'll take traditional Medicare if
12 that's what you have to offer, or no, do you have
13 anything else, then they may have an obligation to
14 do that. I agree that they would tend to sell
15 their product, and usually that means they also
16 believe in their product. But I would agree they
17 would tend to sell their product.

18 Q. You say in paragraph 63 of your
19 statement that you understand that the standards
20 applying to this merger in Florida are similar to
21 those that apply in Missouri. Do you see that?

22 A. Yes.

23 Q. Okay. What do you --

24 A. I don't see it yet, but I understand
25 what you're saying.

1 **Q. Okay. And what do you understand**
2 **those standards to be in Florida?**

3 A. I was talking about the NAIC
4 standards for what triggers a threshold and what
5 triggers a prima facie case and what the rules are
6 that invite a contrary argument.

7 **Q. Do you know whether the Florida**
8 **statute contains the same market share thresholds**
9 **that would establish a prima facie case that are in**
10 **this statute in Missouri?**

11 A. I believe that the ones you mentioned
12 earlier are in the Florida statute, but I don't
13 remember now. I mean, that's not -- that's not
14 something I committed to memory.

15 **Q. Okay. Do you know whether there are**
16 **numerical standards in the Florida statute at all**
17 **governing market shares?**

18 A. When you mean governing market
19 shares, do you mean, you know, a 10 and a 2 and a 4
20 and a 4, those kinds of share standards?

21 **Q. Yes.**

22 A. Those are the NAIC standards that I
23 believe Florida had, but I don't remember
24 precisely.

25 **Q. And you went through -- you go**

1 through in your statement and also you went through
2 on the chart a little bit earlier five reasons that
3 Florida Insurance Department put forward for
4 determining that MA and traditional Medicare were
5 in the same market, right?

6 A. Yes. These are Florida's labels,
7 yes.

8 Q. That's right. And one of those was
9 market fluidity, citing the switching between MA
10 and traditional Medicare, correct?

11 A. Correct.

12 Q. How many switching does there have to
13 be in order for the two products to be in the same
14 market?

15 A. Well, switching is one element,
16 right, and I think -- I think you've had that
17 answered for you already from Mr. Orszag.

18 Q. I didn't understand a lot of what
19 Mr. Orszag said. I'm asking you.

20 A. Under a careful analysis of the data,
21 he's saying that the diversion to traditional
22 Medicare is strong and that it has to be included
23 in the market. And so part of my answer would be,
24 this is Florida's characterization of it. I agree
25 with it, but how much it has to be, I don't -- you

1 would have to find where that tradeoff goes, but we
2 know there is enough according to, at least in
3 Missouri, Dr. Orszag's -- Mr. Orszag's
4 calculations.

5 Q. But you haven't done any independent
6 investigation of the question whether there's
7 sufficient switching in Missouri to justify the
8 conclusion that TM and MA are in the same market?

9 A. I agree with Mr. Orszag's conclusion.
10 He has done the study. It seems a very well done
11 study. It is consistent with the switching that we
12 see, not just here but in other states. And,
13 therefore, I believe that Florida is right in
14 citing that.

15 Q. Sure. But you haven't done any
16 independent investigation of the amount of
17 switching that's necessary for both products to be
18 in the same market?

19 A. Not specifically, no.

20 Q. And then the second criterion that
21 the Florida department points out is the market
22 dynamic, citing the fact that MA benefits are
23 richer than traditional Medicare. Do you see that
24 there?

25 A. Yes.

1 Q. Wouldn't that cut the other way, that
2 TM -- doesn't the fact that Medicare Advantage
3 benefits are different and more generous than
4 traditional Medicare, isn't that an argument in
5 favor of there being two different markets?

6 A. No.

7 Q. Why not?

8 A. Well, I think you heard it again.
9 You spent a lot of time with Mr. Orszag on this
10 subject. Just because you have qualitative
11 differences between products doesn't mean that they
12 don't compete vigorously. And I think you had a
13 long colloquy with him on that, and he talked about
14 computers and the differences between the
15 computers. They can have quite different
16 characteristics but they compete vigorously.

17 Q. And I'm just asking you,
18 Dr. McCarthy, if you can give me a little more
19 straightforward answer than Mr. Orszag did.

20 MR. WHITMER: Objection to form.

21 THE WITNESS: What I'm telling you --

22 HEARING OFFICER ERICKSON: Hold on,
23 please. Mr. Angoff, can you rephrase? Is there a
24 question pending?

25 MR. ANGOFF: Fair enough.

1 BY MR. ANGOFF:

2 Q. Can you tell me in your own words why
3 the fact that Medicare Advantage benefits being
4 different and more generous than traditional
5 Medicare benefits does not cut in favor of the two
6 products being in different markets?

7 A. Yeah, for a couple reasons. One,
8 there's -- there are other differences. The main
9 difference, one big difference anyway would be that
10 you have much more access to more providers in the
11 TM. So it's an offsetting benefit. Even though
12 there are greater benefits, there's still this
13 choice of network that's possible.

14 But I think what the Florida OIR also
15 said was, we see that when those benefits grow,
16 then that difference changes and the scale tips a
17 little more in favor of Medicare Advantage and the
18 penetration rate for Medicare Advantage goes up.
19 So you see a substitution when those benefits grow.

