UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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STATE OF TENNESSEE
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and

COMMONWEALTH OF VIRGINIA
202 North 9th Street
Richmond, VA 23219

Plaintiffs,

v.

ANTHEM, INC.
120 Monument Circle
Indianapolis, IN 46204

and

CIGNA CORP.
900 Cottage Grove Road
Bloomfield, CT 06002

Defendants.

COMPLAINT

The United States of America, acting under the direction of the Attorney General of the United States, and the States of California, Colorado, Connecticut, Georgia, Iowa, Maine, Maryland, New Hampshire, New York, and Tennessee, the Commonwealth of Virginia, and the District of Columbia ("Plaintiff States"), acting by and through their respective Attorneys General, bring this civil antitrust action to prevent Anthem, Inc. from acquiring Cigna Corp.

I. INTRODUCTION

1. Anthem's proposed $54 billion acquisition of Cigna would be the largest merger in the history of the health-insurance industry. It would combine two of the few remaining commercial health-insurance options for businesses and individuals in markets throughout the country. And in doing so, it would substantially lessen competition, harming millions of American consumers, as well as doctors and hospitals.

2. The U.S. healthcare system—including commercial health insurance—affects the lives and pocketbooks of virtually every citizen. Each year, Americans visit the doctor or hospital more than a billion times and spend more than $3 trillion on healthcare. Half of all Americans obtain healthcare through their employers, which purchase plans from insurance companies such as Anthem and Cigna. Millions more citizens purchase health insurance on public exchanges established by the Affordable Care Act.

3. Competition among insurance companies like Anthem and Cigna ensures that employers and individuals can purchase high-quality policies at affordable prices. Employers seek competitive bids when selecting plans to offer their employees. Individuals choose among competing insurers when purchasing policies on the public exchanges. And competition is critical for doctors and hospitals who obtain access to most of their commercial health-insurance patients by contracting with insurers to be "in-network" providers.

4. This competition is now at risk. Today, the industry is dominated by five large insurers commonly referred to as "the big five." In a scramble to become even bigger, four of the big five now propose to merge: Anthem seeks to buy Cigna for $54 billion, and Aetna seeks to acquire Humana for $37 billion. These mergers would reshape the industry, eliminating two innovative competitors—Cigna and Humana—at a time when the industry is experimenting with new ways to lower healthcare costs. Other insurers lack the scope and scale to fill this

competitive void. As one Anthem executive vice president explained in 2015, this "very consolidated" industry is "really down to a big five and then, it gets much more smaller in terms of players that are available after that." After the mergers, the big five would become the big three, each of which would have almost twice the revenue of the next largest insurer.

5. Today, the United States and a number of states have filed lawsuits in this Court to enjoin both mergers. This complaint seeks to block Anthem's attempt to buy Cigna. If allowed to proceed, this merger would enhance Anthem's power to profit at the expense of both consumers and the doctors and hospitals providing their medical care.

6. Anthem is the largest member of the Blue Cross and Blue Shield Association. It competes in 14 states as the Blue licensee and partners with other Blue plans to compete throughout the country. Anthem admits in business documents that its share is already "dominant in most of [its] markets," a position that gives it "a clear advantage and provides opportunities to drive margin growth." But Anthem has also earned a reputation in many markets for having poor customer service, being slow to innovate, and being difficult to work with for doctors and hospitals. The president of Anthem's Indiana business conceded, "There are some customers, some prospects who loathe us."

7. Cigna increasingly competes head to head with Anthem by finding innovative ways to lower its customers' medical costs. Cigna offers sophisticated wellness programs that improve the health of its members, provides highly-regarded customer service, and works closely with doctors and hospitals to improve the quality and lower the cost of care. These efforts have been well received by consumers and healthcare providers, pressuring Anthem to respond. Without the merger, Cigna expects to double in size in the next seven to eight years.

8. Anthem's purchase of Cigna would eliminate it as a competitive threat and substantially lessen competition in numerous markets around the country. The harm to competition in any one of these markets is sufficient to enjoin the transaction.

(a) ***National accounts.*** Of the big five, only four insurers offer a nationwide commercial network sufficient to serve the country's largest employers, known as "national accounts." Anthem, working together with its fellow Blues, is one; Cigna is another. Anthem and Cigna view each other as close competitors for these accounts and have adopted strategies for winning national business from each other.

(b) ***Local commercial markets.*** Anthem and Cigna are often two of few remaining options for large-group employers in at least 35 metropolitan areas, including New York, Los Angeles, San Francisco, Atlanta, and Indianapolis. In some of these areas, Cigna has won most of its new accounts from Anthem, and Anthem has described Cigna as "aggressive" and "our number one competitor."

(c) ***Individual exchanges.*** In at least two metropolitan areas—St. Louis and Denver—Anthem and Cigna are key competitors selling policies to individuals and families on the public exchanges. Cigna has grown rapidly in these markets. For example, in the two years Cigna has participated on the exchange in St. Louis, it has captured nearly 25 percent of the market—with much of that growth coming at Anthem's expense. Without the merger, Cigna plans to continue to expand on the exchanges.

(d) ***Purchase of healthcare services by commercial health insurers.*** Anthem's high market shares already give it significant bargaining leverage with doctors and hospitals. In the same 35 metropolitan areas referenced above, this merger would substantially increase Anthem's ability to dictate the reimbursement rates it pays providers, threatening the availability and quality of medical care. The merger also would deprive both providers and consumers of Cigna's innovative efforts to work cooperatively with providers and enter into "value-based" contracts that reward them for improving patient health and lowering cost.

9. If permitted to proceed, Anthem's purchase of Cigna likely would lead to higher prices and reduced benefits, and would deprive consumers and healthcare providers of the innovation and collaboration necessary to improve care outcomes. Because this merger threatens to reduce competition across the country, it violates Section 7 of the Clayton Act. To prevent this unlawful harm, the Court should enjoin this merger.

II. THE DEFENDANTS AND THE MERGER

10. Anthem competes in all 50 states and the District of Columbia either directly or through the Blue Cross and Blue Shield Association, a joint venture of insurance companies that partner to offer their members access to a nationwide network of healthcare providers. Anthem controls the Blue license in all or part of 14 states, covering 39 percent of the U.S. population: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, most of Missouri, Nevada, New Hampshire, parts of New York, Ohio, Virginia (except the DC suburbs), and Wisconsin. In all these states but California and New York, Anthem has the exclusive right to bid for new business under both the Blue Cross and Blue Shield brands. In 2015, Anthem had approximately 39 million members nationwide and earned $78 billion in revenue.

11. Cigna also competes in all 50 states and the District of Columbia. In 2015, it had approximately 13 million U.S. members and earned $38 billion in revenue. Cigna has earned a reputation as an innovator in the industry by developing wellness programs to improve the health of its members and by collaborating with healthcare providers to improve patient health and lower the overall cost of medical care. Cigna has enjoyed compound revenue growth of 13 percent annually over the last six years.

12. In early 2014, Anthem's leadership reflected on a decade of consolidation in the health-insurance industry and determined that there was "perhaps a single significant transaction remaining." Soon after, Anthem began talks to acquire Cigna. The companies were well aware of the competitive problems the deal would create: In October 2014, Cigna's chief financial officer warned the CEO to stop using words like "dominant" and "market share" when analyzing the potential deal because they are "both sensitive words from a post deal review perspective." Anthem and Cigna also realized that the value of their combined company would be limited by the Blue Cross and Blue Shield Association's "best-efforts" rules, which cap the proportion of

revenue that Anthem can earn from brands not affiliated with the Blue network, including Cigna. In February 2015, Anthem's board of directors called off the deal.

13. But just a few months later, Anthem's interest in acquiring Cigna was renewed when Humana began seeking a buyer. This sparked a bidding frenzy in the industry. In a two-month period, Anthem made several bids for Cigna; Cigna made two bids for Humana; UnitedHealthcare made bids for Aetna and Cigna; and Aetna made a bid for Humana, which after only weeks of negotiation resulted in an agreement on July 2, 2015. Just a few weeks later, on July 23, 2015, Anthem agreed to acquire Cigna for $54 billion.

14. Anthem's acquisition of Cigna was contentious from the start. In mid-June 2015, Cigna's board of directors rejected an offer from Anthem in a letter pointing to "a number of major issues," including complications relating to Anthem's membership in the Blue Cross and Blue Shield Association. The insurers also fought publicly about which CEO would lead the combined company. In the months since the agreement was signed, Anthem and Cigna have continued to quarrel over how they should integrate their two companies.

15. Anthem has also been unable to explain how the combined company would address problems created by Anthem's membership in the Blue Cross and Blue Shield Association. For example, Anthem calls other Blue plans "comrades in arms" and works closely with them to win national accounts from Cigna and other insurers. But after this merger, Anthem would also own Cigna. Anthem would thus be competing with—and against—its fellow "Blues brethren" for the same national accounts. Anthem's CEO testified that he did not know how the company would resolve this conflict of interest.

III. BACKGROUND ON COMMERCIAL HEALTH INSURANCE

16. Anthem and Cigna compete vigorously in the sale of both "large group" and "individual" commercial health insurance. Group insurance sold to employers with more than 50 employees (or in four states, more than 100 employees) is called "large group" insurance. Within large groups, the industry recognizes a subset of the largest employers with employees in more than one state called "national accounts." Most large employers buy self-insured plans (also known as administrative-services-only or "ASO" contracts), under which the employer retains most of the risk of its employees' healthcare costs and pays the insurer an administrative fee for access to the insurer's network of doctors and hospitals and for processing medical claims. For employers of any size, health-insurance costs are a significant expense, and even large employers are increasingly shifting more of the costs of healthcare to their employees. Anthem and Cigna also sell "individual" insurance, which individuals and their families most commonly purchase on the public exchanges.

17. To sell plans to employers and individuals, commercial health insurers compete on price, customer service, care management, wellness programs, and reputation. Insurers also compete on the breadth of their network of healthcare providers, including doctors and hospitals, as most people seek medical care close to where they live or work.

18. Traditionally, insurance companies reimburse providers on a "fee-for-service" basis whereby providers receive compensation for all, or almost all, services provided. But insurers are increasingly experimenting with—and competing with each other to create—contractual arrangements that reward doctors and hospitals for better health outcomes and lower total costs. Instead of reimbursing providers based solely on the quantity of services they perform, this value-focused movement gives providers incentives to improve their patients' overall health and perform fewer, but more effective, services. Industry participants call these

arrangements "provider collaborations" or "value-based arrangements," and refer to this shift in approach as the "volume-to-value" movement. Competition is a key ingredient to the volume-to-value movement's continued success, and Cigna has been particularly innovative in advancing these provider collaborations.

IV. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE TO NATIONAL ACCOUNTS

19. Anthem and Cigna vigorously compete against each other to sell commercial health insurance to national accounts. The proposed merger would eliminate that competition and leave national accounts with only three meaningful options.

A. The sale of health insurance to national accounts is a relevant product market.

20. The typical starting point for merger analysis is defining the relevant market. Courts define relevant product markets to help determine which customers are most likely to be affected by the merger. The sale of commercial health insurance to national accounts is one such relevant product market and line of commerce under Section 7 of the Clayton Act.

21. National accounts are distinct customers with unique characteristics. They typically require a provider network covering multiple states; undergo a lengthier, more resource-intensive purchasing process involving requests for proposals; are more likely to hire a large consulting firm to aid them in evaluating and selecting an insurer or insurers; and are more likely to want flexible and customized benefit designs. Anthem and Cigna have dedicated business units focused on selling and marketing to national accounts, and each insurer is able to charge those accounts different prices and offer different plan benefits than they do for other types of accounts.

