

A MARKET ALL ITS OWN: MEDICARE ADVANTAGE AS A SEPARATE PRODUCT MARKET IN THE DOJ'S CASE AGAINST THE AETNA-HUMANA MERGER

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ABSTRACT

This chapter assesses the doctrine of reasonable interchangeability through the lens of the US Department of Justice's (DOJ's) successful effort to enjoin the megamerger of two of the largest national insurance companies, Aetna and Humana. The DOJ focused its challenge on the companies' Medicare Advantage business, arguing that it is a separate product market from original Medicare and the merger would substantially reduce competition in the market for Medicare Advantage in many geographic markets across the country. The case turned on whether there was reasonable interchangeability between original Medicare and Medicare Advantage in the eyes of consumers. The judge relied on both practical indicia of interchangeability, including evidence of how likely Medicare beneficiaries were to switch between Medicare Advantage and Original Medicare, along with econometric evidence. The decision provides a useful roadmap of how a knowledgeable judge reviewing a merger will consider

both Brown Shoe factors and econometric evidence in assessing reasonable interchangeability.

Keywords: Antitrust; product markets; interchangeability; mergers; health insurance

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INTRODUCTION

In the summer of 2015, after a frenzy of merger talks in the health insurance industry, two proposed mergers emerged combining four of the five largest health insurers in the country: Anthem agreed to acquire Cigna, and Aetna moved to acquire Humana. A year later, in July 2016, the Department of Justice (DOJ) filed complaints in the district court for the District of Columbia to enjoin both mergers. While the two cases were litigated at almost the same time, and involved the same industry, the similarities mostly stopped there. As a practical matter, if DOJ was to win its challenges to these megamergers, each of which spanned hundreds of geographic markets and many potential product markets, the agency had to develop a simple, straightforward narrative, similar to the one enforcers can more easily adopt when seeking to enjoin smaller transactions.

In its challenge to the Aetna-Humana merger, the DOJ focused on the companies' Medicare Advantage business. The government argued that Medicare Advantage, which provides broader coverage than the original Medicare program, is a separate product market from "Original Medicare" and the merger would substantially reduce competition in the market for Medicare Advantage in many geographic markets across the country. The parties and their experts did not dispute that "Original Medicare" (often supplemented with a "Medicare Supplement" plan to fill in gaps in Original Medicare's coverage) is functionally interchangeable with Medicare Advantage plans. The case turned on whether there was *reasonable* interchangeability between the two in the eyes of consumers. After a lengthy trial, Judge John Bates ultimately decided that consideration of *Brown Shoe* factors and econometric analysis supported finding a separate market for Medicare Advantage products.

This chapter focuses on the product market question at the heart of the Aetna-Humana case, including the parties' respective positions and the court's ruling. Judge Bates issued a 155-page opinion that found the merger anticompetitive based on a careful, detailed traditional analysis. His approach highlights the evidence that matters to a court when considering the scope of the relevant product market. Judge Bates considered the factors set forth in *Brown Shoe* — are the products in the candidate market functionally interchangeable — but moved on to the key question of whether they were reasonably interchangeable in the eyes

of consumers. To assess this, he relied on testimony, the parties' own documents, evidence of how likely Medicare beneficiaries were to switch between Medicare Advantage and Original Medicare, and econometric evidence. The Aetna-Humana case adds color – and some clarity – to what parties can expect from a knowledgeable judge reviewing a merger in the future.

BACKGROUND

The Legal Framework for Horizontal Merger Challenges

To block a transaction under Section 7 of the Clayton Act, the government (like any plaintiff) must establish the transaction may “substantially lessen competition” or “tend to create a monopoly” in a line of commerce.¹ If the government can show the merger would cause a significant increase in concentration and give the merged firm an undue share of a relevant market, following the *Philadelphia National Bank*² decision, the court presumes the merger will lessen competition. The burden of producing evidence to rebut this presumption shifts to the defendants.³ To rebut the presumption the merging parties can show, among other things, that entry into the market on a sufficient scale to overcome the anticompetitive harm is likely,⁴ that one of the firms is failing (and there is no less anticompetitive alternative than the merger at hand),⁵ or that efficiencies outweigh the possible anticompetitive harm.⁶

If a defendant successfully rebuts the presumption, the burden of producing additional evidence of anticompetitive effect shifts back to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times.⁷

Reasonable Interchangeability: “Practical Indicia,” Price Cross-elasticity of Demand, and More

When courts and enforcers assess a merger under Section 7 of the Clayton Act, they address three key issues: (1) the product market or markets; (2) the geographic market or markets; and (3) the merger's effect on competition in the identified product and geographic markets. This chapter focuses on the first of those issues: the definition of a product market for purposes of assessing whether a transaction violates the antitrust laws. While other issues were in play,⁸ the proper product market was a \$37 billion question, and it was the court's decision to identify a narrower market than urged by the merging parties ultimately torpedoed the deal.