20 So let me state two sentences. One,
21 there are differences between these, but they are
22 what we would call compensating differences. The
23 benefit of one may be greater, meaning more choice.
24 The benefit of another may be vision and dental.
25 But they offset each other and you hit an

1 equilibrium.

2 When that amount of benefit changes
3 for whatever reason, then we see penetration rates
4 increase until we hit a new equilibrium. And I
5 think that's why it's a measure of substitution
6 between the two products.

7 **Q. The fourth criterion is the -- I'm**
8 **sorry. The third criteria is the value**
9 **proposition. You talk about the ebb and flow.**
10 **It's been all flow in the last ten years, right?**
11 **Since 2008 or so, I think you said, the Medicare**
12 **Advantage penetration rate has just continued to go**
13 **up, right?**

14 A. Yeah. I think it's slowed a bit, but
15 it has gone up, and there are some good reasons for
16 that, and that is that payments have changed.
17 There's a star rating system, and those that are
18 offering the best benefits are getting more
19 revenues, just as if the subsidy was going up but
20 it's due to higher quality.

21 **Q. And then the future of Medicare, you**
22 **talked a lot about ACOs, but nobody really knows**
23 **what the government's going to do with Medicare,**
24 **right?**

25 A. Oh, I think there's a pretty clear

1 path. It's true you don't know what can happen.
2 I'm not a soothsayer. But we know the direction of
3 traditional Medicare, and the goal of trying to get
4 more -- two sorts of goals. Get more and more
5 providers being paid based on quality. That's just
6 going to happen. That's going to be mandated.

7 But then also to attract more and
8 more payers to get into risk-sharing arrangements
9 that are an awful lot like what an MA plan, the
10 providers under an MA plan have to do, bear some
11 risk.

12 Q. But you don't know what President
13 Trump is going to do with the Medicare program?

14 A. No. I dare not think of it.

15 Q. The last criterion is the consumer
16 experience. You showed the website where it shows
17 original Medicare on top and then -- and then an MA
18 plan right below it. Did you happen to notice the
19 difference in the out-of-pocket costs in the two
20 plans?

21 A. Well, there are numbers up there, but
22 remember, there are a lot of other plans, and the
23 out-of-pocket costs may be quite different
24 depending upon the choice of plans. You're just
25 looking at what these -- one of the beauties, I

1 suppose, of these websites is that it has various
2 calculators on it.

3 You know, what are my prescriptions?
4 If my prescriptions are substantial, then I really
5 care a lot about finding just the right
6 prescription drug plan, whether that's on
7 traditional or Medicare Advantage. So I've got a
8 calculator for that on there. There are other
9 calculators that will help you to calculate the
10 out-of-pockets.

11 **Q. I'd just like to ask you a couple of**
12 **questions about some of the charts in your -- in**
13 **your statement. Could you turn to page 23 where**
14 **you've got the health exchange silver plan rankings**
15 **in Missouri. Do you see that?**

16 A. Which number?

17 **Q. It's page 23, right above the chart**
18 **on page 23.**

19 A. Are we talking about the --

20 **Q. No. We're talking about your**
21 **statement, your affidavit.**

22 A. I'm there. Sorry it took so long.

23 **Q. I heard you explain how the subsidy**
24 **is tied to the price of the second lowest priced**
25 **silver plan, but how is it -- how is it calculated?**

1 A. It's calculated -- I don't know the
2 exact formula. It's calculated based on the
3 percentage of somebody's income that the government
4 judges is an appropriate level of income,
5 appropriate percentage of income to pay for health
6 insurance if their income is 100 percent of
7 poverty, 200 percent of poverty, 300 percent of
8 poverty.

9 So if you're only at 100 percent of
10 the poverty line, then virtually everything is
11 paid. If you are, let's say, 400 percent of
12 poverty or 399, whatever the cutoff is, then a
13 small percentage of the premium is paid.

14 So the rule has to do with the
15 percentage based on your income, but it's applied
16 to a percentage of a premium. What's that premium?
17 Well, it's the second lowest silver plan.

18 **Q. So does that mean that if you buy a
19 higher-priced silver plan, you get the same dollar
20 amount of subsidy as you would if you bought either
21 of the two lower-priced silver plans?**

22 A. You do. But, of course, there's more
23 left over that you have to pay, and again, if you
24 don't want to pay any premium, you'd like to be
25 maximizing the amount of the subsidy given that

1 benchmark.

2 Q. Because of the way the subsidy is
3 structured, then, you concluded, didn't you, that
4 the -- the two lowest-priced silver plans are
5 likely to get the most business?

6 A. Well, the answer is that's -- that's
7 certainly the hypothesis that comes out of that,
8 but I think that hypothesis has been tested and
9 proved.

10 Q. Has been tested and --

11 A. Looking at the data.

12 Q. That it's true?

13 A. Yes.

14 Q. Yes. Sure. And so in Table 4 when
15 you were discussing the merger of Aetna and Humana
16 in the individual market, one of the points you
17 made in your statement is that on the exchange
18 United and Anthem were in particularly strong
19 positions because they were the ones that were
20 ranked one and two, had the two lowest-priced
21 silver plans in the market, right?

