PROPOSED ACQUISITION OF CAREPLUS HEALTH PLANS, INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., HUMANA MEDICAL PLAN, INC., AND COMPBENEFITS COMPANY BY AETNA, INC.

PROCEDINGS: Public Hearing

DATE: Monday, December 7, 2015

TIME: Commenced at 10:00 a.m.
Concluded at 1:00 p.m.

LOCATION: 404 South Monroe Street
Tallahassee, FL

REPORTED BY: Tracy L. Brown
Certified Registered Reporter
tbrown567@comcast.net
APPEARANCES:

PANEL MEMBERS:

Rich Robleto, Chair
Alyssa Lathrop, Esquire
Mary Mostoller
Carolyn Morgan
Eric Johnson
Sha'Ron James

Also Present:

Fran Soistman, Aetna
Dr. Thomas McCarthy, NERA
Gregory Martino, Aetna
Joseph Ventura, Humana
Dr. Yolangel "Yogi" Hernandez
Steven Whitmer, Esquire, Locke Lord
# INDEX

## WITNESS

<table>
<thead>
<tr>
<th>Witness</th>
<th>Examination by</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR. THOMAS McCARTHY</td>
<td>Mr. Whitmer</td>
<td>28</td>
</tr>
<tr>
<td>GREGORY MARTINO</td>
<td>Mr. Whitmer</td>
<td>62</td>
</tr>
<tr>
<td>JOSEPH VENTURA</td>
<td>Mr. Whitmer</td>
<td>72</td>
</tr>
</tbody>
</table>

## CERTIFICATE OF ADMINISTERING OATH

<table>
<thead>
<tr>
<th>Certificate</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERTIFICATE OF ADMINISTERING OATH</td>
<td>117</td>
</tr>
<tr>
<td>CERTIFICATE OF REPORTER</td>
<td>118</td>
</tr>
</tbody>
</table>
MR. CHAIR: Good morning, everyone. I am Rich Robleto. I'm the deputy commissioner of life and health insurance for the Office of Insurance Regulation, and I will be presiding at today's public hearing. It has been scheduled to discuss Aetna Incorporated's application for the proposed acquisition of Humana and its affiliates. The hearing today will help all parties understand the implications of the proposed merger between the companies and what is at stake, while also providing a better understanding for consumers of the overall process, and for all of us of the thoughts and comments from the consumers.

Let me start by talking about Aetna and Humana in terms of Florida's health insurance market. I warn you, before I get started on that, that the way we summarize the numbers may be a little different from some of the testimony that we will hear regarding the numbers, but they all come out even. We categorized them a little bit differently, but --

To start about Aetna, Aetna was the fourth largest writer of accident health insurance coverage in Florida, with more than $3 billion in
premium. They have 8 percent of market share based on total premium for all lines of business. They provide comprehensive medical coverage. And, in our case, that would include not just the commercial coverage that you can buy on the exchange or off exchange, but also the Medicare and Medicaid businesses to about 800,000 people. And they have more than a million policies in ancillary lines.

Humana, headquartered in Louisville, Kentucky, as of the end of 2014, Humana nationally had about 3.8 million members in its medical benefit plans, as well as approximately 7.7 million members in its special products. And, as of December 2014, here in Florida, they were the second largest writer of accident and health insurance coverage in Florida, with more than 7 billion in premium, 19 percent of the Florida market, based on total premium for all of its lines of business. And they provide comprehensive medical coverage to more than 1.7 million people and more than 1.3 million policies in ancillary lines.

If this acquisition is approved and the two companies merge together, the Office estimates that they would be the largest writer of accident health
insurance in the state, with 27 percent market
share and more than $10 billion in premium.
Aetna's proposed acquisition of Humana and the
reason we're holding the public hearing today is
that it will have a direct impact on four Florida
insurance companies. These include CarePlus Health
Plans, Humana Health Insurance Company of Florida,
Humana Medical Plan and CompBenefits Company.

With this brief overview of the company's
presence in the state of Florida health insurance
market, let's now proceed to the logistical aspects
of today's hearing.

For the record, today is Monday, December 7th,
2015, and it is approximately 10:00 a.m. If
there's any of that you weren't planning on being
here on Monday, December 7th at 10:00 a.m., you
may now depart. That's the way the professors
always did it in college.