The Supreme Court wrote in *Brown Shoe* that “[t]he outer boundaries of a product market are determined by the reasonable interchangeability of use or

the cross-elasticity of demand between the product itself and substitutes for it.”⁹ The Court held that within a broad product market there can be “submarkets” that are themselves cognizable markets for purposes of the antitrust laws. These submarkets can be identified, the Court wrote, by assessing “practical indicia” such as industry recognition or public treatment of a submarket as separate, the products’ peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors.¹⁰ While the Court referred to this framework as a way of defining “submarkets,” properly understood, the analysis should serve as a way of assessing any *market*, regardless of whether it is contained in part or in whole within a larger market.¹¹

Submarkets have been found relying heavily on one or more of these practical indicia, including (1) industry or public recognition of the submarket;¹² (2) peculiar characteristics and uses;¹³ (3) unique production facilities;¹⁴ (4) distinct customers;¹⁵ (5) specialized vendors;¹⁶ (6) distinct prices;¹⁷ and (7) sensitivity to price changes.¹⁸

Brown Shoe’s “practical indicia” factor-analysis is the type of approach that courts and attorneys regularly navigate in many areas of law. It allows parties and courts leeway to make policy judgments and balance factors based on the particular circumstances of a case.¹⁹

When the Supreme Court created the practical indicia test in *Brown Shoe*, it also recognized that economic analysis can be used to assess the outer bounds of a product market.²⁰ The price cross-elasticity of demand between a product and possible substitutes is generally accepted as a tool by which reasonable interchangeability can be measured.

Although the Horizontal Merger Guidelines increasingly have focused on economic tests for market definition,²¹ the enforcers and courts continue to use both traditional *Brown Shoe* and econometric analyses to assess anticompetitive effects.²²

Original Medicare, Medicare Advantage, and Medicare Supplements

The Medicare program provides healthcare coverage for individuals once they reach the age of eligibility, which is currently 65. Medicare was established in the 1960s through Title XVIII of the Social Security Act.²³ The Medicare program consists of several distinct components. A beneficiary generally receives coverage for hospital services under Part A of the program for free if he or she worked and paid Medicare taxes. A beneficiary may elect to receive coverage for physician and other outpatient services under Part B upon payment of a premium. Parts A and B are what as referred to here and in the Aetna-Humana decision as Original Medicare.²⁴ Almost all hospitals and physician groups accept Original Medicare, so it provides consumers a substantial choice among

providers.²⁵ However, Original Medicare is not comprehensive. There are gaps in coverage (e.g., dental, vision, and hearing services are not covered) and no prescription drug coverage. There is *no* annual limit on out-of-pocket costs incurred under either Part A or Part B. “If beneficiaries want to limit potentially catastrophic out-of-pocket costs, they need to purchase a separate Medicare Supplement plan.”²⁶ To receive prescription drug coverage a beneficiary enrolled in traditional Medicare program must enroll in a Medicare prescription drug plan under Medicare’s Part D for an additional monthly premium.

Medicare Part C allows beneficiaries to opt out of Original Medicare and obtain subsidized insurance through private insurers.

[T]he Balanced Budget Act (BBA) of 1997 created the Medicare Part C program. This program, originally known as the Medicare + Choice (or M+C) program, was revised by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and most recently the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).²⁷

Medicare Advantage plans are the product of Medicare Part C.

Private insurance companies offer Medicare Advantage Plans with more services by, among other things, offering a narrower network of providers. About two-thirds of Medicare Advantage enrollees participate in an HMO; approximately one-third participate in PPOs.²⁸ Medicare Advantage plans – unlike Original Medicare – often include prescription drug coverage.²⁹ Medicare Advantage plans also often include coverage for services that fall with gaps in Original Medicare coverage such as dental, vision, and hearing. There can be very wide differences in the scope of coverage offered by different Medicare Advantage plans.

While Medicare Advantage has unique characteristics, it has been argued that it “really *is* a form of Medicare, governed by many of the same statutory and regulatory provisions as the traditional Medicare fee-for-service option created by Parts A and B of the Act.”³⁰

As of June 2016, 69 percent of Medicare enrollees received healthcare coverage through Original Medicare, while 31 percent were enrolled in Medicare Advantage plans.³¹

The History of the Aetna-Humana Merger

Aetna and Humana are two of the Big 5 National Insurers.³² Within that small group of health insurance titans, Aetna and Humana are two of the biggest players in Medicare Advantage. Humana is the largest and fastest growing individual Medicare Advantage insurer, with over 2.5 million enrollees.³³ Aetna has historically been more of a commercial health insurance giant, but after its 2013 acquisition of Coventry Health Care – a major Medicare Advantage player – it became a significant Medicare Advantage player itself, fourth largest in the nation.³⁴ Together Aetna and Humana serve 25 percent of all Medicare Advantage enrollees.

On July 2, 2015, Aetna and Humana signed an Agreement and Plan of Merger under which Aetna would acquire Humana for \$37 billion.³⁵ The companies touted the merger as a “complementary combination” that would:

bring[] together Humana’s growing Medicare Advantage business with Aetna’s diversified portfolio and commercial capabilities to create a company serving the most seniors in the Medicare Advantage program and the second-largest managed care company in the United States.³⁶

According to the companies’ press release, “[t]he combined entity will help drive better value and higher-quality healthcare by reducing administrative costs, [and] leveraging best-in-breed practices from the two companies.”³⁷

A year later, in July 2016, the DOJ filed suits to block both the Aetna-Humana merger and the other mammoth that had been marching along in parallel, Anthem’s proposed acquisition of Cigna.³⁸ The Attorney General at the time, Loretta Lynch, painted the DOJ’s two-pronged enforcement effort in broad brushstrokes, stating that “[i]f these mergers were to take place, the competition among insurers that has pushed them to provide lower premiums, higher-quality care and better benefits would be eliminated.”³⁹ To the public, the two deals may have been horses of the same color. But even a cursory review of the complaints made it clear the DOJ had tailored its approach to the two cases very differently, with an eye to the unique weak points in each transaction. In the Anthem-Cigna case, the DOJ challenged the transaction based on anticompetitive effects in the markets for large group insurance, also known as the national account market. In Aetna-Humana, the DOJ chose to focus its case on the market for Medicare Advantage plans.