22 A. Yeah. Depends on the market.

23 Depends on whether they do or don't, but yes.

24 Q. Okay.

25 A. I mean, this is done county by

1 county. So they lose in some counties and they win
2 in other counties. On this chart I'm simply
3 saying, if you look at United, in 2016 they're --
4 in 46 counties they're the lowest price, and in 53
5 counties they're the second lowest price.

6 Q. Okay. And United has told -- has
7 written the Missouri Insurance Department that it
8 is withdrawing from the Missouri exchange, it won't
9 be on the exchange in 2017, right?

10 A. That is my understanding.

11 Q. And then this second -- this second
12 carrier you've got listed there, Anthem, they're a
13 big carrier, but they're not a statewide carrier,
14 right, because they're Blue Cross company, they've
15 only got a certain territory, right?

16 A. They're limited in the Kansas City
17 area.

18 Q. And then Cigna, they're a fairly
19 small carrier on the exchange, right? They only
20 participate and write in St. Louis?

21 A. No. I think they entered -- they
22 entered this year. I thought it was in Kansas
23 City.

24 Q. Okay. And you're aware that Anthem
25 has filed to acquire Cigna?

1 A. Yes.

2 Q. Okay. And then --

3 A. Well, but think about what you're
4 saying there. Let's say Anthem does acquire Cigna.
5 Anthem can't get into Kansas City. Cigna's in
6 Kansas City. Now they're statewide.

7 Q. Are you sure that Cigna's in
8 Kansas City?

9 A. I thought they -- I would have to
10 check. I think they are. I think they entered
11 there.

12 Q. And I don't want to go this far
13 afield. Are you aware of the rules of the Blue
14 Cross Association that prevent Cigna from writing
15 as much business as it would otherwise because it's
16 being acquired by a Blue plan?

17 A. I'm generally aware of it, and what I
18 would tell you my interpretation of the rule is
19 they keep the Cigna name as a subsidiary. It's an
20 off brand that is non-Blue brand name, like other
21 Blues have a non-Blue brand name, and they can sell
22 it anywhere they want. They may have some
23 limitations as to how much they can earn
24 everywhere, but they can sell it where they want.

25 Q. And then Blue Cross of Kansas City on

1 the bottom there, they're -- they write and they
2 have their own service area in the Kansas City
3 area, right?

4 A. Yes.

5 Q. Okay. So in the individual market,
6 if this merger is approved and if Anthem acquires
7 Cigna, then the only statewide carrier on the
8 exchange is Anthem-Humana, right?

9 A. No. I mean, you're -- in part, I
10 don't think you're understanding that other chart
11 that we looked at, which is how rapidly when there
12 were only two carriers in every county except --
13 I'm sorry -- that there were no carriers, no more
14 than two carriers in any county in 2014, and now we
15 have only two counties where there's two or less --

16 Q. Sure.

17 A. -- that that signals ready entry,
18 ready competition to enter the exchange.

19 Q. Well, and I'll get to the issue of
20 entry and how easy or hard it is, but I just want
21 to first understand that, before we start
22 discussing the entry issue, it is true, isn't it,
23 that if the Department approves the Anthem/Cigna
24 merger, there is no other statewide carrier in the
25 exchange than the merged Aetna/Humana today?

1 A. Today. Okay. You've got two
2 hypotheticals. You've got both of them merging,
3 and you've got United dropping out.

4 Q. Well, no. United dropping out is not
5 a hypothetical.

6 A. That's a given. That's a given.
7 I'll grant you that.

8 Q. You know what the three Rs are,
9 right?

10 A. Remind me.

11 Q. You've heard of the reinsurance, risk
12 corridors and risk adjustment program, right?

13 A. Right.

14 Q. And you know that two of them expire
15 in 2016? They won't be available to carriers in
16 2017, right?

17 A. That was -- I wasn't sure of that
18 date, but I knew that two did expire or will
19 expire.

20 Q. And did you read -- did you read
21 about the Supreme Court's -- not the Supreme Court.
22 Did you read about the federal court's decision the
23 other day holding that one of the other subsidy
24 programs was unlawful, unconstitutional in this
25 case?

1 A. Yes, I saw that decision.

2 Q. Yeah. So does it give you any pause,
3 does it make you think that maybe this merger
4 really could have an anti-competitive effect in
5 Missouri given the fact that United has withdrawn
6 for 2017 and that two of the three Rs will no
7 longer exist in 2017 and this additional subsidy
8 was struck down at least by this one federal court?

9 A. What you're telling me is that it's
10 bad regulation that's causing problems, not the
11 willingness of any supplier to come in and serve a
12 market. What scares people away is that, partly
13 because of the three Rs, at least some of the --
14 and the risk corridor was not paid the way it was
15 promised to have been paid. It's a very uncertain
16 and dicey business. That's a regulatory problem.
17 It is not a market power problem.

18 What I'm showing you on the
19 volatility side is that you present an opportunity
20 that a company can count on and feel a little bit
21 certain of, they will come in and enter and serve
22 the market.

23 Q. Okay. So let's talk about entry.
24 Paragraph 46 you say the competitive entry is also
25 possible in the individual market, right?

1 A. I'm sorry. I must have the wrong --

2 Q. That's okay. Paragraph 46.

3 A. 46.

4 Q. The first line there, competitive
5 entry is also possible. Do you see that?

6 A. Yes.

7 Q. Do you think that competitive entry
8 is likely?

9 A. I do.

10 Q. Okay.

11 A. I do.

12 Q. You haven't seen -- no one at Centene
13 has -- you've talked about Centene as a potential
14 entry. No one at Centene has told you that they're
15 going to enter, right?