22. The sale of commercial health insurance to national accounts satisfies the well-accepted "hypothetical monopolist" test set forth in the U.S. Department of Justice and Federal

Trade Commission 2010 Horizontal Merger Guidelines. Under the Guidelines, relevant markets may be defined as a group of customers that could be profitably targeted for price increases. A hypothetical monopolist of commercial health insurance sold to national accounts likely would impose a small but significant and non-transitory price increase because an insufficient number of national accounts would stop purchasing commercial health insurance to make that price increase unprofitable. Because health insurance is a significant employment benefit, and national accounts offer it to recruit and retain highly qualified employees, very few national accounts will stop buying health insurance for their employees in the event of a small but significant price increase. Nor are a sufficient number of national accounts likely to build their own provider networks by contracting directly with doctors and hospitals or attempt to process all of their employees' healthcare claims themselves. And arbitrage (the reselling of a product from one customer to another) is impossible, so national employers could not avoid a price increase by buying health insurance from other employers.

B. This merger would harm national accounts in two relevant geographic markets.

23. The proposed merger would harm national accounts in (1) the parts of the 14 states where Anthem sells under a Blue license; and (2) the United States generally.

(1) The 14 Anthem states are a relevant geographic market.

24. Anthem and Cigna compete directly for national accounts headquartered in the Anthem states, and national accounts headquartered in those states have similar options for health insurance. Therefore, it is appropriate to consider these 14 states together as a single relevant geographic market and section of the country under Section 7 of the Clayton Act.

25. This geographic market satisfies the hypothetical monopolist test. National accounts headquartered in the Anthem states do not have reasonable substitutes to purchasing

commercial health insurance from insurers doing business in these states. National accounts would not close their headquarters and move them to different states in response to a small but significant and non-transitory price increase.

(2) The United States is a relevant geographic market.

26. It is also appropriate to consider the United States as a single relevant geographic market and section of the country under Section 7 of the Clayton Act. National accounts headquartered throughout the United States have similar options for health insurance. And, in addition to competing in the 14 Anthem states, Anthem and Cigna compete for national accounts headquartered throughout the rest of the country. Cigna has a nationwide provider network and competes throughout the United States, and Anthem competes for national accounts headquartered in the 36 states in which it does not have a Blue license in at least two ways.

27. First, Anthem bids directly for national accounts headquartered outside its 14 states when other Blue plans "cede" that right to Anthem. The Association's rules generally permit only one Blue plan to bid on an account—the plan holding the license in the territory where the national account is headquartered. For example, only BlueCross BlueShield of Tennessee can submit a bid for a national account based in Tennessee. But Blue plans can cede that right to each other on an account-by-account basis. Anthem has received hundreds of cedes from its fellow Blue plans.

28. Second, even when Anthem is not ceded an account, it competes indirectly as part of the bid submitted by the local Blue plan. For example, when BlueCross BlueShield of Tennessee bids for a national account based in Nashville, that account evaluates the strength of the Blues' provider network in other states where it has employees, including the 14 states that Anthem's network covers. And Anthem profits when the Tennessee Blue wins the account because Anthem receives "BlueCard fees" when any of that account's employees obtain medical

care in Anthem's territories. Because almost 40 percent of the U.S. population lives in the 14 Anthem states, Anthem earns significant BlueCard revenue—$450 million in 2014 alone, much of it from national accounts.

29. This geographic market satisfies the hypothetical monopolist test, as national accounts headquartered in the United States do not have reasonable substitutes to purchasing commercial health insurance from insurers doing business in this country. National accounts would not close their offices and move their companies to different countries in response to a small but significant and non-transitory increase in the price of commercial health insurance.

C. This merger is presumptively unlawful in both the 14 Anthem states and across the entire United States.

30. The Supreme Court has held that mergers that significantly increase concentration in already concentrated markets are presumptively anticompetitive and therefore presumptively unlawful. To measure market concentration, courts often use the Herfindahl–Hirschman Index ("HHI") as described in the Merger Guidelines. HHIs range from 0 in markets with no concentration to 10,000 in markets where one firm has a 100 percent market share. According to the Guidelines, mergers that increase the HHI by more than 200 and result in an HHI above 2,500 in any market are presumed to be anticompetitive.

31. For national accounts headquartered in the 14 Anthem states, Anthem and Cigna have a combined market share of at least 40 percent. For national accounts in the United States as a whole, Anthem (together with the other Blues) and Cigna have a combined market share of at least 30 percent. In these markets, the merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines.

32. These measures of market concentration understate the competitive harm likely to result from the proposed merger, in part, because they include so-called "slice" insurers—local

insurers that compete for only a portion of a national account's business. Such "slice" insurers cannot compete to fully replace Anthem, Cigna, Aetna, or UnitedHealthcare nationwide. Among national accounts in the 14 Anthem states seeking to buy a nationwide plan from one of these four insurers, Anthem and Cigna would have a combined market share of at least 50 percent. Among national accounts across the country seeking a nationwide plan from one of these four insurers, Anthem (together with the other Blues) and Cigna would similarly have a combined market share of at least 50 percent.

D. This merger likely would harm national accounts in the Anthem states and throughout the country.

33. In the 14 Anthem states, the proposed merger would combine Anthem and Cigna and thus eliminate Cigna as a competitor for national accounts. Anthem and Cigna have frequently been the two finalists when these national accounts seek competitive bids for commercial health insurance, and those accounts have been able to use the competition between Anthem and Cigna to obtain lower prices and better terms. This merger would end that competition.

34. For example, in a 2013 bid, Anthem feared that Cigna would aggressively market the benefits of its clinical programs, and Anthem ended up lowering its fees to the customer to ward off a competitive bid. In another bid that year, Cigna won what its executives called a "dogfight with Anthem" by offering better overall value to the customer. In 2014, Anthem targeted a longtime Cigna customer as a "good opportunity to continue to pick off Cigna accounts." Anthem made a competitive offer and won the account.

35. Anthem has introduced strategies specifically designed to win national accounts from Cigna and Aetna, another national rival. For example, Anthem has offered flexible renewal pricing, which allows its sales teams to adjust pricing for accounts in which "Aetna or Cigna is

an incumbent for at least one-third of the [account]"; trend guarantees, which cap the rate of increase of medical costs for national customers "where Aetna or Cigna is the alternate carrier and/or the account is significantly increasing [its] clinical offering"; and a "bounty" program that compensated Anthem sales agents who won new accounts from Cigna or Aetna. These and other initiatives reflect Anthem's view that Cigna and Aetna "should not exist."

36. In the 36 non-Anthem states, the proposed merger would also substantially harm competition in at least three ways. First, as explained above, Anthem often competes directly with Cigna for national accounts that other Blue plans have ceded to Anthem. That competition would be lost. Second, after the merger, Cigna would not compete as hard against other Blue plans for national accounts because Cigna (through its owner, Anthem) would likely receive significant BlueCard fees if a Blue plan won the account. Third, Anthem would have a reduced incentive to compete aggressively with the Cigna brand because the Blue Cross and Blue Shield Association's best-efforts rules would limit Cigna's growth relative to Anthem's. Anthem has already conceded that it would violate one of the best-efforts rules if it acquires Cigna's substantial commercial membership, meaning Anthem may have to limit Cigna's competitiveness throughout the country.

37. In both the Anthem states and in the United States as a whole, the merger also would enhance coordination among insurers competing for national accounts. For example, after the merger, Anthem, the biggest of the Blue plans, would also own Cigna—one of the Blues' most formidable competitors—making coordination among the Blue plans and Cigna significantly more likely.

V. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE TO LARGE-GROUP EMPLOYERS

38. In local markets throughout the country, head-to-head competition between Anthem and Cigna has created substantial benefits for large-group employers. In many of these markets, Anthem and Cigna are two of very few competitive options. The proposed merger would eliminate the valuable benefits of this competition and leave large groups with even fewer options.

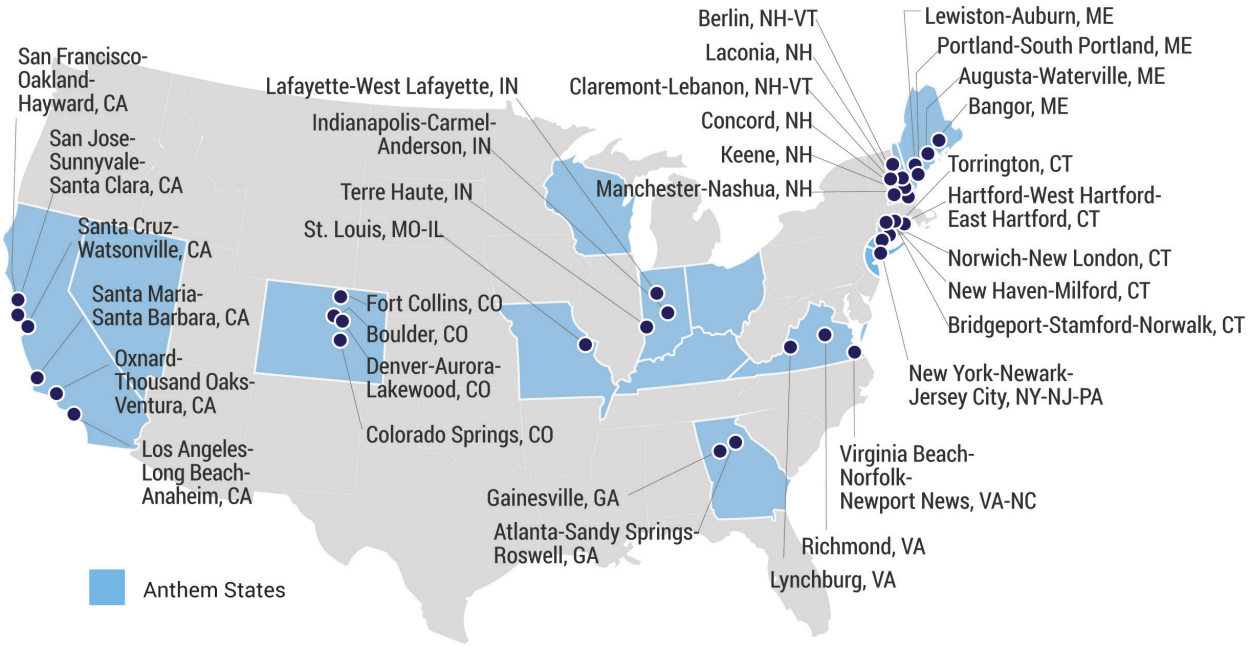
A. The sale of health insurance to large groups is a relevant product market.

39. The sale of commercial health insurance to large groups (employers with more than 50 employees or, in four states, more than 100 employees) is a relevant product market and line of commerce under Section 7 of the Clayton Act. Large-group employers are distinct customers, and insurers that sell to them do not need to follow various regulatory requirements applicable to small groups, including limitations on the factors that can be used in determining rates and other licensing and rate-filing requirements. Anthem, Cigna, and other insurers have dedicated business units focused on selling and marketing to large groups, charge those accounts different prices, and offer them different plan benefits than they do for other types of accounts.

40. Large-group employers are a relevant market for assessing the competitive effects of this merger because an insufficient number of large groups would stop buying commercial health insurance to make a small but significant and non-transitory price increase unprofitable. Nor are large groups likely to build their own provider networks and administer their health plans themselves. And, as with national accounts, large-group employers cannot avoid a price increase by purchasing commercial health insurance from other employers.