The DOJ identified 364 counties around the country where, the agency alleged, concentration in the Medicare Advantage market would rise above the presumptively unlawful level if Aetna and Humana merged and there were no divestitures.⁴⁰ The DOJ argued that post-merger, the company would have a monopoly in 70 of the counties and serve over 80 percent of Medicare Advantage consumers in 80 counties.⁴¹

Shortly after the DOJ filed its complaint, Aetna and Humana presented a proposed divestiture, recognizing that in some markets the post-merger concentration levels would be very high. The parties identified Molina, a managed Medicaid specialist, as the divestiture candidate.⁴² The companies proposed to sell lives to Molina in all 364 counties at issue.⁴³

MARKET DEFINITION: THE HEART OF THE AETNA-HUMANA CASE

The DOJ’s choice of product markets in the Aetna-Humana case brought to a head an issue that was presented, but not resolved, in earlier mergers: is there a separate relevant market for Medicare Advantage plans that does not include

Original Medicare?⁴⁴ While the DOJ's complaint challenged other aspects of the transaction,⁴⁵ the central focus was the transaction's likely effect on competition in what the DOJ alleged was a separate market for Medicare Advantage plans. The government asserted that "Medicare Advantage is different from the products available under traditional Medicare" and so excluded Original Medicare from its analysis of the merger's effects in the identified geographic markets.⁴⁶ The defendants did not concede that the transaction was doomed if the court accepted Medicare Advantage as the relevant product market, raising numerous additional defenses. Still, the parties' arguments in briefing and their presentations at trial made it clear that the main battleground was over the definition of the relevant product market.

The Practical Indicia Approach to the Product Market

The complaint framed the Medicare-Advantage-only product market in a way that has intuitive appeal: Medicare Advantage plans have distinct features and characteristics that differentiate them from Original Medicare, such as broader coverage, lower cost, and narrower provider network.⁴⁷ Although the distinctions are not as stark as between entirely dissimilar products (e.g., short-term travel health insurance vs traditional annual commercial health insurance), there are many ways in which Medicare Advantage plans stand apart from Original Medicare, including additional coverage (e.g., dental, vision, etc.), more limited choice of providers, lower copays, and lower out-of-pocket maximums.

The defendants developed a substantial body of evidence on both sides that fed their arguments that Medicare Advantage and Original Medicare are reasonably interchangeable. Aetna and Cigna argued that Medicare and Medicare Advantage are offered to the same set of customers – people over the age of 65 – and the companies compete for these customers both at enrollment (when they "age in" to Medicare) and after enrollment (when enrollees may periodically switch plans). Approximately 10,000 people age into Medicare every day.⁴⁸ As a result, the companies argued, there is constant pressure on Medicare Advantage to compete against Original Medicare for a bigger share of the new entrants at the same time they compete for enrollees considering a switch.

The defendants also highlighted significant differentiation *among* Medicare Advantage plans. They argued that the diverse options available within Medicare Advantage products make the differences between Medicare Advantage and Original Medicare less significant. Medicare enrollees regularly reevaluate their healthcare needs – healthcare needs change significantly for people over the age of 65 as they age. Medicare Advantage plans continue to compete for Original Medicare customers year after year, because eventually some Original Medicare enrollees may be driven by cost or other pressures to

reevaluate whether Medicare Advantage is a better fit, perhaps because of dwindling retirement savings or rising medical costs.

The defendants presented internal business materials and testimony that demonstrated the companies themselves often consider MedSupp and Medicare Advantage together.⁴⁹ They presented evidence as well showing how the government itself advertises, and often treats, Medicare Advantage as an alternative to Original Medicare. For example, the government makes clear at the time of initial enrollment that those turning 65 have a choice between Medicare Advantage and Original Medicare.⁵⁰

The government responded that there are a number of key ways that Medicare Advantage differs from Original Medicare. First, the two have different pricing models. Medicare Advantage plans must cap annual out-of-pocket spending for enrollees at no more than \$6,700.⁵¹ As a result of competition, many plans offer a cap well below this level.⁵² Medicare Advantage plans have the ability to charge a premium over and above the Original Medicare cost. But competitive pricing pressures have resulted in about half of the plans in 2016 charging no additional premium.⁵³ To replicate the out-of-pocket maximum protection of a Medicare Advantage plan with Original Medicare, enrollees usually have to purchase separate MedSupp coverage and/or Medicare Part D prescription coverage.⁵⁴

Second, Original Medicare and Medicare Advantage have different features. Typically, more services are offered in Medicare Advantage plans (wellness, dental, vision, etc.), and there is more room for innovation (gym memberships, wellness programs, and coordinated care models).⁵⁵ Third, the two have different sets of providers. Original Medicare offers a broad network; Medicare Advantage plans control costs in part by offering a much narrower choice of providers.⁵⁶ For consumers for whom provider choice is important, Original Medicare is preferable, but for consumers who want cheaper plans and more assured coverage and protection from large bills, Medicare Advantage is preferable.⁵⁷