16 A. They certainly haven't told me. The
17 question is, what's their behavior, and their
18 behavior is to enter other states. They did enter
19 Florida. They entered Florida very aggressively,
20 took many of those low spots. They are actually --
21 the understanding is that they are making money.
22 They are here as part of a Medicaid program. They
23 can follow exactly the model they've been
24 following, and they can enter first and foremost
25 the exchanges.

1 Second, they've bought Health Net
2 with a press release that says we want the Health
3 Net Medicare Advantage platform to, I think, spread
4 across our whole system or some phrase like that.

5 So Centene to me is a leading
6 contestant for coming into both of those markets in
7 Missouri.

8 **Q. So it makes sense to you that Centene**
9 **could come into Missouri?**

10 A. It makes a great deal of sense.

11 **Q. But you haven't seen any evidence**
12 **that they are, in fact, coming into Missouri?**

13 A. I have not, but I've seen
14 responsiveness before in these markets, supplier
15 responsiveness in these markets.

16 **Q. And you also think that Centene -- it**
17 **would make sense for Centene to come into the**
18 **Medicare Advantage market?**

19 A. It might. I think it would, but I'm
20 not the CFO of Centene.

21 **Q. Again, you have no evidence that they**
22 **are, in fact, coming into Missouri?**

23 A. I've given you my evidence. My
24 evidence is they did it aggressively in Florida,
25 and it fits the model that they've discussed to

1 also at some point go into Medicare Advantage.

2 Q. But have you ever heard or read that
3 Centene is coming into the Medicare Advantage
4 market in Missouri?

5 A. I have not read that.

6 Q. And have you done your own
7 independent investigation to determine if they are?

8 A. What I'm -- I'm speaking to you
9 probabilistically.

10 Q. Okay. And you say that Anthem is
11 poised -- they're not in the Medicare Advantage
12 market in any significant extent, but they're
13 poised to expand if the opportunity prevents (sic)
14 itself. What do you mean by that?

15 A. Presents itself rather than prevents
16 itself, right?

17 Q. Did I say prevents? Sorry.

18 A. I thought you did. Maybe you
19 didn't. Anyway --

20 Q. What does poised to expand mean?

21 A. They have -- it's in a closed white
22 paper, but in the entry analysis, it's pointed out
23 that Anthem has entered into -- has started to
24 offer SNPs, SSNIPs of that kind, meaning special
25 needs plans, they've been expanding that, and,

1 therefore, they are poised to offer a more complete
2 line of Medicare Advantage products.

3 Q. But again, you haven't either heard
4 or read that Anthem is, in fact, entering the
5 Missouri Medicare Advantage market?

6 A. I have not read that.

7 Q. Let's talk very briefly about
8 efficiencies. You conclude in your statement,
9 paragraph -- paragraph 66, section 8, that the
10 proposed merger will likely result in cost savings,
11 right?

12 A. Yes.

13 Q. Okay. And what is the basis for that
14 conclusion? You talked to -- you spoke to Aetna
15 executives, right?

16 A. Yes.

17 Q. And you spoke to Humana? Did you
18 speak to Humana executives?

19 A. Well, it would be less in their court
20 to estimate the efficiencies, but we've spoke --
21 we've spoken to them. I don't know that we've had,
22 you know, conversations about efficiencies.

23 Q. Did you do --

24 A. Other than to say, that sentence also
25 says cost savings and benefit to consumers. We

1 heard this from Mr. Martino this morning, which is
2 that Humana has a strong reputation for sort of
3 clinical services, and -- and I think that's part
4 of what we have learned from Humana that would be
5 of benefit to consumers.

6 Q. Okay. But right now I'm asking you
7 about the efficiencies. The efficiencies, to
8 determine the efficiencies that the merger would
9 create, you didn't do your own investigation of
10 that, right?

11 A. Correct.

12 Q. You relied on Aetna?

13 A. Correct. Well, Aetna and the CRA
14 white paper.

15 Q. I'm sorry?

16 A. The CRA white paper having to do with
17 the fact that the Coventry efficiencies were
18 realized and exceeded, et cetera.

19 Q. Right. And did you -- do you have
20 any opinion of how likely it is that these
21 efficiencies will actually be accomplished?

22 A. I mean, not -- not to any certainty,
23 but again, the merger guidelines ask the question,
24 you know, under the efficiencies section, can you
25 demonstrate that you have attained efficiencies in

1 previous mergers?

2 And it was a big issue in the St.
3 Luke's case, which had to do with physician merger,
4 not an insurance merger, but it had to do with can
5 you demonstrate that in previous physician mergers
6 you have achieved efficiencies. And that was a
7 case where the court said, I'm not convinced.

8 But in the Aetna/Coventry experience,
9 there is good reason to believe that Aetna knows
10 how to achieve these efficiencies.

11 **Q. I just want to make sure I understand**
12 **your characterization of the St. Luke's case.**
13 **You're not saying that the court there accepted the**
14 **claim that the merger would create efficiencies**
15 **such that those efficiencies were sufficient to**
16 **approve the merger?**

17 A. No. If I suggested that, I'm sorry.
18 It's exactly the opposite. The court, because
19 St. Luke -- the physicians groups had not achieved
20 efficiencies in the past, then their claim to
21 efficiency was not thought to be credible and the
22 court turned them down, if that's a better way of
23 stating it.