B. This merger would harm large groups in 35 relevant geographic markets.

41. The proposed merger would harm large-group employers in at least the 35 metropolitan areas listed on the map below. More than 65 million people live in these areas. Each area is a relevant geographic market and section of the country under Section 7 of the Clayton Act.



42. Patients typically seek medical care close to where they live or work, so they strongly prefer health plans offering a network of doctors and hospitals in those same areas. Thus, when purchasing commercial health insurance, large-group employers want insurers to provide access to healthcare provider networks in the areas where their employees are located. In each of the 35 metropolitan areas listed above, large groups do not view insurance companies that lack a meaningful provider network in that area as reasonable substitutes for those that offer such a network.

43. Each of these markets satisfies the hypothetical monopolist test. In each area, large groups are unlikely to move their offices to a different area in response to a small but significant and non-transitory increase in the price of commercial health insurance.

C. This merger is presumptively unlawful in most of the relevant geographic markets.

44. Anthem already has a large share in many of these local markets, which would increase further if it acquired Cigna. Even when treating each Blue plan as a separate competitor and including all other insurers in these markets, the proposed merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines in at least 20 of the relevant markets. But that understates the merger's effect on concentration for two reasons. First, the Blue plans effectively compete as a single entity; with very few exceptions, only one Blue plan at a time competes for an employer's business. When accounting for this market reality, the merger is presumptively unlawful in nearly all of the 35 markets listed above. Second, some insurers included in these market-share calculations are not close competitors to Anthem and Cigna. For example, in California, Kaiser's share is significant but its integrated business model and its "closed network" of providers is very different from Anthem's and Cigna's. One Cigna executive in California testified that he did not believe Cigna had "ever lost an ASO customer to Kaiser."

D. This merger likely would harm large-group employers by eliminating competition between Anthem and Cigna.

45. For some large groups in local markets, Anthem and Cigna are the only two competitive options. For many others, Anthem and Cigna are two of very few competitive options. In each of the 35 relevant markets, Anthem and Cigna are close competitors. In each market, Anthem has a substantial market share and competes using its well-known Blue brand and low provider reimbursement rates. Cigna is able in some of these markets to compete with Anthem on the basis of reimbursement rates. But even where its reimbursement rates are not as

attractive, Cigna competes vigorously with Anthem for large groups by offering exceptional customer service, innovative wellness programs that lower its members' utilization of healthcare, and provider-collaboration programs with hospitals and doctors. By contrast, many large-group employers believe that Anthem provides poor customer service and is far less innovative. Soon after the merger was announced, two prospective customers complained to Cigna: "We hate Anthem and you guys are about to become them."

46. In company documents, Anthem has frequently viewed Cigna as a close competitor in these 35 markets:

- In 2015, Anthem's Georgia sales force described Cigna as "aggressive" and "our toughest competition in a number of situations."
- In 2014, an Anthem sales executive wrote, "Cigna continues to present a very strong clinical/care management story, coupled with a great deal of financial flexibility. They remain our number one competitor in the 1,000+ arena."
- In a 2015 strategy document for its New Hampshire business, Anthem stated that it "remains the dominant carrier in New Hampshire, with among the highest total market shares [of any region] in the company." Despite that dominance, one of its points of strategic focus for the large-group business was to "focus on Cigna groups."
- A 2014 presentation to investors noted that in Indiana, Anthem held "a 42% to 12% [market-share] advantage over our closest competitor (FYI—Cigna)."

47. Cigna has similar views of Anthem in these same markets:

- In 2015, a Cigna executive referring to Maine, New Hampshire, and Connecticut wrote, "we have Anthem in 3 of the New England states. Over the past 4 years 40% of our new business growth has come from these Anthem plans. Those companies primarily chose Cigna, to move away from the Anthem service model, to reduce plan spend and to become more engaged consumers."
- In 2015, a Cigna executive in California estimated that "60% of our 1/1/16 regional pre sale opportunities are coming from Anthem."

48. Cigna has been particularly effective in using its innovative wellness programs to compete with Anthem. For example, in September 2015, an Anthem sales account executive noted that Cigna was offering a large municipal account in New Hampshire up to $70,000 in wellness dollars, compared to Anthem's $6,000. In response, his boss replied, "What? That's absurd. What are their current admin rates?" Around that same time, Anthem learned that Cigna was competing hard for a bid in California by selling its care management and wellness programs. An Anthem executive complained to the broker handling the bid, asking: "Does [the client] realize we are going to own Cigna in about a year anyways?"

49. Competition between Anthem and Cigna has also spurred innovation and led both companies to develop new products for large-group employers. For example, Cigna has expanded its popular "level funded" product. This product allows smaller large-group employers to pay fixed monthly installments with a chance to get money back at the end of year if claims costs fall below the anticipated level. A survey of brokers conducted by Anthem confirmed that "Cigna is the strongest competitor in this space" with "the most robust alternative funding options." Anthem further noted that, in California, Cigna was "[d]ominating the down-market ASO product sales, taking 31 clients from Anthem." To respond to Cigna, Anthem introduced its own similar product, which it made a strategic priority in California. In 2015, as Anthem rolled out several enhancements to that product, Cigna recognized that Anthem had "created a product that is a much greater threat."

50. Anthem and Cigna also compete to offer customers value-based programs and provider collaborations. An Anthem executive explained that "since we tend to have the best overall discount position in the market…our competitors have a strong incentive to be more aggressive and flexible with their [value-based] programs than Anthem." Indeed, Cigna has been

particularly focused on investing time and resources in value-based arrangements as a way to gain share against Anthem and other larger competitors. Cigna's internal plans show that absent the merger it would continue to aggressively develop its provider collaborations. The proposed merger, however, would eliminate Cigna as a competitor against Anthem and significantly reduce the incentives of the combined Anthem–Cigna to develop these innovative and beneficial programs.

VI. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION IN THE SALE OF HEALTH INSURANCE ON THE PUBLIC EXCHANGES

51. Anthem and Cigna compete head to head in the sale of individual health insurance on the public exchanges. Anthem's CEO has testified that the company is "committed to expanding our presence in the exchange marketplace." Likewise, Cigna's CEO has testified that the company is "committed to the public exchanges" and is expanding into at least three new states next year. Anthem and Cigna are close competitors on the exchange in local areas in Colorado and Missouri. The proposed merger would eliminate that competition and the important benefits it offers for individuals and families seeking affordable health insurance.

A. The sale of health insurance on the public exchanges is a relevant product market.

52. The sale of commercial health insurance on the public exchanges is a relevant product market and line of commerce under Section 7 of the Clayton Act. The majority of consumers who purchase individual health-insurance plans purchase them through the public exchanges. Through these exchanges, consumers can learn about their coverage options, compare health plans, and enroll in one. Financial assistance in the form of tax credits and cost-sharing reductions is available for many individuals and families who purchase through the public exchanges.

53. Anthem, Cigna, and other insurers recognize individuals purchasing health insurance on the public exchanges as a separate group of customers. These customers have distinct characteristics, and insurers may offer them different provider networks and different sets of benefits than other customers. Insurers consider different factors when setting prices for the public exchanges, both because most consumers receive financial assistance and because insurers selling on public exchanges incur additional fees and costs, such as user fees and the cost of technology required to connect with the exchange platform.

54. The sale of health insurance on the public exchanges satisfies the hypothetical monopolist test because consumers who use the exchanges have no reasonable substitutes that they could turn to in response to a small but significant and non-transitory increase in price. Individuals below certain income thresholds are eligible for tax credits and cost-sharing reductions, but only if they purchase their health insurance through a public exchange. Approximately 85 percent of consumers who purchase health insurance on the public exchanges receive some financial assistance. And purchasing healthcare directly from doctors and hospitals is prohibitively expensive for individuals and their families.

B. This merger would harm individuals and families in 22 relevant geographic markets.

55. Individuals may only enroll in exchange plans that have been approved for sale in their county. Therefore, competition in each county is limited to the insurers that have been approved to operate in that county, and individuals cannot practicably switch to a plan offered in another county. Likewise, the amount of any financial assistance is calculated based on the plans available to a consumer in their county. Each of the following counties is a relevant geographic market and section of the country under Section 7 of the Clayton Act:

(a) ***Colorado:*** Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Eagle, Jefferson, La Plata, Lake, Montezuma, and Summit counties; and

(b) ***Missouri:*** Franklin, Jefferson, Lincoln, Saint Charles, Saint Francois, Saint Louis, Saint Louis City, Sainte Genevieve, Warren, and Washington counties.

C. This merger is presumptively unlawful in each of the relevant geographic markets.

(1) Colorado

56. Anthem and Cigna are the second- and third-largest insurers on the Colorado public exchange. Combined, they insure almost 55,000 lives—more than one-third of all enrollees on the exchange.

57. In 12 counties in Colorado, in which more than 95,000 people rely on the public exchange for health insurance, the proposed merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines. Notably, current market concentration levels understate the competitive harm likely to result from the proposed merger because both Humana and UnitedHealthcare—the fourth- and fifth-largest insurers in the Denver area—have announced that they will not offer individual health-insurance plans in Colorado in 2017, leaving Kaiser as Anthem and Cigna's only significant competitor.

(2) Missouri

58. In the counties surrounding St. Louis, Cigna and Anthem are the second- and third-largest insurers on the public exchange. Combined, they insure over 81,000 lives on the Missouri public exchange—over 25 percent of all enrollees on the exchange.

59. In 10 counties in Missouri, in which more than 112,000 people rely on the public exchanges for health insurance, the proposed merger is presumptively unlawful. As in Colorado, current market concentration levels understate the competitive harm likely to result from the proposed merger because UnitedHealthcare—the fourth-largest insurer on the exchange in the St.

Louis area—has announced that it will withdraw from the Missouri public exchange next year, leaving Aetna as Anthem and Cigna's only significant competitor.

D. This merger would harm individuals and families who buy health insurance on the public exchanges.

60. Anthem and Cigna compete head to head to sell insurance to individuals and families who use public exchanges. Anthem competes on public exchanges in all 14 states where it controls the Blue license. Cigna has begun expanding its sale of individual insurance by focusing first on certain markets, including the relevant counties. More than 200,000 people buy their health insurance on the public exchanges in these 22 counties. These consumers have benefited from Cigna's efforts to compete with Anthem; consumers in other markets would similarly benefit as Cigna follows through on its plans to aggressively expand in the next few years. The proposed merger harms these individuals and families who depend on competition to keep the price of their health insurance affordable.

61. As with other types of commercial health insurance, Cigna competes effectively for enrollment from individuals and families through its innovative products and customer service, helping to offset Anthem's bargaining leverage with providers. For example, Cigna's approach in Colorado has been to "leverage the strength of its provider relationships" to "drive superior products & manage risk." In 2016, Cigna introduced two new provider networks in the Denver area that built on its relationships with doctors and hospitals to provide prices competitive with Anthem's. As a result, Cigna's market share increased substantially.

62. In Missouri, Anthem planned to "dominate the [exchange] marketplace for a long time" by creating "a competitive advantage around network, pricing, marketing, and distribution." But since entering the Missouri public exchange in 2015, Cigna has been an

important competitive constraint on Anthem's dominance. Cigna considers its success in St. Louis a "success recipe" for future growth in other public-exchange markets across the country.

63. Anthem and Cigna are likely to be even stronger competitors on the public exchanges in the future. Absent the merger, both companies would continue to compete on the public exchanges in Colorado and Missouri, as well as to grow their business on the public exchanges in other states. The proposed merger would eliminate that competition, to the detriment of individuals and their families that rely on health insurance purchased on the public exchanges. It likely would also lead to increases in the amount of financial assistance offered through the public exchanges, harming taxpayers as well.