Fourth, Medicare Advantage and Original Medicare have different consumer demographics. The evidence showed that enrollees who opt for Medicare Advantage plans tend on average to have lower income and lower educational levels than enrollees in Original Medicare.⁵⁸ Enrollees in Original Medicare and MedSupp also tended to live in smaller towns and rural areas. These demographic differences suggest that while the two products are functionally interchangeable, many consumers are not actively choosing between the two. Defendants countered that “[d]emographics do not determine whether seniors prefer Original Medicare options or Medicare Advantage plans.”⁵⁹ They tried to make the case that every enrollee is different and healthcare is too personal to reduce to demographics: “no two seniors are exactly alike.”⁶⁰ The court was unpersuaded, stating that although “seniors make individualized healthcare decisions,” this “does not mean . . . all generalization is futile.”⁶¹

The court assessed the parties’ practical indicia evidence in a traditional way. It accepted that Medicare Advantage and Original Medicare are

functionally interchangeable (they by and large do the same thing) but recognized this didn't answer the question whether the products were *reasonably* interchangeable in the eyes of consumers. Medicare Advantage is less expensive than the cost Original Medicare together with a Medicare Supplement (which is needed to achieve functional interchangeability), both upfront and over time. Original Medicare allows broad consumer choice of providers; Medicare Advantage plans offer much narrower provider networks. Original Medicare has significant gaps in coverage and more limited services; Medicare Advantage fills many of those gaps (e.g., with prescription drug coverage) and offers extras such as gym memberships, vision, dental, and hearing coverage.

The court recognized that Medicare Supplement plans can fill the gaps in Original Medicare. But the court was persuaded by evidence from the parties that Medicare Advantage and Original Medicare/MedSupp plans are not treated as reasonably interchangeable in the defendants' own businesses. The evidence indicated that the parties thought of and treated the two quite differently from a competitive standpoint. In some internal documents, both Aetna and Humana focused on the goal of maintaining their Medicare Advantage products as a superior value proposition when compared to Original Medicare.⁶² But both Aetna and Humana reported the financials of their Medicare Advantage businesses separate from MedSupp plans, which in turn facilitates separate analysis of the business units by investors.⁶³ Both Aetna and Humana maintained separate business units, with the bulk of the relevant employees dedicated to *either* Medicare Advantage *or* MedSupp plans, not both.⁶⁴ In one of the government's most powerful documents on this issue, an Aetna executive referred to Medicare Advantage and MedSupp plans as "apples and oranges."⁶⁵

The court also looked at the evidence of enrollee switching. The "data generally shows that more than 80 percent of seniors leaving one Medicare Advantage plan switch to another."⁶⁶ The data also showed that enrollees in Medicare Advantage generally stick with their existing plans year after year: in 2013 and 2014, 78 percent of Medicare Advantage enrollees stayed with their plan, 11 percent voluntarily left their plan for another Medicare Advantage plan, and only 2 percent voluntarily left their plan for Original Medicare.⁶⁷ Put another way, fewer than 20 percent of Medicare Advantage enrollees that voluntarily switched opted for Original Medicare. The data were similar for Medicare Advantage enrollees who switched in response to premium increases.⁶⁸ When Medicare Advantage enrollees involuntarily switched (e.g., after their plans were cancelled), the vast majority chose another Medicare Advantage instead of Original Medicare.⁶⁹

The court found that this switching data demonstrated:

[T]here are some seniors with durable preferences for Medicare Advantage. These seniors would be less likely than average to switch to an (often more costly) Original Medicare option in the event of a small but significant non-transitory increase in Medicare Advantage prices, and perhaps much less likely if they are low-income.⁷⁰

The defendants were unable to provide a convincing explanation why the switching data weren't important. They argued the data did not capture consumer choice for the large number of new consumers aging into Medicare. The court acknowledged the point, but was unconvinced that this ongoing initial access to the market should undermine switching data as a proxy for consumer preferences. The court found that regardless of how newly eligible enrollees behave, the consumer preferences demonstrated by the switching data would allow a Medicare Advantage monopolist to increase price without losing customers to Original Medicare.⁷¹

The court did not give any indication of what evidence related to the consumers aging into Medicare *could* have undermined the switching data. The court also did not engage with the argument that Medicare Advantage needs to continue to innovate and compete for consumers as their needs change over time (e.g., decreasing retirement funds, increasing healthcare costs). The court seemed sufficiently convinced that the market should be limited to Medicare Advantage by the switching data and the parties' own documents showing that they treated Medicare Advantage differently.