The public hearing is being conducted in the
Jim King Committee Room, which is located in the
Senate Office Building of the Capitol in
Tallahassee, Florida. It is being streamed live
online thanks to the Florida Channel. And a link
to the video of the hearing will also be made
available on the Office's website, FLOIR.com.
Notice of the hearing was published in the Florida Administrative Register on November 20th, 2015. And for those in attendance, copies of the agenda are available at the registration table. For those watching live who would like to follow along, the agenda can also be viewed online at the Office's website, again, WWW.FLOIR.com, and selecting the Aetna probably hearing link on the left side menu bar.

For members of the public who are interested in providing comments today or -- sorry. For those of you who are not here and would like to submit comments, please do so by sending an email to Aetnahearing -- that's all one word -- at FLOIR.com. And we will certainly accept public comments. We encourage public comments. But we'll accept them until December 17th.

We're making a record of this proceeding, so, to help clarify the record, I ask that all speakers, please state your name prior to making comments, and that only one person speaks at a time. And if any members of the audience wish to speak, please complete a public comment request form, which can be found, again, at the registration table. You will be asked to come
forward at the appropriate time during the hearing and offered the opportunity to present your comments.

Let me introduce the people on the panel today. I would like to start somewhat in the middle, if you don't mind, but we are honored to have Sha'Ron James, Florida's Consumer -- Florida's Insurance Consumer Advocate, representing the Department of Financial Services with us today. And we certainly appreciate her participating in this hearing. Sha'Ron is two people to my left.

So, as I said, I started in the middle, but, moving all the way to the left, we have Alyssa Lathrop. She is assistant general counsel for the Florida Office of Insurance Regulation.

To my immediate left, I have Eric Johnson. Eric is OIR's chief actuary and director of the life and health product review division.

To my right, Mary Mostoller. She's the director of company admissions and business development.

Further to my right, Carolyn Morgan, the director of life and health financial oversight.

And far to the right, I have Tracy Brown, who is our court reporter today. She will also be
doing some swearing in of all of the witnesses in just a few moments.

So, with that, I'd like to introduce Steven Whitmer of Locke Lord -- he's outside counsel for Aetna -- to briefly introduce the presenters from Aetna today and any witnesses.

MR. WHITMER: Thank you, Mr. Robleto and distinguished panel members. And thank you for the opportunity to be here today. I'm going to introduce to you now the five witnesses that you'll hear from today, and I'll introduce them in the order that you're going to hear from them.

First, to your right is Mr. Fran Soistman. And he serves as the executive vice-president and head of government services for Aetna.

To your left, and the second witness, will be Dr. Yogi Hernandez. To your left is Dr. Yogi Hernandez. She is the vice-president and chief medical officer, care delivery organization for Humana.

The third witness you'll hear from today is at the end of the table to your right. This is Dr. Thomas McCarthy. He's an economist and a senior vice-president for NERA Economic Consulting.

The fourth witness you'll hear from is on your
left at the end of the table, Gregory Martino. And he is the assistant vice-president for state government relations for Aetna.

And finally, you'll hear from, on your left in the middle, from Mr. Joseph Ventura, who serves as the associate general counsel and the assistant corporate secretary for Humana.

And with that, the first of the witnesses we'd like to call is Mr. Soistman.

Mr. Robleto, would you like to do that at this time?

**MR. CHAIR:** I think I have a couple more things I need to go through before we do that, if you don't mind.

Again, mostly for the record, but the hearing today is being held pursuant to Section 628.4615 of the Florida Statutes, Section 628.461, and Section 641.255. They govern the proposed acquisition that is the subject of this hearing. This is a fact-finding hearing. It is not an adversarial hearing in any way. It is an opportunity for Aetna to present its proposals and for affected or other interested parties to provide their input and their feedback.

At this time, the Office has not made any
decision regarding the application for acquisition
and we certainly will not do so today.

Sha'Ron, would you like to say anything?

**MS. JAMES:** Rich, I'll waive my time. Thank
you.

**MR. CHAIR:** So now I will reintroduce Tracy
Brown, who will be assisting us today by swearing
in the witnesses as well as keeping the record.

(Witness sworn in.)

**MR. CHAIR:** Thank you, Tracy. Thank you all.
And now, I will turn the meeting back over to
you to begin introducing your witnesses. Thank you
very much.