24 **Q. And do you have any opinion as to**
25 **when these efficiencies would occur?**

1 A. There's a -- there's a schedule of
2 efficiencies, and the number of 1.25 billion is a
3 2018 number. That's the target.

4 **Q. But you haven't done any independent**
5 **investigation yourself to determine whether those**
6 **are accurate?**

7 A. No, I haven't.

8 **Q. Okay. And in paragraph 68, you talk**
9 **about medical cost efficiencies. Medical cost**
10 **efficiencies means paying providers less, right?**

11 A. No. It means pharmaceuticals. It
12 means -- it means other things as well. But it
13 doesn't mean -- it doesn't necessarily mean paying
14 them less. It means that you have a bigger volume
15 to offer. It means that you can negotiate with
16 narrow network products and bring enough volume
17 that somebody would be willing to give you a narrow
18 network product. It doesn't mean you're
19 necessarily just going to pay providers less.

20 **Q. So a merger can create medical cost**
21 **efficiencies without the merger driving down the**
22 **direct cost of care?**

23 A. No. It can drive down the direct
24 cost of care. I'm giving you ways that can happen.

25 **Q. Okay. How can you drive down the**

1 **direct cost of care without paying those who give**
2 **the care less?**

3 A. You may have to -- you may pay them
4 less, but it's for a different reason that you're
5 paying them less. You may negotiate better rates
6 with pharmaceutical companies. You may have other
7 kinds of negotiations that you can achieve. But
8 you can develop different products and you have a
9 higher volume to negotiate with providers about.
10 So you can get lower prices willingly from
11 providers who want the higher volume.

12 **Q. And you didn't do any investigation,**
13 **did you, to determine the extent, if any, to which**
14 **any medical cost efficiencies would be passed on to**
15 **consumers?**

16 A. I think what I've been telling you
17 all evening is that competition is sufficiently
18 preserved to pass these savings on to patients.

19 **Q. So you believe that just the forces**
20 **of competition will force the savings to be passed**
21 **on to consumers?**

22 A. To the normal competitive levels,
23 yes.

24 MR. ANGOFF: I could ask some
25 additional questions, your Honor, but I know

1 everybody would strangle me. No further questions.

2 Thank you, Dr. McCarthy.

3 HEARING OFFICER ERICKSON: Redirect,
4 Mr. Whitmer?

5 MR. WHITMER: Yeah. Your Honor, it's
6 late. I will keep it very short.

7 REDIRECT EXAMINATION BY MR. WHITMER:

8 Q. Dr. McCarthy, you were asked a lot of
9 questions about Centene, and you were asked
10 specifically you don't know for sure whether
11 Centene will or will not be doing anything in the
12 future. Sir, is the threat of entry in and of
13 itself enough to constrain price?

14 A. Good point. Yes. The answer is that
15 even the threat of entry is, an announcement of
16 entry is. People know that someone may be coming,
17 so, yeah, there are various stages before actually
18 being in the market and competing where you can get
19 a competitive effect.

20 Q. And you discussed for us behaviors
21 that you witnessed that send signals about what
22 Centene may do in the future, correct?

23 A. That's correct.

24 Q. And Centene, do you know where
25 Centene's based, where it's headquartered?

1 A. I did.

2 Q. St. Louis sound familiar?

3 A. I was going to say, it was either
4 St. Louis or Kansas City,

5 Q. A company that knows Missouri pretty
6 well?

7 A. I think so.

8 Q. Okay.

9 A. And is here. I mean, not just here
10 as headquarters but is here.

11 Q. So, sir, you were asked a lot of
12 questions about three concepts, I'm going to put
13 them together, benefits, pricing, Medicare. You
14 and I have spent a lot of time together. We've had
15 a chance to talk about these concepts. I'm going
16 to give you an opportunity to talk about -- to
17 paint two word pictures. I'm going to give you two
18 scenarios. The first one I would like you to talk
19 about are suits and your colleague over here,
20 Mr. Munk. How do those concepts connect with
21 suits? We talked about this. I'm giving you an
22 opportunity.

23 A. Well, I mean, the argument is that
24 Dave has a beautiful suit and mine is, you know,
25 mine is just sort of barely wool and his is a nice

1 finally tailored suit. So he's -- the quality is
2 better. Mine is not as good, but mine's cheaper.

3 So you can't just look at price. I
4 mean, this has to do with this product
5 differentiation point. You can't just look at
6 price. You have to look at what you're getting for
7 the price. So to the extent that the benefits of
8 his suit are greater than the benefits of my suit,
9 although I don't think it would fit me, that
10 difference comes out in the price.

11 **Q. Different word picture concerns price**
12 **discrimination. Again, the same concepts, and this**
13 **is in the context of, for example, television**
14 **service. Can you give us -- can you paint that**
15 **word picture for us? I think it might be helpful**
16 **to connect some of the dots.**

17 A. Yeah. One of the things that's true
18 under Medicare Advantage is that you cannot price
19 discriminate, and this is what it means. Using the
20 example you asked about television services, if
21 you're ready to sign up with cable or satellite or,
22 you know, phone delivery of cable, you're offered
23 all these sweet deals, real low price, get sports,
24 HBO and Showtime for free. You've offered all
25 these things. And then, lo and behold, six months

1 or a year later they disappear.