The Econometric Analysis

The parties and the court evaluated the product market both using a traditional practical indicia and econometric analyses. The parties' experts assessed the market using diversion ratios and the Merger Guidelines' hypothetical monopolist test. That test asks if:

a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products ("hypothetical monopolist") likely would impose at least a small but significant and non-transitory increase in price ("SSNIP") on at least one product in the market, including at least one product sold by one of the merging firms.⁷²

The government's economist, Dr. Aviv Nevo, found that Medicare Advantage "passed under all formulations of [the] hypothetical monopolist test."⁷³ Nevo considered industry evidence, switching data (which he found tied switching decisions largely to price), other empirical studies of how seniors choose their coverage, and his own "nested logit model." The nested logit model assesses whether seniors prefer a Medicare Advantage plan "*because* it is a Medicare Advantage plan."⁷⁴ The nested logit model found that 70 percent of the enrollees leaving Medicare Advantage plans as a result of a price increase would choose another Medicare Advantage plan.⁷⁵ Nevo considered this result conservative given that available data indicated a diversion ratio closer to 80 percent.⁷⁶ Using the results from his nested logit model, Nevo then ran two versions of the hypothetical monopolist test, both of which indicated that Medicare Advantage alone is a proper product market because a hypothetical

monopolist could impose a small but significant non-transitory increase in price (“SSNIP”).

The defendants’ economist, Jonathan Orszag, countered that diversion ratios are more important than switching data because switching data fails to capture the critical “age-in” population that is entering the market for the first time at age 65.⁷⁷ Orszag found a diversion ratio of 50 percent from Medicare Advantage to Original Medicare in response to a price increase or quality drop. Orszag also argued that Nevo’s switching-data analysis failed to recognize a significant portion of individuals would switch from Medicare Advantage plans to Original Medicare (plus a supplement) *before* they would choose some Medicare Advantage plans. In other words, while the switching data showed enrollees moving between similar Medicare advantage plans, some of those enrollees would switch to Original Medicare (plus MedSupp) in preference to other, less similar, Medicare Advantage plans.⁷⁸ Orszag argued that including all Medicare Advantage plans in the market, while excluding all Original Medicare plus MedSupp combinations, was erroneous.⁷⁹ To support his argument Orszag relied on an example (Example 6) in the Horizontal Merger Guidelines, in which the agencies state that if two products (A and B) satisfy the hypothetical monopolist test, a third product, C, should “normally” be included in the relevant market as well if, when the price of A is raised, more sales are diverted to C than to B. The court faulted the analysis, however, because Orszag failed to identify particular Original Medicare and MedSupp combinations existing in the market that were preferred to particular Medicare Advantage products. The court also clearly was troubled by the notion that a theoretical econometric analysis should be allowed to override the market definition the judge felt was impelled by the market facts:

If taken to its logical conclusion, defendants’ position implies a purely econometric approach to market definition, requiring the government to calculate individual diversion ratios for all the products potentially in the market, rank them from highest to lowest, and, at some point, draw a line between those products that fall within the market and those products that fall outside. But that technical approach is not taken by the cases. Econometric evidence can be powerful evidence, but it is not the only evidence that courts consider in defining the relevant market.⁸⁰

The court’s approach is representative of what parties can reasonably expect in merger litigation. While some judges understand and evaluate econometric evidence (and Judge Bates did far better than most), the natural tendency for a judge is to consider the market facts, including the documents and testimony, and give far more weight to those than to the econometric work, which often is reduced to a battle of opposing experts, models and assumptions. Judge Bates made no secret of his preferences in his opinion. He commented that cases relied on by the parties “have considered the *Brown Shoe* factors and ordinary course of business documents, in addition to econometric evidence, before reaching conclusions about the proper market definition.”⁸¹ Judge Bates did the same. The “wide array of qualitative evidence” introduced by the

government “points to the existence of a Medicare-Advantage-only market.”⁸² None of the evidence at trial, he wrote, suggested “frequent, close competition between Medicare Advantage plans and particular Original Medicare” and MedSupp combinations.⁸³ Given what he had seen and heard from the witnesses and documents, he was not inclined to take the word of an economist that the market should be broadened beyond Medicare Advantage products, when the facts he had heard at trial were sufficient to persuade him of the narrower market.⁸⁴

Shortly after the decision was issued, Aetna and Humana abandoned the merger.⁸⁵ Aetna’s chief executive was quoted saying it was “too challenging to continue pursuing the transaction” and “both companies need to move forward with their respective strategies.”⁸⁶ The decision means an appellate court will not review the district court’s decision. But the lower court’s fact-intensive analysis left little room for an appellate court to reverse on the critical market definition issue, even if it was more sympathetic to the defendants’ view of the econometric evidence.

REASONABLE INTERCHANGEABILITY AND THE ENDURING LEGACY OF *BROWN SHOE*

The DOJ’s choice of a product market in Aetna-Humana set up a fight about reasonable interchangeability. The fight took center stage and was the focal point of the ruling that killed the \$37 billion deal. The parties understandably hedged their bets and addressed the product market question both using traditional practical indicia evidence and economic analysis. There was nothing extraordinary about the traditional analysis, but it shines a light on some of the ongoing challenges in determining the proper product market when products are differentiated.

In nearly all markets, each product has some attribute that distinguishes it from other products and makes it more or less attractive to consumers. These differences can include surface-level image/branding, quality/durability, and many other features. Most products have a unique set of characteristics so that there is no perfect substitute. Frequently, two products that differ only in some minimal way are both functionally and reasonably interchangeable. But some apparently superficial differences are not trivial — color can be a meaningful difference if consumers attach significance to different colors (e.g., pink and blue in infants’ clothing or team or school colors on sporting paraphernalia). Even when two products have the same functional end use and very similar attributes, specific kinds of product differentiation can put the products in different markets.