VII. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE PURCHASE OF HEALTHCARE SERVICES

64. Anthem and Cigna, like other commercial health insurers, compete to sign up doctors, hospitals, and other healthcare providers for their networks. Competition in this market is the mirror image of competition in the markets discussed above. Insurers compete by offering healthcare providers access to greater numbers of patients, more generous reimbursement terms, better service, and more innovative collaborations. The proposed merger will eliminate this competition between Anthem and Cigna and likely lead to lower reimbursement rates, less access to medical care, reduced quality, and fewer value-based provider collaborations.

A. The purchase of healthcare services by commercial health insurers is a relevant product market.

65. The purchase of healthcare services by commercial health insurers is a relevant product market and line of commerce under Section 7 of the Clayton Act. Because healthcare providers in each relevant market face similar competitive conditions when selling services to

commercial insurers, it is appropriate to aggregate these services into a single relevant product market for analytical convenience.

66. Anthem, Cigna, and other insurers view the purchase of healthcare services for commercial patients as a distinct line of business. They have separate business units for negotiating such purchases, employ staff dedicated to those negotiations, and develop provider-specific reimbursement strategies.

67. This market satisfies the hypothetical monopsonist test (a "monopsonist" is a buyer that controls the purchases in a given market), the buyer-side counterpart to the hypothetical monopolist test. For doctors, hospitals, and other healthcare providers, there are no reasonable substitutes for the sale of their services to commercial health insurers. In response to a reduction in reimbursement rates from those insurers, few providers would be able to compensate for the loss of revenue by selling more services to government programs such as Medicare Advantage, Medicare, or Medicaid. Those government programs generally reimburse providers at far lower rates than do commercial health insurers, and it is difficult for providers to greatly increase the number of their Medicare Advantage, Medicare, or Medicaid patients because the total number of enrollees in those programs is relatively fixed. Most people also cannot afford to pay for many healthcare services directly, making direct sales to patients a poor substitute for sales to commercial health insurers. In response to a small but significant and non-transitory reduction in reimbursement rates, an insufficient number of providers would start selling their services to other purchasers to make that rate reduction unprofitable.

B. The relevant geographic markets for identifying harm to competition for the purchase of healthcare services are the same 35 markets in which large groups would be harmed.

68. The purchase of healthcare services by commercial health insurers in each of the 35 metropolitan areas identified in the map in paragraph 41 above satisfies the hypothetical monopsonist test and constitutes a relevant geographic market and section of the country under Section 7 of the Clayton Act. The markets for the purchase of these services are local because in the vast majority of cases patients seek care from doctors and hospitals in the same area where they live and work. In response to lower reimbursement rates by local insurers, very few healthcare providers would move their practice or facilities to a different metropolitan area.

C. This merger is presumptively unlawful in most of the relevant geographic markets.

69. The proposed merger would substantially increase concentration for the purchase of healthcare services by commercial health insurers in each of the relevant markets. In at least 25 of these markets, the merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines.

D. This merger would harm doctors, hospitals, and their patients by eliminating competition between Anthem and Cigna.

70. Anthem already has substantial bargaining leverage when negotiating with doctors and hospitals because it represents a large share of their commercial patients and revenue. As one Anthem executive put it: "[T]he more patients doctors and hospitals see from [an insurance] carrier, the more leverage that carrier has to negotiate the best arrangements in the market." Noting that in California more than half of consumers "have an Anthem logo on their ID card," the executive added: "I hope this data helps support the argument about the leverage we have in the market."

71. The proposed merger would enhance Anthem's leverage—both over physician practices that receive "take-it-or-leave-it" terms (without any negotiation) and over hospitals and physician groups that individually negotiate their contracts and rates with Anthem. As a result of the merger, Anthem likely would reduce the rates that both types of providers earn by providing medical care to their patients.

72. This reduction in reimbursement rates likely would lead to a reduction in consumers' access to medical care. For example, lower reimbursement rates likely would cause some physician practices to limit their hours of operation or reduce their staff. It may become more difficult to recruit new physicians to many of these markets. Other more experienced doctors may decide to retire early. This would exacerbate the shortage of certain doctors—such as those providing primary care—that plagues many of these markets.

73. As Anthem has recognized, these rate reductions would not result from any additional efficiencies or potentially procompetitive volume discounts. Rather, as noted by Anthem's head of provider contracting, the rate reductions from this merger would be perceived by many providers as "an incremental discount with no corresponding incremental value (no new members)."

74. The merger also likely would slow down the much-needed transition to value-based contracting. Historically, with its larger market share and lower reimbursement rates, Anthem has had fewer incentives to collaborate with providers. In many markets, it has acknowledged that it has lagged behind its competition—particularly Cigna, which it identified as "our closest competitor" for value-based contracts—and that providers view it as being "slow to respond, cumbersome, and not nimble." The merger would make that situation worse, eliminating Cigna and further reducing Anthem's incentives to enter into value-based contracts.

75. The merger would also jeopardize Cigna's existing provider collaborations. Anthem plans to lower reimbursement rates by applying its generally lower rates to the Cigna membership it acquires, which would threaten Cigna's value-based contracts with doctors and hospitals. As Cigna's executive in charge of provider contracting testified, "if you're going to have mostly a discount-based discussion with the hospital, you're not going to have [] provider collaboration coming out of that discussion." Even Anthem recognizes this tension. One of its top executives alerted Anthem's CEO that the company may "have two, conflicting strategies—collaborate in new models on the one hand, and 'drop the hammer' on the other."

VIII. ABSENCE OF COUNTERVAILING FACTORS

76. Entry of new commercial health insurers or expansion of existing commercial health insurers is unlikely to prevent or remedy the proposed merger's likely anticompetitive effects.

77. The proposed merger would be unlikely to generate verifiable, merger-specific efficiencies sufficient to reverse or outweigh the anticompetitive effects that are likely to occur. To the extent the merging parties anticipate cutting the reimbursement rates paid to doctors and hospitals for their services as a result of the merger, these reductions stem from a reduction in competition and may not be treated as efficiencies.

IX. THE DEFENDANTS HAVE NOT PROPOSED A REMEDY THAT WOULD FIX THE MERGER'S ANTICOMPETITIVE EFFECTS

78. Restoring competition is the key to any effective antitrust remedy. The only acceptable remedy for an anticompetitive merger is one that completely resolves the competitive problems created by the merger. Proposed remedies including divestitures must give the buyer both the means and the incentive to effectively compete. Defendants bear the burden of showing

that any remedy they propose meets these standards. The Defendants have not proposed any remedy that would negate the anticompetitive effects of this merger.

X. VIOLATION ALLEGED

79. The United States brings this action, and this Court has subject-matter jurisdiction over this action, under Section 15 of the Clayton Act, 15 U.S.C. § 25, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

80. The Plaintiff States bring this action under Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18. The Plaintiff States, by and through their respective Attorneys General, bring this action as *parens patriae* on behalf of and to protect the health and welfare of their citizens and the general economy of each of their states.

81. The Defendants are engaged in, and their activities substantially affect, interstate commerce. Anthem and Cigna sell commercial health insurance to national accounts with a substantial number of employees located in several different states, and that insurance covers enrollees when they travel across state lines. Anthem and Cigna also purchase healthcare services in several different states, as well as healthcare products and services (such as pharmaceuticals) in interstate commerce.

82. This Court has personal jurisdiction over each Defendant under Section 12 of the Clayton Act, 15 U.S.C. § 22. Anthem and Cigna both transact business in this district.

83. Venue is proper under Section 12 of the Clayton Act, 15 U.S.C. § 22, and under 28 U.S.C. §§ 1391(b) and (c).

84. The effect of the proposed merger, if approved, likely would be to lessen competition substantially, and to tend to create monopoly, in interstate trade and commerce in each of the relevant markets, in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18.

85. Among other things, the transaction would likely have the following effects:

(a) eliminating significant present and future head-to-head competition between Anthem and Cigna in the relevant markets;

(b) reducing competition generally in the relevant markets;

(c) causing prices to rise for customers in the relevant markets;

(d) causing reimbursements to drop for healthcare providers in the relevant markets;

(e) causing a reduction in quality in the relevant markets; and

(f) reducing competition over innovation and new product development.

XI. REQUEST FOR RELIEF

86. Plaintiffs request:

(a) that Anthem's proposed acquisition of Cigna be adjudged to violate Section 7 of the Clayton Act, 15 U.S.C. § 18;

(b) that the Defendants be permanently enjoined and restrained from carrying out the planned acquisition or any other transaction that would combine the two companies;

(c) that Plaintiffs be awarded their costs of this action, including attorneys' fees to Plaintiff States; and

(d) that Plaintiffs be awarded such other relief as the Court may deem just and proper.

Dated: July 21, 2016

Respectfully submitted,

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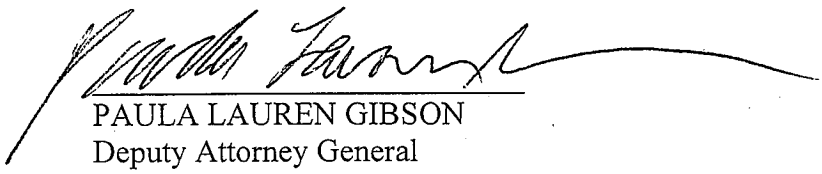

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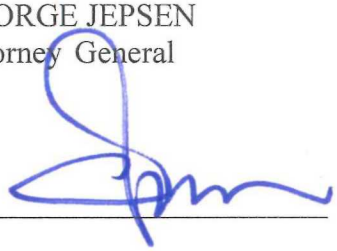

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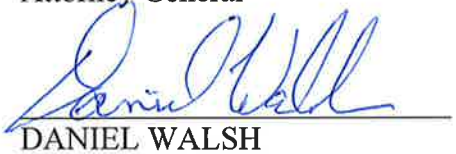

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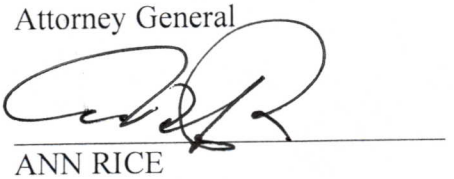

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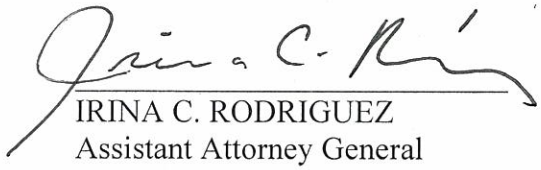

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Plaintiffs,

v.

AETNA INC.
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and

HUMANA INC.
500 West Main Street
Louisville, KY 40202

Defendants.

COMPLAINT

The United States of America, acting under the direction of the Attorney General of the United States, and the States of Delaware, Florida, Georgia, Illinois, Iowa, and Ohio, the Commonwealths of Pennsylvania and Virginia, and the District of Columbia ("Plaintiff States"), acting by and through their respective Attorneys General, bring this civil antitrust action to prevent Aetna Inc. from acquiring Humana Inc.

I. INTRODUCTION

1. Aetna's proposed $37 billion merger with Humana would lead to higher health-insurance prices, reduced benefits, less innovation, and worse service for over a million Americans.