**MR. WHITMER:** Thank you, Mr. Robleto. Because
the microphone was off the first time, I will take
a second opportunity to introduce Mr. Fran
Soistman, who serves as the executive
vice-president, head of government services, for
Aetna.

**MR. SOISTMAN:** Thank you, Steve. Good
morning. As Steve indicated, my name is Fran
Soistman. I am the executive vice-president and
head of government services for Aetna. I'd like to
thank the Office of Insurance Regulation for the
opportunity to present to you the Aetna Humana
transaction.

While Aetna's headquartered in Connecticut, we're proud to have a very large presence right here in Florida. We have nearly over 5,000 dedicated employees that reside within the state, making Florida the state with the third largest number of Aetna employees. These employees are located in offices in Jacksonville, Plantation, Sunrise, Orlando, and Tampa. Aetna's flexible workplace arrangements allow for over 2,000 of these employees to work from home. In addition, Humana has over 10,000 employees in Florida.

So let me begin with the rationale for our acquisition. For several years, Aetna has been pursuing a mission of building a healthier world, reshaping the healthcare system to be more consumer-centric in order to give our members as many healthy days as possible.

In Humana, we have found the ideal partner to complement and accelerate our efforts, a company with an enterprise goal to improve the health of the communities they serve by 20 percent by 2020. The Aetna acquisition of Humana is about two companies coming together to offer more people a broader choice of higher quality and more
affordable health plan options. Our companies are
highly complementary, combining Aetna's focus on
commercial, group, and specialty products with
Humana's concentration on Medicare Advantage.

As I will explain in more detail, we believe
that individuals will benefit in many ways from
this transaction. Most notably, Medicare Advantage
enrollees will benefit from the combination of two
two companies with top rated Medicare plans, as this
transaction allows Aetna to offer Humana's high
quality care and service model to the rapidly
growing Medicare-eligible population.

After the acquisition, Aetna will have a
product portfolio balanced more evenly between
commercial and government products such as Medicare
and Medicaid. We'll take the best practices, the
best systems, the best capabilities and programs of
both companies in order to make us an even stronger
and more reliable source of quality affordable
products for Florida consumers in the years to
come.

We're committed to working with the Office of
Insurance Regulation through the regulatory
approval process. We want to provide you, along
with our customers, our provider partners, our
associates, and the people of Florida greater insight into this transaction, and to share with you our vision for how, with Humana, we can help more people to lead healthier lives.

We believe that the new combined Aetna will bring many advancements to the healthcare markets in Florida, and that robust choice and competition will remain. Our retained economist, Dr. McCarthy, will share his expert perspective on the competitive impacts in Florida.

As this transaction is primarily about Medicare, I want to share a few national, in Florida specific perspectives, on how the combination of the two companies impacts Medicare offerings in competition. As you all know, the Medicare population is the fastest growing segment in our country. And, in fact, over 10,000 Americans every day age into Medicare eligibility. By 2030, 67 million Americans age 65 and older will be enrolled in Medicare, an increase of more than 27 million from 2010.

19 percent of Florida's population is eligible for Medicare, which is the highest percentage of the country, and continues to grow each year. Today there are nearly 3.7 million Medicare
beneficiaries in Florida, second only to California, with over 5 million. Merging with Humana gives Aetna the opportunity to extend its existing capabilities to serve more Medicare members and provide a richer array of highly effective capabilities.

So a little more about the transaction itself. I'd like to take a couple minutes to briefly review the business terms of the transaction to provide a sense of how the new combined company will be organized, and also provide an update on our work to date to secure state and federal regulatory approvals.

Under the terms of the transaction, each of Humana's insurers, HMOs, and other companies will become a direct wholly-owned subsidiary of Aetna. Mark Bertolini, the CEO, will remain the CEO of the new combined entity. Aetna's board of directors will be expanded to include four of the current Humana board members to be determined.

On October 19th of this year, shareholders of both Aetna and Humana approved the transaction. And last, we're currently working with the states and the Department of Justice on the approval of this transaction, which we anticipate to occur in
the second half of 2016. So we have many constituents that are very interested about this transaction. And I'd like to cover each of those and start with our consumers.

You're here because you want insurance to work. And we want it to work as well. We collectively want the best possible outcomes for our customers. This transaction will benefit consumers by accelerating improvements to quality and patient outcomes, simplifying the healthcare experience, improving access and engagement, increasing healthy days, and developing technology innovations to help make healthcare more affordable.