Antitrust enforcers and courts have recognized that functionally interchangeable products are often in distinct markets.⁸⁷ There has also been general

recognition that there can be cognizable submarkets within broader markets.⁸⁸ The challenge is using *Brown Shoe* — a multifactor analysis without any clear directive on which factors to give more or less weight — to determine when interchangeability is *reasonable*.

The Aetna-Humana decision did not move the ball: it was emblematic of the kind of traditional *Brown Shoe* factor-analysis parties can expect from courts in merger cases today. The court seemed most influenced by the switching data and the parties' own documents, which treated Medicare Advantage and Original Medicare/MedSupp separately. The decision confirms the continuing importance of the *Brown Shoe* but also exposes the infamous case to more of the same criticism it has endured for decades. *Brown Shoe* has been subjected to a steady stream of abuse. Judge Bork famously wrote that “[i]t would be overhasty to say that the *Brown Shoe* opinion is the worst antitrust essay ever written. ... Still, all things considered, *Brown Shoe* has considerable claim to the title.”⁸⁹ Another federal judge referred to it as a “1960s-era relic” characterized by a “free-wheeling antitrust analysis [that] has not stood the test of time.”⁹⁰ Yet most judges and practitioners are more comfortable navigating the *Brown Shoe* factors than assessing complicated expert testimony and other econometric evidence.

The *Brown Shoe* practical indicia do not usually offer a straightforward roadmap for assessing the proper product market. There are many ways to assess substitutability of products using the *Brown Shoe* factors and little direction from courts on which factors are the most important and under what circumstances. The court in Aetna-Humana did not dig in much to the demographics of consumers to assess whether there was actually consumer choice occurring between Original Medicare and Medicare Advantage. The court acknowledged that “there is evidence suggesting that Medicare Advantage plans tend to attract seniors with lower incomes.”⁹¹ But readers are left wondering how demographic data might be used in future to determine if products exist in the same or separate markets.

The case also shows, once again, the harm that bad documents can do to defendants in a merger case.⁹² The court concluded that Original Medicare was not reasonably interchangeable with Medicare Advantage in part because the parties themselves treated these products very differently in their own documents and business operations. In this respect, the worst of the documents may have been the one in which an Aetna executive referred to Medicare Advantage and MedSupp as “apples and oranges.”⁹³ This document and a handful of others appeared to sway the court's *Brown Shoe* analysis. In antitrust, substance usually prevails over form,⁹⁴ and some of the distinctions between Medicare Advantage and Original Medicare — such as the defendants' separate business units for each and some isolated comments that highlight the differences between the two — appeared to be more form than substance. Many companies have different business units for products that are plainly in the same market. In this respect, the decision is a reminder that optics matter even if substance ultimately *should* prevail over form.

The court did not neglect the econometric evidence entirely in favor of the traditional analysis, but the econometrics come off as secondary. Notably, the court cautioned against reliance on purely econometric evidence: “Econometric evidence can be powerful evidence, but it is not the only evidence that courts consider in defining the relevant market.”⁹⁵ The court lent support to what many practitioners believe: econometric analysis is necessary, because to do without it leaves the economic field open to one’s opponent, but if it is inconsistent with the weight of the evidence in the documents and testimony, it is unlikely to carry the day. The decision suggests that defendants must win on both ball fields for a contested merger to survive: they have to present a compelling traditional analysis *and* a strong counter to any econometric evidence offered by the government.

The court’s product market analysis was sensible given the state of the law and the facts introduced at trial. Different people see the products differently – there is a durable preference among a sizeable segment of the population for Medicare Advantage products. Permitting the merger would have lessened competition between two of the industry’s giants and harmed consumers in the process.

CONCLUSION

The DOJ’s successful case enjoining the Aetna-Humana merger demonstrates what parties can expect from a court reviewing a merger where the reasonable interchangeability of products is at issue. The court’s analysis is detailed and disciplined: it hits all the points one would expect in a thorough, well-reasoned ruling, tackling traditional *Brown Shoe* practical indicia and econometrics, both in detail. The opinion reminds us of the importance of the facts to a proper definition of a relevant product market when assessing a potential transaction, and also that econometric tools, while necessary (and expensive), still have not reached the point where they can turn the tide of battle in the face of facts that march in the opposite direction.

With the benefit of hindsight, the result seems predictable. The companies were aggressive and may have overestimated their odds of success.⁹⁶ Traditional market definition, founded on straightforward economics and common sense, still determines the outcome. The econometricians have not (or not yet) wrested control from lawyers and judges.

NOTES

1. See *United States v. Citizens & Southern Nat’l Bank* (1975, pp. 120–122); *United States v. Philadelphia Nat’l Bank* (1963, p. 363).
2. 374 U.S. 321 (1963).

3. See, e.g., *United States v. Marine Bancorporation* (1974, p. 631); *United States v. General Dynamics Corp.* (1974, pp. 496–504).

4. Horizontal Merger Guidelines § 9.

5. Horizontal Merger Guidelines § 11 (“[A] merger is not likely to enhance market power if imminent failure ... of one of the merging firms would cause the assets of that firm to exit the relevant market.”).