2. Today, Aetna and Humana compete across the country to sell Medicare Advantage plans, a market-based alternative to traditional Medicare. They also compete to sell health insurance on the public exchanges established by the Affordable Care Act. Their competition benefits Americans who can least afford health insurance. It benefits seniors, who visit doctors and hospitals more than twice as much as the average person and have less income than the

average American household. It also benefits low- and moderate-income individuals and families who buy insurance on the public exchanges. The merger would end this rivalry and deny consumers its benefits.

3. Like most Americans, these individuals turn to Aetna, Humana, and other health insurance companies to provide affordable access to doctors and hospitals, process medical claims, and provide security against unexpected medical costs. Competition to attract consumers causes insurance companies to offer lower premiums, improved benefits, more attractive networks of doctors and hospitals, and more effective care management.

4. This competition is now at risk. Today, the industry is dominated by five large insurers commonly referred to as "the big five" or, as Humana's CEO described the group, the "G-5." In a scramble to become even bigger, four of the big five now propose to merge: Aetna seeks to buy Humana for $37 billion, and Anthem seeks to acquire Cigna for $54 billion. These mergers would reshape the industry, eliminating two innovative competitors—Humana and Cigna—at a time when the industry is experimenting with new ways to lower healthcare costs. Other insurers lack the scope and scale to fill this competitive void. After the mergers, the big five would become the big three, each of which would have almost twice the revenue of the next largest insurer.

5. Today, the United States and a number of states have filed lawsuits in this Court to enjoin both mergers. This complaint seeks to block Aetna's attempt to buy Humana. If allowed to proceed, this merger would enhance Aetna's power to profit at the expense of seniors who rely on Medicare Advantage and individuals and families who rely on the public exchanges for affordable health insurance.

6. Congress created the Medicare Advantage program in 1997 to offer seniors a market-based alternative to traditional Medicare. Humana and Aetna are two of the largest and fastest-growing Medicare Advantage competitors in the country.

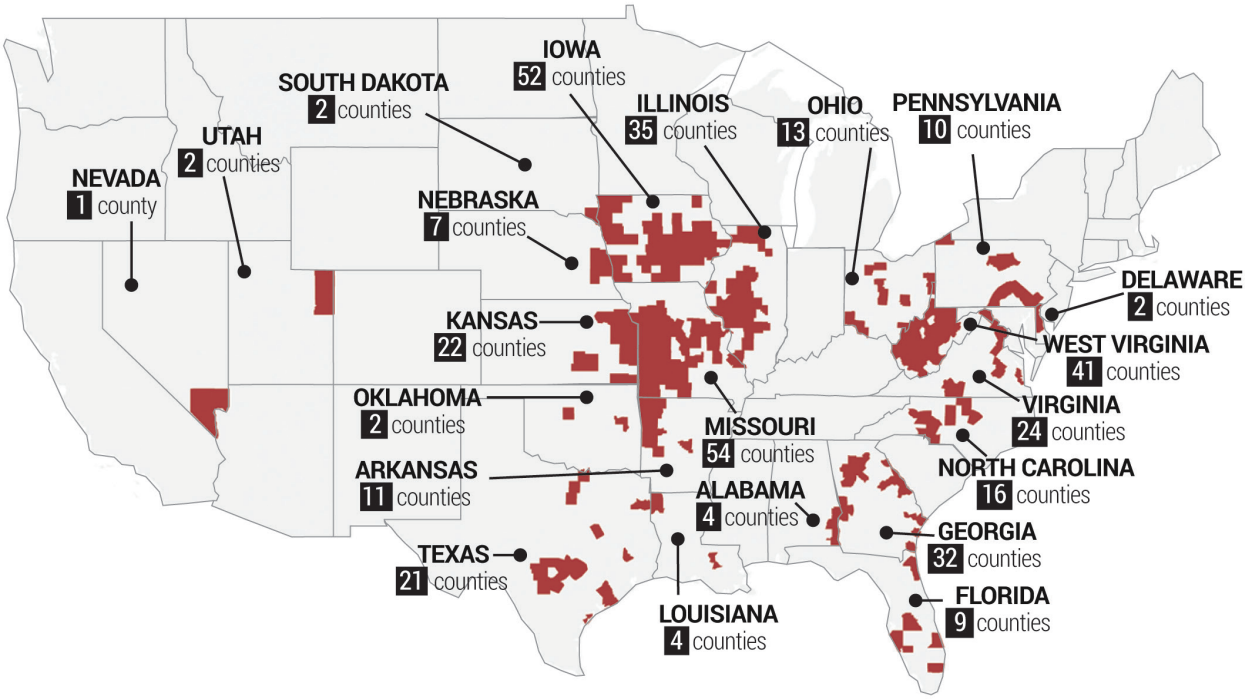
7. Humana was one of the first large insurers to enroll seniors in private Medicare health-insurance plans, now called Medicare Advantage. Humana is the second-largest Medicare Advantage insurer, providing coverage to more than 3.1 million individuals around the country. And it continues to grow. Over the past three years, Humana has added more Medicare Advantage customers than any other insurer. Before agreeing to merge with Aetna, Humana was projecting continued enrollment growth in its Medicare Advantage business.

8. Aetna is also a major, and growing, Medicare Advantage competitor. It is the fourth-largest Medicare Advantage insurer in the country. Between 2012 and 2016, Aetna entered more new counties—over 300—than any other Medicare Advantage insurer, almost doubling its footprint. Before agreeing to this merger, Aetna had planned to grow on its own, including "the largest [Medicare Advantage] expansion in [the] company's history" in 2017.

9. Aetna's aggressive expansion has led to increased competition with Humana. The two now compete in more than 600 counties—nearly 90 percent of the counties where Aetna offers Medicare Advantage. Medicare Advantage serves over six million seniors in these counties, nearly two million of whom have enrolled with Aetna or Humana. The two companies compete to enroll these seniors in their Medicare Advantage plans, and each describes the other as a "formidable competitor." Competition between Humana and Aetna has led to lower premiums, more generous benefits, better provider networks, and improved coordination of care.

10. This merger is unprecedented in the Medicare Advantage industry and affects hundreds of markets across the country. The loss of competition and harm to consumers is likely

to be particularly acute in the 364 counties listed in the Appendix and depicted in the map below. In these counties, Medicare Advantage serves approximately 1.6 million seniors, nearly 980,000 of whom have enrolled with Aetna or Humana.



11. In addition to putting an end to this present-day competition between Aetna and Humana, the merger would deny consumers the benefits of the additional competition likely to occur as both defendants continue to expand their Medicare Advantage offerings in new areas.

12. This merger is also likely to raise prices and reduce benefits for individuals and families buying health insurance on the public exchanges. Aetna and Humana have been two of the most active insurers on the exchanges. This deal would eliminate competition between them on public exchanges in at least Florida, Georgia, and Missouri, reducing choice for more than 700,000 people. The adverse effects would fall most heavily on individuals and families with low or moderate incomes.

13. Aetna's attempt to buy Humana undermines the central role that competition is meant to play in Medicare Advantage and on the public exchanges in holding down healthcare

costs and improving quality for seniors, families, and individuals. Indeed, one of the governing principles of the Medicare Advantage program, as described by the Centers for Medicare and Medicaid Services ("CMS"), is that insurers "are under continued competitive pressure to improve their benefits, reduce their premiums and cost sharing, and improve their networks and services."

14. If permitted to proceed, Aetna's purchase of Humana likely would lead to higher prices and reduced benefits for seniors, families, and individuals. It would also likely reduce competition to provide innovative wellness programs and likely would lower the quality of care that Aetna's and Humana's customers receive. Because this merger threatens to reduce competition across the country, it violates Section 7 of the Clayton Act. To prevent this unlawful harm, the Court should enjoin this merger.

II. THE DEFENDANTS AND THE MERGER

15. Aetna is the nation's third-largest health-insurance company and is rapidly growing. It has a broad national footprint and competes in every state and the District of Columbia. In 2015, 23.5 million Americans obtained health insurance through Aetna, and the company earned revenue of $60 billion. Before this merger, Aetna planned to achieve $100 billion in revenue by 2020, in large part by expanding its Medicare Advantage business and growing its presence on the public exchanges. Aetna already has significantly grown these lines of business. For example, its Medicare Advantage membership increased by approximately 19 percent from 2014 to 2016. Aetna's government-sponsored products (including Medicare Advantage) now account for approximately 40 percent of its revenue.

16. Humana is the nation's fifth-largest health-insurance company, with nearly 14.2 million enrollees and more than $54 billion in revenue. Like Aetna, it has a broad national

footprint and competes in every state and the District of Columbia. Humana is now the second-largest Medicare Advantage insurer in the country. Between 2014 and 2016, it added more individual Medicare Advantage enrollees than any other insurer in the nation. Its government-sponsored products account for over 75 percent of its revenue.

17. In March 2015, Aetna began to talk to Humana about a potential deal. Mindful that Anthem and Cigna were also seeking to combine, Aetna asked its board of directors to authorize formal discussions with Humana and told the board it could get a "first mover advantage." Aetna entered into a definitive agreement to acquire Humana for $37 billion in cash and stock on July 2, 2015. Just a few weeks later, on July 23, 2015, Anthem agreed to acquire Cigna for $54 billion.

18. From the outset, Aetna and Humana realized that their deal raised significant antitrust issues. To convince Humana to proceed in the face of antitrust risks, Aetna agreed to pay a $1 billion break-up fee if the merger is not consummated by December 31, 2016. Aetna sought to downplay the antitrust issues it knew this deal would raise. When preparing a presentation for the company's board of directors, senior Aetna executives circulated a list of "words to avoid," which included terms likely to raise law enforcement concerns, such as "markets," "dominate/dominance," and "consolidate." But merely avoiding those words does not make the merger any less likely to harm consumers by eliminating competition.

III. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF MEDICARE ADVANTAGE PLANS

19. Since they began their negotiations, Aetna and Humana knew that their competition against each other in Medicare Advantage was an antitrust problem. The facts explain why. In nearly 90 percent of the counties where Aetna offers Medicare Advantage, it

competes directly with Humana. That competition benefits many of the people who rely on the Medicare Advantage program to help cover their healthcare costs.

20. Americans 65 or older and other Medicare-eligible individuals can enroll in traditional Medicare; they also can purchase supplemental insurance plans to help cover out-of-pocket expenses and prescription-drug costs that traditional Medicare does not cover. With traditional Medicare and these supplemental plans, enrollees are not limited to a specific network of doctors and hospitals.

21. But many seniors instead choose Medicare Advantage, the program Congress introduced in 1997 to bring the benefits of competition among private insurers to Medicare. The program has proved to be immensely popular, and enrollment in Medicare Advantage has more than tripled since 2004. More and more seniors are choosing Medicare Advantage because it offers them better benefits at a lower cost than their options under traditional Medicare. Medicare Advantage provides all the insurance coverage of traditional Medicare, but also caps out-of-pocket costs and frequently covers additional services that traditional Medicare does not cover, including dental, vision, and hearing care. Medicare Advantage insurers are able to offer these benefits at lower costs by partnering with networks of doctors and hospitals to effectively manage and coordinate treatments, identify gaps in care, and comprehensively treat chronic conditions.

22. As Medicare Advantage enrollment continues to grow, preserving competition among Medicare Advantage insurers is more important than ever. More than 50 million Americans are now eligible for Medicare, and as "baby boomers" reach retirement age, approximately 10,000 more people qualify for Medicare every day. For many of them, Medicare Advantage is, or will be, their best option for health insurance. These individuals will be worse

off if Aetna is permitted to acquire Humana because they are unlikely to consider insurance plans under traditional Medicare to be cost-effective substitutes for Medicare Advantage.