Today the market competes on price and choice of doctors, and that won't change. But to create greater consumer value, we believe we need to better engage our members, simplify their experience, and increase the number of healthy days.

With this transaction, we expect to achieve 1.25 billion in cost savings in 2018, and recurring savings thereafter by becoming more efficient. We intend to have a significant portion of these savings flow back to consumers through medical and
pharmacy coverage that remains affordable with lower out-of-pocket costs and better health outcomes. Consumers will see overall costs and a simpler experience than they would otherwise.

These savings will improve consumers' experience and options in ways beyond increasing coverage options and improving long-term affordability. We also intend to invest these savings to improve the quality and effectiveness of the services we offer to consumers. We will build upon the important programs both companies have in place today in Florida, to provide a richer consumer experience with programs and services that truly help people experience healthier days.

For many years, the Centers for Disease Control have consistently measured the number of healthy and unhealthy days Americans have. The simple survey asks people how many physical and mentally healthy days they've had in a month. Both companies see healthy days as a valid measure of individual and community health improvement. Aetna and Humana are committed to offer products and services that will help our members improve the number of healthy days they can enjoy each year.

For example, Aetna partners with a program
called Medical Doctor House Calls, which provides home-based physician or nurse practitioner medical services to Medicare Advantage patients in many counties in Florida. The program provides 24-7 access to home-based care for patients who do not have an established relationship with a primary care provider.

Since we started the program, Medical Doctor House Calls has made approximately 2,000 home visits, averaging around 50 to 60 visits per month. The program has been very successful and has found primary care doctors for approximately 85 percent of the patients it serves. For the other roughly 15 percent, Medical Doctor House Calls becomes the patient's permanent primary care provider. Now, it's our objective that 100 percent of our members have an established primary care physician relationship to help coordinate care and navigate the healthcare system.

Another example I'd like to feature comes from Humana. Humana helps increase members' healthy days through the Humana At Home Program. Through this program, Humana supports members, care managers who connect with them personally in their homes to develop a more holistic approach to their
health. This approach has helped nearly 345,000 Humana chronic care program members stay out of the hospital across the country, and a large number of these are in the State of Florida. These individuals were also 42 percent less likely to be readmitted to the hospital within 30 days than nonmembers. That's an extraordinary accomplishment.

While clinical services play an important role in this individualized holistic approach, Humana also addresses the social determinants of care by arranging to deploy ramps and hold bars into members' homes, provide transportation for these members to see their physicians, ensure they have food in their homes, and have access to needed financial assistance. The physician community doesn't have the capacity to do these. And the health insurance industry has stepped in to fill these needs. And this is what's keeping people from slipping through the cracks, and it's making a difference.

You can see the results of these efforts reflected in both Aetna and Humana's Medicare Star ratings. Medicare uses a Star Rating System to measure how well Medicare Advantage and
prescription drug plans perform. This is established by CMS. It scores how well plans perform in several different categories, including quality of care, HTAS, prescription safety, operations, and surveys measuring satisfaction with their providers in their health plan. Ratings range from one to five stars, with five being the highest and one being the lowest. The overall Star rating scores provides a way to compare performance among several plans. The two companies are number one and number two in Star ratings among publicly traded companies in the nation, and 85 percent of Aetna's Medicare Advantage members are in plans with a four or higher Star rating.

Let's talk about our providers, important partners to make this whole system work well. We know doctors want to care for patients to help them stay well or get better, not spend time on paperwork and administrative bureaucracy. We're committed to a new value base system where we work collectively with hospitals and physicians to align incentives and reward the overall health of the individual. Many providers support these efforts. We believe that, by coming together, we can grow our partnership with providers and improve care.
I'd like to share a few examples that illustrate how Aetna and Humana have already had success with provider partnerships and clinical programs that resulted in improved health outcomes right here in Florida.

Aetna and the Catholic Health Services in Miami-Dade and Broward counties have a care transition program where we work together to provide physician services, pharmacy reconciliation services, personal health records, coaching, transportation, and meals to keep people from returning to the hospital after discharge. We've had excellent results from this partnership, with a readmission rate decrease of 65 percent for the target population.