2 So basically any new subscriber to
3 that cable system will get the same sweet deal you
4 did for a year, they'll get it for a year, but not
5 you. You've already had their -- your year of
6 discounts, and, therefore, they raise the price to
7 you. Well, that's price discrimination. They're
8 charging the new client a low amount of money with
9 all the discounts and charging you this sort of
10 full price and you wonder how your bill got so
11 high.

12 In Medicare Advantage, you can't do
13 that. What you're -- the price that a new enrollee
14 is charged must be made available to anybody who's
15 switching in, anybody who's staying in. So you
16 don't get that price discrimination, and that
17 facilitates switching from traditional to Medicare
18 Advantage, but it also keeps the price low. It
19 protects anybody who has signed up with a given
20 Medicare Advantage company and is still getting the
21 good price.

22 MR. WHITMER: Thank you for those
23 word pictures. I have no further questions.

24 RECROSS-EXAMINATION BY MR. ANGOFF:

25 Q. I have one question. Dr. McCarthy,

1 couple of instances.

2 MR. ANGOFF: I don't have any more
3 questions, your Honor.

4 HEARING OFFICER ERICKSON: Redirect?

5 MR. WHITMER: No further questions at
6 all.

7 HEARING OFFICER ERICKSON: Thank you.

8 THE WITNESS: Thank you. You're very
9 patient.

10 HEARING OFFICER ERICKSON: Any
11 further evidence from Aetna?

12 MR. WHITMER: No further evidence,
13 your Honor.

14 HEARING OFFICER ERICKSON: Humana,
15 would you like to make an opening or would you like
16 to present evidence?

17 MS. COYLE: Humana will not be
18 presenting any evidence into the record today, your
19 Honor. In fact, Humana will be resting its case on
20 the basis of the evidence already submitted by our
21 co-respondent Aetna.

22 HEARING OFFICER ERICKSON: That is
23 fine. I will remind you, Humana, that you are a
24 separate party. You are free to file separate
25 Findings of Fact, Conclusions of Law, briefs,

1 arguments. You may join as you wish, but I just
2 want you to have that opportunity.

3 Doctor, you may step down if you
4 wish.

5 THE WITNESS: Thank you. I was going
6 to clean up.

7 HEARING OFFICER ERICKSON: Is there
8 any rebuttal evidence from the Division?

9 MR. ANGOFF: No, your Honor.

10 HEARING OFFICER ERICKSON: Thank you.
11 At this time I will ask if there's any interested
12 person who would like to come forward and make an
13 oral comment or to submit a written comment or
14 both. I'd like to remind everyone that it's very
15 easy to submit a written comment on our website.
16 But if anyone is interested. Please, sir, step
17 forward.

18 MR. WASSER: I apologize in advance.
19 I know it's very late, but since I've been here --
20 I don't know if there's anything confidential in
21 here that I shouldn't see.

22 HEARING OFFICER ERICKSON: I think
23 you're very wise. If you-all could assist. I
24 think those are original exhibits. You can give
25 them to me. Thank you, sir. That was very

1 courteous of you.

2 MR. WASSER: Absolutely. Great.

3 Your Honor, I will try to be very brief. My name
4 is Brad Wasser, W-a-s-s-e-r. I'm an attorney with
5 the law office of David Balto. On May 9th we
6 submitted comments on behalf of a number of
7 national and local consumer groups. I'm happy to
8 name those organizations if that's necessary right
9 now.

10 HEARING OFFICER ERICKSON: Please do.

11 MR. WASSER: Sure. So those
12 organizations are Consumers Union, Consumer
13 Federation of America, Consumer Action, U.S. PIRG,
14 Empower Missouri, Missouri Budget Project, Missouri
15 Health Advocacy Alliance, Missouri Health Care for
16 All, and SEIU, which is a union. Stands for
17 Service Employees International Union.

18 And I'm not going to go through the
19 details of that statement right now. I think it's
20 actually online and available to the public. So I
21 just wanted to make three quick points, but really
22 quickly, before I do that, I just want to mention
23 that our firm has testified before Congress and
24 many state legislatures on health care competition
25 issues and testified before the state insurance

1 83 percent.

2 HEARING OFFICER ERICKSON:

3 Mr. Wasser, slow down just a tad for the court
4 reporter.

5 MR. WASSER: Absolutely. Under which
6 over 300,000 Missouri Medicare beneficiaries are
7 enrolled. The combination of Aetna and Humana will
8 put an end to significant existing and future
9 competition in this market leading to approximately
10 a 54 percent market share for the company, with an
11 even higher concentration in many counties. I
12 believe Mr. Angoff had referenced 33 counties with
13 combined market share of 70 percent or greater in
14 the individual Medicare Advantage market.

15 Certainly the combination goes far
16 beyond the competitive standards of the Missouri
17 statute, resulting in a prima facie violation,
18 prima facie evidence of a violation, and goes
19 beyond the federal antitrust guidelines and the
20 Supreme Court precedent which have viewed market
21 shares of over 30 percent as sufficient to reach
22 the anti-competitive threshold.