A. Medicare Advantage is a relevant product market.

23. The typical starting point for merger analysis is defining the relevant market. Courts define relevant product markets to help determine the areas of competition most likely to be affected by the merger. The sale of Medicare Advantage plans is one such relevant product market and line of commerce under Section 7 of the Clayton Act. As used in this Complaint, Medicare Advantage plans are health-insurance plans sold to individuals eligible for Medicare, except for plans designed for those who are also eligible for Medicaid or have special needs.

24. Medicare Advantage is different from the products available under traditional Medicare. By itself, traditional Medicare is administered by the government and requires seniors to pay for a significant portion of their medical care. For example, seniors with traditional Medicare must pay annual deductibles and 20% coinsurance for most services, including physician and outpatient services. Traditional Medicare does not limit how much seniors must pay out-of-pocket annually. If seniors want to limit these out-of-pocket costs, they must pay an additional monthly premium for a separate Medicare Supplement plan. Additionally, to receive prescription drug coverage under traditional Medicare, seniors must purchase a separate Medicare Part D prescription drug plan, again for an additional premium each month. Medicare Supplement and Part D prescription drug plans are sold by private insurance companies, including Aetna and Humana, but these plans offer a different set of terms and benefits than Medicare Advantage and are more expensive for many seniors.

25. Medicare Advantage was designed to harness the benefits of competition among private insurers, and it is a much better deal for many seniors. Medicare Advantage plans receive funding from CMS based on the amount that would be required to cover a patient under

traditional Medicare, and they provide all of the insurance coverage that traditional Medicare does. And Medicare Advantage plans offer seniors additional benefits. Most Medicare Advantage plans feature lower copayments and lower coinsurance than traditional Medicare. Medicare Advantage plans also cap annual out-of-pocket costs and typically offer prescription drug coverage without additional charges. Because Medicare Advantage usually covers both medical expenses and prescription drugs, it is easier for seniors to navigate than if they had multiple insurance plans under traditional Medicare. Medicare Advantage plans also frequently offer dental, vision, and hearing coverage, as well as care management and wellness programs, hotlines staffed with nurses, home safety assessments, education, preventive care, gym memberships, and transportation to and from doctors' offices.

26. Seniors with Medicare Advantage receive these additional benefits and typically pay less for them than if they had traditional Medicare, with or without a Medicare Supplement or Part D plan. As Aetna's CEO testified, for seniors on a fixed income, choosing traditional Medicare over Medicare Advantage is "economically irrational." Medicare Advantage insurers are able to lower their costs—and offer lower prices to many seniors—because they work with networks of doctors and hospitals to care for patients more effectively. For seniors willing to accept a network of healthcare providers, the relationships between insurers and doctors can provide more comprehensive care while lowering overall healthcare costs. In contrast, the products available under traditional Medicare do not involve provider networks and typically do little to coordinate patients' care.

27. Because of these differences in cost and benefits, many seniors using Medicare Advantage are unlikely to consider any of the traditional Medicare products to be adequate alternatives for Medicare Advantage. Indeed, despite funding cuts to the Medicare Advantage

program over the last several years—cuts that will be fully phased in by 2017—the total number of individual Medicare Advantage enrollees and the percentage of Medicare-eligible individuals enrolled in the program have continued to grow.

28. Aetna and Humana and other industry participants recognize Medicare Advantage as a distinct product. Health insurers, including Aetna and Humana, have different business units for their Medicare Advantage plans than for their Medicare Supplement plans, including different salespeople, actuaries, and managers. Insurers separately monitor and report their Medicare Advantage enrollment, premiums, plan benefits, and financial performance.

29. Finally, Medicare Advantage satisfies the well-accepted "hypothetical monopolist" test set forth in the U.S. Department of Justice and Federal Trade Commission 2010 Horizontal Merger Guidelines. A hypothetical monopolist selling Medicare Advantage plans likely would impose a small but significant and non-transitory price increase because an insufficient number of seniors would switch to alternatives to make that price increase unprofitable. For many seniors, combinations of traditional Medicare, Medicare Supplement plans, and Part D prescription drug plans are not cost-effective substitutes for Medicare Advantage.

B. The merger would harm seniors in each of the relevant geographic markets.

30. Aetna and Humana compete against each other to enroll consumers in their Medicare Advantage plans in hundreds of counties across the United States. CMS allows seniors to enroll only in those Medicare Advantage plans that have been approved for the county in which they live. Therefore, competition in each county is limited to the insurers that have applied to and been approved by CMS to operate in that county, and seniors cannot switch to a plan offered in another county without moving. Each of the 364 counties listed in the Appendix is a relevant geographic market and section of the country under Section 7 of the Clayton Act.

C. This merger is presumptively unlawful in hundreds of counties where Aetna and Humana currently compete against each other.

31. The Supreme Court has held that mergers that significantly increase concentration in already concentrated markets are presumptively anticompetitive and therefore presumptively unlawful. To measure market concentration, courts often use the Herfindahl-Hirschman Index ("HHI") as described in the Merger Guidelines. HHIs range from 0 in markets with no concentration to 10,000 in markets where one firm has a 100 percent market share. According to the Guidelines, mergers that increase the HHI by more than 200 and result in an HHI above 2,500 in any market are presumed to be anticompetitive. Accordingly, Aetna's proposed merger with Humana is presumptively unlawful under Supreme Court precedent and the Merger Guidelines in hundreds of counties across the country.

32. The loss of competition and harm to consumers is likely to be particularly acute in the 364 counties listed in the Appendix. In 70 of these counties, the combined company would have a Medicare Advantage monopoly. In nearly 100 additional counties, Aetna and Humana are the two largest sellers of Medicare Advantage plans.

33. But harm from this deal is not limited to these counties. If this merger goes through, seniors in many other counties likely would lose the benefits of significant head-to-head competition. For example, in 2017 Aetna is introducing Medicare Advantage plans in 11 counties where Humana previously had a Medicare Advantage monopoly. As Aetna and Humana continue to target other counties for expansion, even more head-to-head competition would result. Competition between Aetna and Humana would be lost in all of these markets.

D. This merger likely would harm seniors by eliminating competition to sell Medicare Advantage plans.

34. Aetna and Humana compete against each other to attract seniors enrolled in Medicare Advantage plans by offering lower prices, more generous benefits, better wellness and

care management programs, and higher quality plans. The merger would eliminate this competition between them, and substantially lessen competition in the market generally, in violation of Section 7 of the Clayton Act.

35. The ordinary course business documents of Aetna and Humana detail their rivalry. Just three months before the merger was announced, Aetna's head of Medicare Advantage described Humana as Aetna's "most formidable competitor," stating that "[w]e compete with them everywhere and they have momentum." Aetna and Humana executives repeatedly discuss the intense competition between the two companies:

- In Atlanta, Georgia, Humana expressed concern in late 2014 that Aetna had "the most competitive benefits for a major plan in the market" and worried that its own plan would "suffer from Aetna's potential gain."
- The next year, an Aetna executive called Humana one of their "strongest competitors" in Atlanta.
- When preparing its 2016 plan offerings in Kansas City, Missouri, Aetna sought to "maximize the opportunity of competing against Humana."
- Upon seeing that Aetna had lowered premiums in Kansas City, a Humana executive observed, "They are going to be a really tough competitor this year."

36. Aetna and Humana compete to offer seniors lower-cost coverage by working to keep premiums, maximum annual out-of-pocket costs, and the amounts of copayments and coinsurance low. For example, in 2015 Aetna introduced a "low price PPO to compete with Humana's $10 [Regional] PPO that led market growth" in San Antonio, Texas. Aetna introduced a similar PPO product "with competitive premium to compete with Humana PPO" in Las Vegas, Nevada.

37. Aetna and Humana also compete by offering wellness and care management programs. Both companies have invested successfully in programs designed to keep seniors healthier and in their own homes longer by, for example, installing ramps and providing

transportation services. Aetna and Humana are also leaders in collaborating with doctors and hospitals to improve quality of care and reduce costs by improving patients' health. For example, Aetna's Healthagen subsidiary and Humana's Transcend subsidiary provide doctors and hospitals with the technology to share health data across various platforms, allowing healthcare providers to coordinate care more effectively, catch health issues sooner, and reduce unnecessary treatment.

38. Aetna and Humana also compete to distinguish themselves by offering higher quality plans. The Centers for Medicare and Medicaid Services assesses the quality of Medicare Advantage plans using a star-rating system and assigns plans up to five stars based on a number of quality metrics, such as success in managing chronic conditions and resolving customer complaints. This system rewards insurers with bonus payments and other financial incentives if they perform well.

39. Star ratings, despite being phased in just four years ago, are a key factor that distinguishes Medicare Advantage insurers from each other. First, the ratings provide seniors with clear information about the quality of a plan. Second, CMS gives plans that earn ratings of four stars or higher a number of financial benefits, including at least a five percent bonus payment and a larger portion of the savings if the insurer is able to lower costs. By regulation, insurers must use part of these savings to offer more generous benefits or lower premiums. As a result of this reinvestment, plans with high star ratings are generally more attractive to seniors than lower star-rated competitors.

40. Aetna and Humana are leaders in star ratings. In many of the highly concentrated counties listed in the Appendix, Aetna and Humana are the only insurers with plans that have four or more stars. Across all counties in the Appendix, over 75% of Aetna's and Humana's Medicare Advantage members are in plans with four or more stars. Other Medicare Advantage

insurers in these counties do not perform as well. According to Aetna's CEO, the "key driver of Aetna's Medicare Advantage membership growth trajectory has been [its] star ratings."

41. Because of their plans' high star ratings, Aetna and Humana receive large bonus payments from CMS. In turn, each is able to offer more generous benefits. Insurers that are unable to achieve at least four stars for their plans are less likely to have long-term competitive significance because the bonus payments reinforce high-quality plans and allow them to become even better. As Aetna's CEO testified, it will be "tough" for plans that do not have four stars to be viable in the long run. As consumers leave low star-rated plans, they are likely to choose higher-quality plans that offer greater benefits. In the vast majority of their competitive territories, Humana and Aetna are the competitors best positioned to offer these high-quality plans. The merger would eliminate competition that has led Aetna and Humana to offer these high-quality plans, substantially lessen competition in the market generally, and end a rivalry that has led to lower prices, better benefits, more choices, and higher-quality care for seniors around the country.

IV. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE ON THE PUBLIC EXCHANGES

42. Aetna's merger with Humana also threatens to harm those individuals and families who rely on the public exchanges to buy health insurance, particularly in Florida, Georgia, and Missouri. Since they began selling insurance on the public exchanges in 2014, Aetna and Humana have competed aggressively and viewed each other as major competitors. Aetna sells insurance on the public exchanges in 15 states and described itself as the "Number One" insurer on the public exchanges. Humana also sells insurance on the public exchanges in 15 states, and the two compete in more than 100 counties.

43. Competition on the public exchanges is evolving. UnitedHealthcare, one of the big five, recently announced plans to exit most public exchanges next year. In addition, after it agreed to be acquired by Aetna, Humana decided to reduce its public exchange offerings—including exiting several states and discontinuing plans in many counties. Even as it scales back, Humana plans to continue to compete on the public exchanges in 11 states in 2017. Both Aetna and Humana remain committed to competing on the exchanges. For example, Aetna's CEO has testified that "we believe that putting people on the public exchange in the individual market is the best way to go" because "I am running a for-profit company," and the company expects "modest growth on the exchanges." Likewise, Humana's CEO has testified that the company wants to keep its options open "to see how it progresses" so that Humana is "able to then come back into the marketplace" and expand its presence. Eliminating the competition between Aetna and Humana would further reduce the choices available to hundreds of thousands of consumers, many of whom could not afford health insurance purchased off the public exchanges.