6. Horizontal Merger Guidelines § 10. Although the Merger Guidelines recognize efficiencies as a defense, the closest the Supreme Court has come to discussing the defense was in *FTC v. Procter & Gamble Co.* (1967, 580), where the court said “possible economies cannot be used as a defense to illegality.” (*But see id.* at pp. 597–598 (Harlan J., concurring) (arguing that efficiencies are important to consider in assessing competitive effects)). The viability of an efficiencies defense remains uncertain, and the defense has never determined the outcome of an appellate decision. Compare *FTC v. Penn State Hershey Med. Ctr.* (3rd Cir. 2016) (questioning whether there is an efficiencies defense); *Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke’s Health Sys., Ltd.* (9th Cir. 2015) (same); with *FTC v. Tenet Health Care Corp.* (8th Cir. 1999) (allowing consideration of efficiencies), *FTC v. University Health, Inc.* (11th Cir. 1991) (same).

7. See *Kaiser Aluminum & Chem. Corp. v. FTC* (7th Cir. 1981, 1340 & no. 12); *United States v. Baker Hughes Inc.* (D.C. Cir. 1990, 983).

8. The parties focused on a number of other issues, including (1) whether regulation of Medicare Advantage by the Centers for Medicare and Medicaid Services rebuts the presumption of anticompetitive effects (Opinion at 67); (2) whether the defendants’ proposed divestiture resolved any competitive concerns (Opinion at 88); and (3) whether the merger would substantially lessen competition in the public exchanges in 17 counties in Florida, Missouri, and Georgia (Opinion at 114).

9. *Brown Shoe Co. v. U.S.* (1962). This standard remains the prevailing way of expressing the doctrine (*Lenox MacLaren Surgical Corp. v. Medtronic, Inc.* (10th Cir. 2014)).

10. *Brown Shoe*, 370 U.S. at 325 (citing Bock, Mergers and Markets, An Economic Analysis of Case Law 25-35 (1960)).

11. See *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.* (D.C. Cir. 1986, 218 no. 4) (the *Brown Shoe* “submarket” indicia are “proxies for cross-elasticities [of supply and demand], and thus the identification of a submarket is in principle no different than the identification of a relevant market.”); *Geneva Pharms. Tech. Corp. v. Barr Labs., Inc.* (2nd Cir. 2004, 496) (“The term ‘submarket’ is somewhat of a misnomer, since the ‘submarket’ analysis simply clarifies whether two products are in fact ‘reasonable’ substitutes and are therefore part of the same market.”).

12. See, e.g., *General Foods Corp. v. F. T. C.* (3rd Cir. 1967) (considering industry recognition of the household steel wool submarket based on the testimony of several household steel wool producers).

13. See, e.g., *Matter of United Fruit Co.* (1973), set aside on other grounds, 499 F.2d 395 (5th Cir. 1974) (noting that bananas have specific product characteristics which require specialized vendors and facilities).

14. See, e.g., *Abex Corp. v. F. T. C.* (6th Cir. 1970) (upholding the commission’s finding that there were unique production facilities, which bears on product market analysis).

15. See, e.g., *Reynolds Metals Co. v. F. T. C.* (D.C. Cir. 1962) (recognizing market for “florist foil” based on, among other things, almost all purchasers of the product were the nation’s largest wholesale florist outlets and the large number of retail florists purchasing through those wholesalers).

16. See, e.g., *Matter of Fruehauf Trailer Co.* (1965) (noting existence of specialized vendors in distinct market for certain types of truck trailers and vans)

17. *See, e.g., Abex Corp. v. F. T. C.* (6th Cir. 1970) (upholding commission’s finding of a market for sintered metal friction devices upon a showing of, among other things distinct prices).

18. *See, e.g., Matter of General Foods Corp.* (1966; aff’d 3rd Cir. 1967) (noting that steel wool manufacturers did not consider pricing impact of the non-steel wool devices.

19. *See* Opinion at 26-35.

20. *Brown Shoe Co. v. United States* (1962, p. 325).

21. *See, e.g.,* Horizontal Merger Guidelines § 4.

22. *See, e.g., Pozen* (2011), (“We continue to apply traditional merger analysis techniques to our matters” such as the “successful challenge to the proposed merger between H&R Block and Tax Act.”).

23. Pub. L. No. 89-97, 79 Stat. 286, 286 (1965), codified at 42 U.S.C.A. §§ 1395, *et seq.*

24. Original Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS).

25. Opinion at 6-8.

26. Competitive Impact Statement, *United States v. UnitedHealth, supra*, at 5.

27. Health Law Practice Guide (2016, § 25:9)

28. Jacobson, Damico, and Gold (2015, Figure 1); Jacobson, Gold, Damico, Neuman, and Casillas (2015).

29. Original Medicare enrollees have the option of obtaining prescription drug coverage, but they have to do so separately under Medicare Part D. Opinion at 6-7.

30. Schiff and Abate (2016, p. 21) (emphasis in original).

31. 3 *Advising the Elderly Client* § 26A:1

32. DOJ Post-trial Brief ¶ 6. The others are Anthem, Cigna, and United Healthcare. *Id.*

33. DOJ Post-trial Brief ¶ 7; Opinion at 4.

34. Opinion at 4.

35. Aetna (2015).

36. *Id.*

37. *Id.*

38. Picker and Abelson (2016).

39. *Id.*

40. Complaint ¶ 10. In these 364 target counties, “Medicare Advantage serves approximately 1.6 million seniors, nearly 980,000 of whom have enrolled with Aetna or Humana” (*Id.*).