23 Highly concentrated markets are
24 problematic. And I'm going to skip the HHI
25 analysis as I'm sure everybody's exhausted of that.

1 Just to say highly concentrated markets are
2 problematic because when there is little or no
3 competition, consumers are made worse off if a firm
4 uses its market power to raise prices, lower
5 quality for consumers or block entry by potential
6 competitors.

7 Sometimes it's hard to measure the
8 importance of competition in a market. The Center
9 for American Progress, for example, recently has
10 found that where Aetna and Humana compete head to
11 head, as in Missouri, premiums are lower by up to
12 \$302 in certain circumstances.

13 And currently in Missouri the parties
14 are competing in over 60 counties, and the loss of
15 competition would be harmful and certainly result
16 in higher premiums. When insurers merge, there's
17 almost always an increase in premiums, and every
18 economic study echoes this finding.

19 But for the merger, Aetna and Humana
20 would continue to compete and likely increase
21 competition by expanding into other Missouri
22 counties in which both do not currently compete.
23 The merger is a violation of the competitive
24 standards that cannot be remedied.

25 I'd like to turn very quickly to the

1 parties' proposed efficiencies, which we've also
2 heard about today. It's our belief that they will
3 not overcome a finding that the merger is
4 anti-competitive.

5 The critical question here is why is
6 the merger necessary in order to achieve any of the
7 potential efficiencies the merging parties point
8 to? To note, no court of law has held that a
9 merger has been justified because of efficiencies.

10 In answering the question I just
11 posed a substantial burden. In order to show that
12 the efficiencies could justify the merger, the
13 parties need to demonstrate, number one, that
14 they're merger specific; two, that the efficiencies
15 outweigh any competitive harm; and three, that they
16 benefit consumers.

17 From what we've heard in testimony
18 today and our understanding of information that's
19 public, we've not been able to understand, the
20 parties have not been able to quantify, for
21 example, line items with regard to the
22 \$1.25 billion savings that have been proffered.

23 We do leave it to the Department to
24 determine if the parties' proffered efficiencies
25 are substantiated. Both parties have tremendous

1 resources and expertise and, but for the merger,
2 would continue to expand competition in the state.

3 We do not think there is a reason
4 they need the merger to achieve efficiencies, but
5 even if the efficiencies -- even if they could
6 demonstrate the efficiencies, that they would be
7 met, we do not think that they would outweigh the
8 competitive harm. There's no evidence or scholarly
9 study showing that insurance mergers lead to
10 savings for consumers or that any merger has been
11 based on the proffered efficiencies.

12 Third, that leads me to my last
13 question. If there is a problem, is there a
14 solution? We obviously believe that there is a
15 competitive problem and something needs to be done
16 here. And the Department should consider whether
17 any remedies would properly protect Missourians and
18 ensure that the merger is in the public interest.

19 It is important to remember that the
20 law requires that a remedy must fully restore the
21 competition that would otherwise be lost or must
22 otherwise effectively prevent the harm that would
23 result.

24 Nearly every other health insurance
25 merger enforcement action in the last two decades

1 the Department of Justice has relied on the
2 structural remedy of divestitures. Divestitures
3 require that the merging insurance companies spin
4 off subscribers or operations to another, a
5 preferably independent insurance company that's
6 fully capable of restoring competition.

7 In Missouri the scope and the breadth
8 of market shares of the merging companies in
9 particularly Medicare Advantage operations are
10 significant. We estimate through internal
11 calculations that Aetna would have to divest close
12 to 50,000 lives in various markets. Constructing
13 any remedy involving divestitures can be an
14 extremely difficult and daunting task.

15 Furthermore, the Department of
16 Justice's traditional approach of divestiture has a
17 poor track record of solving problems in health
18 insurance mergers. Recent studies by the Center
19 for American Progress in the Capital Forum found
20 that divestitures in the 2012 Humana/Arcadian
21 merger have largely failed to address the
22 competitive concerns with two of the three firms
23 failing and resulting in a substantial increase in
24 premiums.

25 And as previously mentioned, health

1 insurance mergers have resulted in higher premiums
2 even despite remedies. And moreover, no remedy in
3 this case could address the loss of potential
4 competition.

5 So, your Honor, there's no reason to
6 believe if you succeed in divestiture of 12,000
7 Medicare lives such as in Humana/Arcadian that you
8 can succeed with a divestiture of approximately
9 50,000 lives that would be necessary here.

10 We believe the merger is a recipe for
11 consumer harm, and the Department has the power to
12 disprove the merger. State insurance commissioners
13 have disapproved health insurance mergers in the
14 past, such as Pennsylvania's 2009 decision to deny
15 Highmark's acquisition of Independence Blue Cross
16 merger. We urge the Department to do that.

17 Thank you for your time.

18 HEARING OFFICER ERICKSON: Thank you,
19 sir. Are there any other interested persons who
20 wish to come forward to offer oral comment or
21 written comment or both? Thank you.

22 Before we proceed, housekeeping. I
23 want to confirm that at this time it appears to my
24 record that we have admitted all of the
25 Petitioner's Exhibits Nos. 1 through 36, and we

1 have closed certain designated ones as we discussed
2 previously on the record. Is that correct, all
3 exhibits have been admitted?