A. The sale of health insurance on the public exchanges is a relevant product market.

44. The sale of commercial health insurance on the public exchanges is a relevant product market and line of commerce under Section 7 of the Clayton Act. The majority of consumers who purchase individual health-insurance plans purchase them through the public exchanges. Through these exchanges, consumers can learn about their coverage options, compare health plans, and enroll in one. Financial assistance in the form of tax credits and cost-sharing reductions is available for most individuals and families who purchase through the public exchanges.

45. Aetna, Humana, and other insurers recognize individuals purchasing health insurance on the public exchanges as a separate group of customers. These customers have

distinct characteristics, and insurers may offer them different provider networks and different sets of benefits than other customers. Insurers consider different factors when setting prices for the public exchanges, both because most consumers receive financial assistance and because insurers selling on public exchanges incur additional fees and costs, such as user fees and the cost of technology required to connect with the exchange platform.

46. The sale of health insurance on the public exchanges satisfies the hypothetical monopolist test because consumers who use the exchanges have no reasonable substitutes that they could turn to in response to a small but significant and non-transitory increase in price. Individuals below certain income thresholds are eligible for tax credits and cost-sharing reductions, but only if they purchase their health insurance through a public exchange. Approximately 85 percent of consumers who purchase health insurance on the public exchanges receive some financial assistance. And purchasing healthcare directly from doctors and hospitals is prohibitively expensive for individuals and their families.

B. This merger would harm individuals and families in 17 relevant geographic markets.

47. Today, Aetna and Humana compete against each other to enroll consumers in their public exchange plans in many counties across the United States. As with Medicare Advantage, individuals in the counties listed below may only enroll in exchange plans that have been approved for sale in their county. Therefore, competition in each county is limited to the insurers that have been approved to operate in that county, and individuals cannot practicably switch to a plan offered in another county. Likewise, the amount of any financial assistance is calculated based on the plans available to a consumer in their county. Each of the following counties is a relevant geographic market and section of the country under Section 7 of the Clayton Act:

(a) ***Florida***: Broward, Palm Beach, and Volusia counties;

(b) ***Georgia***: Bibb, Chatham, Cherokee, Forsyth, Fulton, Gwinnett, Houston, Muscogee, and Peach counties; and

(c) ***Missouri***: Clay, Greene, Jackson, Jasper, and Newton counties.

C. This merger is presumptively unlawful in each of the relevant geographic markets.

48. Aetna and Humana have been two of the most significant participants on the public exchanges in Florida, Georgia, and Missouri. After it agreed to be bought by Aetna, Humana decided to stop competing in numerous counties in these states and elsewhere. Taking Humana's decision into account, the proposed merger is presumptively unlawful in at least each of the 17 relevant geographic markets, where Aetna and Humana will continue to compete and where more than 700,000 people secure health insurance through the public exchanges.

49. Moreover, these current market-concentration levels likely understate the competitive harm from the merger. With UnitedHealthcare's recent announcement that it will exit most public exchanges, including in Florida, Missouri, and most of Georgia, the number of competitors in those areas will decrease and concentration—and the importance of Aetna and Humana as independent competitors—will increase. In each of the relevant markets in Missouri, for example, where currently only four competitors participate on the public exchange, UnitedHealthcare's exit would leave only one significant competitor to Aetna other than Humana. If Aetna acquired Humana, Aetna's market share would substantially increase, further entrenching its position in those markets.

D. This merger would harm individuals and families who buy health insurance on the public exchanges.

50. Aetna and Humana regard one another as formidable competitors on the public exchanges. Both companies have closely followed and responded to the other's strategies. For example, in Atlanta, Georgia, Aetna monitored and expressed concern about the pricing of its

"number one competitor, Humana." Similarly, Humana developed an "approach of monitoring Aetna's filings closely in our largest markets, and amending or revising our rates (by a few points) to maintain share" in Florida and other states where they compete. Aetna is "well-positioned for long-term growth" because of its value-based arrangements with doctors and hospitals—"where there's financial gain share and risk share with the [healthcare] providers"—and Humana's low prices allowed it to become "a market leader regarding overall share."

51. Further, both Aetna and Humana view health insurance sold directly to individuals and families as central to future competition in the health-insurance industry. Humana's CEO sees health insurance "moving to an individual-based insurance product," and Aetna's CEO echoed that the "market is moving more toward a retail marketplace." Without the proposed merger, Aetna and Humana would likely continue to invest in and compete for business on public exchanges in Florida, Georgia, and Missouri.

52. The merger would eliminate competition between Aetna and Humana and likely lead to higher premiums, reduced quality of products and services, and reduced choice for many consumers that have no other affordable health-insurance options. It likely would also lead to increases in the amount of financial assistance offered through the public exchanges, harming taxpayers as well. Because the proposed merger likely would substantially lessen competition in the sale of health insurance on the public exchanges in the relevant markets, it violates Section 7 of the Clayton Act.

V. ABSENCE OF COUNTERVAILING FACTORS

53. Entry of new health insurers or expansion of existing health insurers in the relevant markets is unlikely to prevent or remedy the proposed merger's anticompetitive effects.

54. The proposed merger would be unlikely to generate verifiable, merger-specific efficiencies sufficient to reverse or outweigh the anticompetitive effects that are likely to occur.

VI. AETNA'S PROPOSED REMEDY WILL NOT FIX THE MERGER'S ANTICOMPETITIVE EFFECTS

55. Restoring competition is the key to any effective antitrust remedy. The only acceptable remedy for an anticompetitive merger is one that completely resolves the competitive problems created by the merger. Proposed remedies including divestitures must give the buyer both the means and the incentive to effectively compete. Defendants bear the burden of showing that any remedy they propose meets these standards.

56. Aetna has proposed divesting limited pieces of its or Humana's Medicare Advantage business in an attempt to remedy the anticompetitive effects of the merger. Aetna has had some discussions with potential buyers, but has not entered into a purchase agreement.

57. The proposal, as Aetna has described it to the Plaintiffs, would include transferring to another health insurer parts of Aetna's and Humana's contracts with CMS to cover individual enrollees in numerous counties throughout the United States. These enrollees would have no choice but to move from the Medicare Advantage plan they had chosen to one that Aetna has chosen for them. During the next period when seniors are able to switch plans, nothing would prevent these enrollees from simply switching back to the Aetna or Humana plan they had originally chosen. Having lost these enrollees, the buyer would not restore the competition that had existed between Aetna and Humana.

58. The plan outlined to Plaintiffs has many problems, including:

- The buyer would not receive any intact business units. Instead, the Defendants propose to sell only parts of contracts to cover individual enrollees, stripped out from the infrastructure that currently operates to provide those enrollees high-quality health insurance. The buyer would be unable to replicate that infrastructure.

- The buyer would not have the necessary contracts with doctors and hospitals, technology platforms, claims processing systems, or employees with specialized knowledge, and no guarantee that the enrollees it just bought would not immediately return to Aetna or Humana.

- The buyer would not receive complete groups of Medicare Advantage enrollees enrolled under particular contracts between Aetna or Humana and CMS. The proposed divestiture would involve picking out enrollees from within these contracts, transferring some of them to the buyer, and leaving others with Aetna or Humana. This process would require significant oversight by CMS.

- The buyer would not receive assets sufficient to give it the scope and scale of Aetna and Humana because the buyer would not acquire enrollees in related lines of business or geographic areas, including:

    - Enrollees in Medicare Advantage special needs plans;

    - Enrollees in group Medicare Advantage plans;

    - Enrollees in any plans sold to employer groups;

    - Enrollees in Medicare Advantage plans in counties adjacent to the counties where Aetna and Humana have proposed divestitures.

- Neither the Aetna nor the Humana brand would transfer to the buyer.

- The proposal only seeks to address the harm to Medicare Advantage consumers. It does not even attempt to address the loss of competition for individuals and families purchasing health insurance on the public exchanges.

59. Under Aetna's proposal, no buyer could compete as effectively as Aetna or Humana do today, nor would a buyer be as well-positioned as Aetna or Humana to expand. The buyer's business would be smaller in both the affected and neighboring counties and across different types of plans, diminishing the buyer's ability to negotiate favorable contracts with doctors and hospitals—contracts that form much of the basis of Aetna's and Humana's success.

60. The buyer would not be an independent competitor as Humana is today. The proposed remedy would leave the buyer dependent on Aetna—potentially for years—for providing basic services. Since the buyer would not have a healthcare provider network in place or be acquiring an intact business unit that would enable it to operate on its own, it would have to

rely on Aetna's healthcare provider network and receive administrative services from Aetna for a lengthy period. Because the buyer would receive only limited assets, the buyer would be highly unlikely to timely replicate Aetna's and Humana's existing provider networks and competitive strengths in the relevant markets.

61. For these reasons, among others, the assets that Aetna proposes to divest would have lower sales volume and lower market shares, be less efficient, be of lower quality, provide fewer opportunities for innovation, and otherwise fail to replicate the competition between Aetna and Humana today. The proposed remedy would also impose a heavy burden on the Court, the Plaintiffs, and CMS, as it would require oversight of Aetna, Humana, and the buyers' businesses in hundreds of markets throughout the United States. CMS would be required to manage the transfer of some enrollees in some counties from Aetna or Humana to the buyer, and the Plaintiffs would need to monitor the ongoing relationship between Aetna and the buyer. If offered by Aetna as a remedy in this case, the Court should reject this proposal as wholly inadequate to resolve the harm to competition that the merger would cause.

VII. VIOLATION ALLEGED

62. The United States brings this action, and this Court has subject-matter jurisdiction over this action, under Section 15 of the Clayton Act, 15 U.S.C. § 25, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

63. The Plaintiff States bring this action under Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18. The Plaintiff States, by and through their respective Attorneys General, bring this action as *parens patriae* on behalf of and to protect the health and welfare of their citizens and the general economy of each of their states.

64. The Defendants are engaged in, and their activities substantially affect, interstate commerce. Aetna and Humana sell products and services to numerous customers located throughout the United States, and that insurance covers enrollees when they travel across state lines.

65. This Court has personal jurisdiction over each Defendant under Section 12 of the Clayton Act, 15 U.S.C. § 22. Aetna and Humana both transact business in this district.

66. Venue is proper under Section 12 of the Clayton Act, 15 U.S.C. § 22, and under 28 U.S.C. §§ 1391(b) and (c).

67. The effect of the proposed merger, if approved, likely would be to lessen competition substantially, and to tend to create a monopoly, in interstate trade and commerce in each of the relevant markets, in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18.

68. Among other things, the merger would likely have the following effects:

(a) eliminating significant present and future head-to-head competition between Aetna and Humana in the relevant markets;

(b) reducing competition generally in the relevant markets;

(c) causing prices to rise for customers in the relevant markets;

(d) causing a reduction in quality in the relevant markets; and

(e) reducing competition over innovation and new product development.

VIII. REQUEST FOR RELIEF

69. Plaintiffs request:

(a) that Aetna's proposed acquisition of Humana be adjudged to violate Section 7 of the Clayton Act, 15 U.S.C. § 18;

(b) that the Defendants be permanently enjoined and restrained from carrying out the planned acquisition or any other transaction that would combine the two companies;

(c) that Plaintiffs be awarded their costs of this action, including attorneys' fees to the Plaintiff States; and

(d) that Plaintiffs be awarded such other relief as the Court may deem just and proper.