41. Complaint ¶¶ 32-33; DOJ Post-trial brief ¶ 162; Opinion at 68.

42. Opinion at 2, 88-90.

43. The court ultimately decided that the proposed Molina divestiture did not adequately “counteract the competitive effects of the merger” (Opinion at 113, 88-113). Despite finding that the Molina divestiture was likely enough to occur, *id.* at 113, the Court found that the evidence did not indicate Molina would be a “successful competitor in the Medicare Advantage market” (*Id.*). The court was troubled by Molina’s poor track record in the Medicare Advantage business, *id.* at pp. 111–112, and seemed convinced that some of the significant barriers to entry (e.g., building provider networks) would make Molina struggle to manage the 290,000 Medicare Advantage lives that would be subject to the proposed divestiture. Perhaps the fact that Molina was the best suitor the merging parties could come up with was an indication of how concentrated the Medicare Advantage market already is.

44. *See United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322; *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464.

45. The DOJ also alleged that the transaction would harm competition on the public exchanges. (See Complaint ¶¶ 42-52).

46. Complaint ¶ 24.

47. Complaint ¶ 25 (“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.”).

48. Opinion at 42.

49. This evidence was more limited and general than the DOJ’s evidence that the parties treated the two separately, particularly when it comes to price. See Opinion at 27-29.

50. DOJ Post-Trial Brief at ¶¶ 30-32.

51. 42 C.F.R. § 422.100(f)(4); 42 C.F.R. § 422.101(d)(2).

52. DOJ Post-Trial Brief ¶ 38.

53. DOJ Post-Trial Brief ¶ 39.

54. DOJ Post-Trial Brief ¶¶ 40-41.

55. DOJ Post-Trial Brief ¶ 37.

56. Opinion at 10 (“[U]nlike Original Medicare, Medicare Advantage plans tend to be managed care plans with limited provider networks”).

57. Opinion at 38 (“Because Original Medicare plus MedSupp is the most expensive plan combo, seniors who select it are willing to pay more for a flexible network of physicians and comprehensive coverage. Medicare Advantage, on the other hand, attracts those seniors who want additional health coverage, but [are] willing to sacrifice having a flexible network to keep costs low.”) (quotations and citations omitted).

58. Opinion at 38.

59. Defendants Post-Trial Brief ¶ 86.

60. Defendants Post-Trial Brief ¶ 69.

61. Opinion at 38.

62. Opinion at 25 (citing internal documents stating, among other things, that Aetna had an “[a]spiration” to “[a]ggressively grow membership by delivering superior value proposition vs. [Original Medicare]”).

63. Opinion at 30.

64. *Id.*

65. Opinion at 39.

66. Opinion at 45.

67. Opinion at 32.

68. Opinion at 33.

69. Opinion at 33 (citing evidence that between 83 percent and 95 percent switch to another Medicare Advantage plan).

70. Opinion at 36-37.

71. Opinion at 37.

72. Horizontal Merger Guidelines § 4.1.1.

73. Opinion at 44.

74. Opinion at 44 (emphasis in original).

75. Opinion at 45.

76. Opinion at 45.

77. Defendants’ Post-Trial Brief ¶ 109.

78. Defendants’ Post-Trial Brief ¶¶ 120-24.

79. Defendants’ Post-Trial Brief ¶ 121.

80. Opinion at 53.
81. *Id.*
82. *Id.*
83. *Id.*
84. Cf. “Who ya gonna believe, me or your own eyes?” Chico Marx, *Duck Soup* (1933).
85. Tracer (2017).
86. *Id.*
87. *See, e.g., United States v. Aluminum Co. of America* (1964) (copper and aluminum conductors are fully functionally interchangeable yet in distinct submarkets); *Reynolds Metals Co. v. F. T. C.* (D.C. Cir. 1962, 226); *General Foods Corp. v. F. T. C.* (3d Cir. 1967, 940) (“The fact that different products may in some sense be competitive with each other is not sufficient to place them in the same market if by themselves they constitute distinct product lines [citations omitted]. Nor does the availability of substitute products compel the conclusion that they belong in the same relevant market.”).
88. *See, e.g., Matter of American Brake Shoe Co.* (1968; *aff’d as modified* 6th Cir. 1970) (a specific type of metal friction products found to be an cognizable market within the larger market of functionally interchangeable friction products).
89. Bork (1978).
90. *FTC v. Whole Foods Market, Inc.* (D.C. Cir. 2008, 1058) (Kavanaugh, J., dissenting). Judge Kavanaugh renewed his criticism of *Brown Shoe* in his dissenting opinion in *United States v. Anthem Inc., and Cigna Corp.* (D.C. Cir., 2017), dissenting op. at 10.
91. Opinion at 36.
92. Bad documents have played a starring role in a number of the government’s recent merger cases. *See Agathoklis Murino* (2016) (discussing the impact of bad documents in recent cases, including the attempted GE/Electrolux merger).
93. Opinion at 39.
94. *See United States v. Yellow Cab Co.* (1947, 227) (Sherman Act is aimed at substance, not form); *accord Ogilvie v. Fotomat Corp.* (8th Cir. 1981, 588) (elevating form over substance is inconsistent with the intent of the antitrust laws).
95. Opinion at 53.
96. The DOJ argued, however, that the parties “recognized from [the] inception that [the transaction] raised serious antitrust concerns,” citing that “Aetna agreed to a \$1 billion break-up fee” (DOJ Post-trial Brief at 15).

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