4 MR. HOPPER: That's my understanding.

5 HEARING OFFICER ERICKSON: And Aetna,
6 Exhibits A through EE have been admitted, and some
7 of them have been closed in the record; is that
8 correct?

9 MR. WHITMER: Correct.

10 HEARING OFFICER ERICKSON: Thank you.
11 One -- pardon me. Two exhibits have appeared to us
12 on a flash drive. I have specifically requested of
13 Aetna to provide a new flash drive or whatever
14 mechanism they deem is appropriate to make
15 documents that are too large into smaller documents
16 that can be viewed and accessible given our
17 computer limitations.

18 One thought, just an aside, if you
19 wanted to put Exhibit H which is open and Exhibit N
20 which is closed, you could -- that won't solve how
21 big the documents are, but they could be on
22 separate flash drives for purposes of keeping
23 exempt and nonexempt materials separate within the
24 records.

25 MR. WHITMER: Understood, and thank

1 you.

2 HEARING OFFICER ERICKSON: Thank you.

3 Findings of -- Proposed Findings of Fact,

4 Conclusions of Law and Order are due by 5 o'clock

5 p.m. on Thursday, May 19th. Heretofore I have

6 required paper filings to be the official filing.

7 I will accept an e-mail filing, if you would please

8 follow up with a paper filing, as is the norm for

9 our records, but that way the e-mail will get into

10 everyone's hands more efficiently. I will respond

11 to your e-mails to acknowledge I received it.

12 If your e-mail contains a document

13 that is too large, our system will reject it and

14 I -- and/or I won't be able to open it. So if you

15 need to send several e-mails, that would be fine.

16 I understand that parties sometimes

17 include legal briefs and legal arguments within

18 their proposed findings. You are welcome to do

19 that, or you are welcome to submit separate legal

20 brief. That is an option. You do not have to file

21 briefs, but if there is some point of law that you

22 believe needs further clarification or something

23 that deserves a legal brief, you may do so.

24 Argument. I would offer to the

25 parties at this point to, in lieu of oral closing,

1 to -- if you wish to submit a written closing, it
2 would also be due five o'clock Thursday, May 19th,
3 along with the briefs. I don't know if your oral
4 closing at this point would have any impact on the
5 hearing officer.

6 Are there any questions regarding
7 those proposed dates and processes?

8 MR. WHITMER: No questions.

9 MR. HOPPER: No questions.

10 HEARING OFFICER ERICKSON: Are the
11 parties comfortable waiving oral argument at this
12 time? Division?

13 MR. ANGOFF: We are, your Honor.

14 HEARING OFFICER ERICKSON: Aetna?

15 MR. WHITMER: Agreed.

16 HEARING OFFICER ERICKSON: Humana?

17 MS. COYLE: Yes, your Honor.

18 HEARING OFFICER ERICKSON: Thank you.

19 I have for me documents that I believe were
20 intended to be public versions of the confidential
21 reports of Aetna's experts. Is that correct?

22 MR. WHITMER: That's correct.

23 HEARING OFFICER ERICKSON: And these
24 were put on the screen. We didn't go through every
25 slide. I consider these to be demonstrative

1 evidence, and I will be placing them on our website
2 and they will be indicated as demonstrative
3 evidence. Acceptable?

4 MR. WHITMER: Acceptable and correct.

5 HEARING OFFICER ERICKSON: I believe
6 that the parties may have received revised
7 Exhibits 20 and 21. Were there other revised
8 exhibits, Mr. Hopper?

9 MR. HOPPER: I believe Exhibit 30 was
10 revised as well.

11 HEARING OFFICER ERICKSON: Yes,
12 Exhibit 30. Thank you.

13 MR. HOPPER: Does the hearing officer
14 have a copy of Petitioner's demonstrative exhibits
15 that were displayed on the television?

16 HEARING OFFICER ERICKSON: Hearing
17 officer is drawing a complete blank.

18 Let's go off the record.

19 (AN OFF-THE-RECORD DISCUSSION WAS
20 HELD.)

21 HEARING OFFICER ERICKSON: I have
22 been handed by Mr. Hopper the demonstrative exhibit
23 that accompanied the testimony of the Division's
24 expert. Is that correct, Mr. Hopper?

25 MR. HOPPER: This demonstrative

1 exhibit accompanied the testimony of John Rehagen.

2 HEARING OFFICER ERICKSON: Mr.

3 Rehagen. Thank you. In accordance with the
4 Amended Notice of Hearing, if the parties wish to
5 file a written response to any of the written
6 comments, such response must be received no later
7 than 5 p.m., Monday, May 23rd, 2016.

8 Division, anything further?

9 MR. HOPPER: No, Madam Hearing
10 Officer.

11 MR. WHITMER: Nothing further, your
12 Honor, other than thank you for your patience.

13 HEARING OFFICER ERICKSON: Thank you.
14 And when we go off record, I would like to say a
15 few more comments regarding everyone's patience,
16 which is greatly appreciated.

17 Anything further from Humana?

18 MS. COYLE: Nothing further, your
19 Honor, but thank you.

20 HEARING OFFICER ERICKSON: Thank you.
21 This hearing is concluded. The record in this
22 matter remains open until I issue an order that the
23 record of the matter is completed and the matter
24 taken under submission. We are off the record.

25 (WHEREUPON, the hearing concluded at

1 10:32 p.m.)

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