Dated: July 21, 2016

Respectfully submitted,

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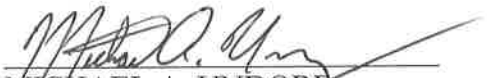

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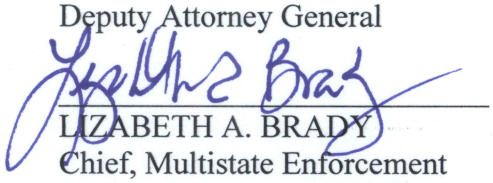

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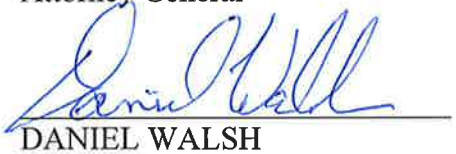

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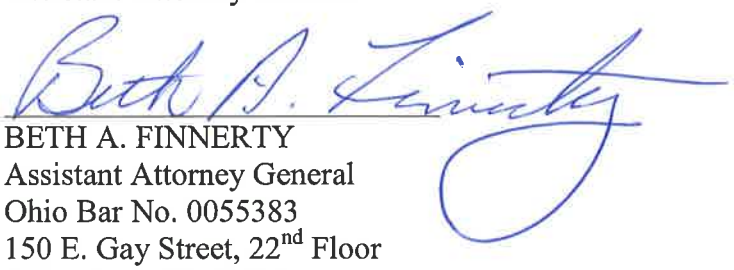

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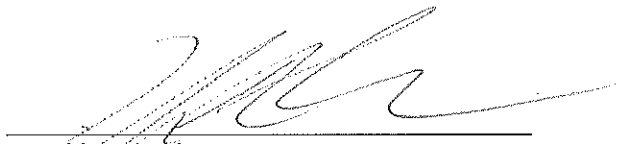

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APPENDIX

Relevant Geographic Markets — Medicare Advantage

As alleged above, Aetna's merger with Humana is likely to substantially lessen competition for the sale of Medicare Advantage plans in the following geographic areas:

STATE	COUNTY
Alabama	Barbour
Alabama	Henry
Alabama	Houston
Alabama	Russell
Arkansas	Benton
Arkansas	Carroll
Arkansas	Crawford
Arkansas	Franklin
Arkansas	Logan
Arkansas	Madison
Arkansas	Montgomery
Arkansas	Pulaski
Arkansas	Scott
Arkansas	Sebastian
Arkansas	Washington
Delaware	Kent
Delaware	New Castle
Florida	Broward
Florida	Charlotte
Florida	Duval
Florida	Manatee
Florida	Martin
Florida	Polk
Florida	Sarasota
Florida	St. Johns
Florida	St. Lucie
Georgia	Bryan
Georgia	Burke
Georgia	Camden
Georgia	Chatham
Georgia	Chattahoochee
Georgia	Cherokee

STATE	COUNTY
Georgia	Clayton
Georgia	Cobb
Georgia	Columbia
Georgia	Coweta
Georgia	DeKalb
Georgia	Douglas
Georgia	Elbert
Georgia	Evans
Georgia	Fayette
Georgia	Forsyth
Georgia	Fulton
Georgia	Gwinnett
Georgia	Hall
Georgia	Hancock
Georgia	Harris
Georgia	Lincoln
Georgia	Marion
Georgia	McDuffie
Georgia	McIntosh
Georgia	Muscogee
Georgia	Newton
Georgia	Paulding
Georgia	Richmond
Georgia	Rockdale
Georgia	Stewart
Georgia	Warren
Iowa	Adair
Iowa	Appanoose
Iowa	Benton
Iowa	Boone
Iowa	Buchanan
Iowa	Butler

STATE	COUNTY
Iowa	Carroll
Iowa	Cedar
Iowa	Clinton
Iowa	Crawford
Iowa	Dallas
Iowa	Decatur
Iowa	Delaware
Iowa	Dickinson
Iowa	Fremont
Iowa	Grundy
Iowa	Hamilton
Iowa	Ida
Iowa	Iowa
Iowa	Jasper
Iowa	Johnson
Iowa	Jones
Iowa	Keokuk
Iowa	Linn
Iowa	Lucas
Iowa	Lyon
Iowa	Madison
Iowa	Mahaska
Iowa	Marion
Iowa	Marshall
Iowa	Mills
Iowa	Monona
Iowa	Monroe
Iowa	Muscatine
Iowa	O'Brien
Iowa	Osceola
Iowa	Page
Iowa	Plymouth
Iowa	Polk
Iowa	Pottawattamie
Iowa	Poweshiek
Iowa	Sioux
Iowa	Story
Iowa	Tama

STATE	COUNTY
Iowa	Union
Iowa	Warren
Iowa	Washington
Iowa	Wayne
Iowa	Webster
Iowa	Winneshiek
Iowa	Woodbury
Iowa	Wright
Illinois	Bond
Illinois	Boone
Illinois	Brown
Illinois	Carroll
Illinois	Cass
Illinois	Christian
Illinois	Clinton
Illinois	DeKalb
Illinois	Effingham
Illinois	Fayette
Illinois	Fulton
Illinois	Greene
Illinois	Hancock
Illinois	Jersey
Illinois	Kendall
Illinois	Logan
Illinois	Macon
Illinois	Macoupin
Illinois	Marshall
Illinois	Mason
Illinois	Menard
Illinois	Montgomery
Illinois	Morgan
Illinois	Moultrie
Illinois	Ogle
Illinois	Peoria
Illinois	Pike
Illinois	Randolph
Illinois	Sangamon
Illinois	Scott

STATE	COUNTY
Illinois	Stephenson
Illinois	Tazewell
Illinois	Washington
Illinois	Winnebago
Illinois	Woodford
Kansas	Allen
Kansas	Anderson
Kansas	Atchison
Kansas	Bourbon
Kansas	Butler
Kansas	Cherokee
Kansas	Douglas
Kansas	Franklin
Kansas	Harvey
Kansas	Jackson
Kansas	Jefferson
Kansas	Johnson
Kansas	Labette
Kansas	Leavenworth
Kansas	Linn
Kansas	Miami
Kansas	Montgomery
Kansas	Osage
Kansas	Pottawatomie
Kansas	Sedgwick
Kansas	Shawnee
Kansas	Wyandotte
Louisiana	Ascension
Louisiana	Bossier
Louisiana	Caddo
Louisiana	East Baton Rouge
Missouri	Audrain
Missouri	Barry
Missouri	Barton
Missouri	Bates
Missouri	Benton
Missouri	Caldwell
Missouri	Callaway

STATE	COUNTY
Missouri	Carroll
Missouri	Cass
Missouri	Cedar
Missouri	Christian
Missouri	Clay
Missouri	Clinton
Missouri	Cole
Missouri	Cooper
Missouri	Dade
Missouri	Dallas
Missouri	Douglas
Missouri	Franklin
Missouri	Greene
Missouri	Henry
Missouri	Hickory
Missouri	Howard
Missouri	Jackson
Missouri	Jasper
Missouri	Johnson
Missouri	Laclede
Missouri	Lafayette
Missouri	Lawrence
Missouri	Lincoln
Missouri	Livingston
Missouri	McDonald
Missouri	Miller
Missouri	Moniteau
Missouri	Montgomery
Missouri	Newton
Missouri	Osage
Missouri	Ozark
Missouri	Perry
Missouri	Pettis
Missouri	Phelps
Missouri	Platte
Missouri	Polk
Missouri	Pulaski
Missouri	Ray

STATE	COUNTY
Missouri	Saline
Missouri	St. Charles
Missouri	St. Clair
Missouri	Ste. Genevieve
Missouri	Vernon
Missouri	Warren
Missouri	Washington
Missouri	Webster
Missouri	Wright
North Carolina	Alexander
North Carolina	Cabarrus
North Carolina	Caldwell
North Carolina	Caswell
North Carolina	Catawba
North Carolina	Durham
North Carolina	Gaston
North Carolina	Guilford
North Carolina	Iredell
North Carolina	Mecklenburg
North Carolina	Orange
North Carolina	Person
North Carolina	Randolph
North Carolina	Rowan
North Carolina	Union
North Carolina	Wake
Nebraska	Cass
Nebraska	Dodge
Nebraska	Douglas
Nebraska	Lancaster
Nebraska	Sarpy
Nebraska	Saunders
Nebraska	Washington
Nevada	Clark
Ohio	Brown
Ohio	Butler
Ohio	Clermont
Ohio	Columbiana
Ohio	Delaware

STATE	COUNTY
Ohio	Franklin
Ohio	Hamilton
Ohio	Hancock
Ohio	Jefferson
Ohio	Marion
Ohio	Meigs
Ohio	Muskingum
Ohio	Seneca
Oklahoma	Kingfisher
Oklahoma	Muskogee
Pennsylvania	Chester
Pennsylvania	Clinton
Pennsylvania	Cumberland
Pennsylvania	Dauphin
Pennsylvania	Erie
Pennsylvania	Franklin
Pennsylvania	Lancaster
Pennsylvania	Lebanon
Pennsylvania	Lycoming
Pennsylvania	Perry
South Dakota	Clay
South Dakota	Union
Texas	Aransas
Texas	Bandera
Texas	Bastrop
Texas	Bexar
Texas	Blanco
Texas	Caldwell
Texas	Comal
Texas	Cooke
Texas	Gillespie
Texas	Gregg
Texas	Harrison
Texas	Hays
Texas	Kerr
Texas	Limestone
Texas	Matagorda
Texas	Medina

STATE	COUNTY
Texas	Parker
Texas	San Jacinto
Texas	Travis
Texas	Wharton
Texas	Wise
Utah	Daggett
Utah	Uintah
Virginia	Alexandria City
Virginia	Arlington
Virginia	Chesterfield
Virginia	Danville City
Virginia	Fairfax
Virginia	Fairfax City
Virginia	Franklin
Virginia	Fredericksburg City
Virginia	Gloucester
Virginia	Hampton City
Virginia	Hanover
Virginia	Henrico
Virginia	Henry
Virginia	Loudoun
Virginia	Manassas City
Virginia	Manassas Park City
Virginia	Martinsville City
Virginia	Newport News City
Virginia	Pittsylvania
Virginia	Prince William
Virginia	Richmond City
Virginia	Spotsylvania
Virginia	Stafford
Virginia	York
West Virginia	Barbour
West Virginia	Berkeley
West Virginia	Boone
West Virginia	Braxton
West Virginia	Brooke
West Virginia	Cabell

STATE	COUNTY
West Virginia	Clay
West Virginia	Fayette
West Virginia	Gilmer
West Virginia	Greenbrier
West Virginia	Hancock
West Virginia	Harrison
West Virginia	Jackson
West Virginia	Jefferson
West Virginia	Kanawha
West Virginia	Lewis
West Virginia	Lincoln
West Virginia	Logan
West Virginia	Marion
West Virginia	Marshall
West Virginia	Mason
West Virginia	Mercer
West Virginia	Monongalia
West Virginia	Morgan
West Virginia	Nicholas
West Virginia	Preston
West Virginia	Putnam
West Virginia	Raleigh
West Virginia	Randolph
West Virginia	Ritchie
West Virginia	Roane
West Virginia	Taylor
West Virginia	Tucker
West Virginia	Tyler
West Virginia	Upshur
West Virginia	Wayne
West Virginia	Webster
West Virginia	Wetzel
West Virginia	Wirt
West Virginia	Wood
West Virginia	Wyoming