On the Humana side, it's my privilege to introduce one of Humana's Florida-based clinical leaders, Dr. Hernandez, to share some of her perspective unique to this state from the experience a physician leads their care delivery organization, an organization that includes 56 Humana-owned clinics right here in Florida.

Dr. Hernandez.

**DR. HERNANDEZ:** Thank you, Mr. Soistman. Good morning.
I am Yogi Hernandez, and I serve as Humana's chief medical officer and vice-president of our care delivery organization, overseeing all of the wholly-owned clinics. As a long-time south Floridian, I wanted to highlight the benefits I see to physicians and providers from being a part of Humana's integrated care delivery approach, and also share a story of how we worked in partnership with physicians to enhance outcomes and care and ultimately improve individuals' healthcare experiences.

Humana has unique experience partnering directly with primary care physicians in the 56 clinics we own and operate in Florida, as well as partnering with community physicians across our state. These innovative, integrated care centers combine medical care and related services that address the social determinants of health that propose barriers to improved health outcomes. These clinics largely serve low income seniors living with multiple chronic conditions in largely medically underserved neighborhoods.

For example, for over 50 years Humana CAC medical centers, known originally as Clínica Asociación Cubana, have served Miami-Dade's
Hispanic community, using an all-in-one approach to healthcare delivery that is based on an all-under-one-roof model that's widely practiced in Latin America. The CAC multi specialty centers in Miami neighborhoods like Little Havana and Westchester are designed to provide a sense of community as well as a convenient treatment setting for health conditions.

As one of our clinic provider engagement leaders said, every day when I come to work, I have a great opportunity to reshape the healthcare system and help our frontline physicians, the real rock stars, deliver the best possible care in the most effective manner. It's really fascinating and meaningful work.

And our patients agree. As described by Melinda, a CAC patient for almost 15 years, the doctors are very empathetic, very professional. They treat you with so much patience. The employees give you so much attention. So much attention. But that is what makes one feel so good.

Beyond anecdotes, the research supports that there are tangible benefits of this model. I'm proud to share that the patients seen at our
centers have a 5 percent lower rate of inpatient admission compared to others in the same market, higher HTAS scores for preventive screenings, and a world class customer satisfaction rate.

Thank you.

**MR. SOISTMAN:** Thank you, Dr. Hernandez.

There are lessons to be shared from this type of clinical engagement and consumer experience. As Humana combines with Aetna to enhance the clinical and healthcare experience, we will continue to focus on achieving our goal of building a healthier world.

Employers. By bringing our insights and solutions together, Aetna and Humana will be able to offer employers new solutions to lower costs and enhance the health and wellness of employees and their families. This will help employers improve the costs and value of their benefit programs as well as their ability to attract and retain top talent.

For example, we recently partnered with our customer, the Broward County Sheriff's Office, to build an employer-specific primary care clinic to increase access to affordable quality health services for their employees and their families.
Our partnership with providers are bringing new products to the market for employers and their employees. Aetna's been able to offer employer-based products that have premiums that are 3 to 5 percent below the competition by offering plans and partnership with leading provider systems around the country. The combination of Aetna and Humana will allow us to offer a broader choice of more affordable, higher quality products to employers.

Florida has maintained a healthy competitive market for health plans across all lines of business. Robust choice of coverage and health plans exist across all programs, in particular within the Medicare and the health insurance exchange. As Dr. McCarthy will testify, the exchange market is very competitive and fluid, with eight insurers offering coverage in 2016.

The Medicare market is also very competitive. Today, at least 6 Medicare Advantage plans are available in all 67 of Florida's counties. Florida Medicare beneficiaries have an average of 26 Medicare Advantage private options from which to choose, with 22 different Medicare Advantage organizations offering plans throughout the state.
Today, Aetna has approximately 98,000 Medicare Advantage enrollees in Florida, and Humana has almost 590,000.

Robust choice and competition exists across the Medicare program today and will be enhanced by our transaction. Aetna's combination with Humana will enhance these choices, promoting choice and competition for Floridians.

Florida is vitally important for Aetna and Humana. As I mentioned earlier, Aetna has 5,000 employees in Florida, and Humana has over 10,000 employees, including its own clinic personnel, in the state. We plan to base our Medicare and Medicaid and federal employee health benefit program business in Louisville, Kentucky. But outside of that, no specific decisions have been made regarding employment in local geographies.

While there's always some dislocation, we see this transaction as helping our company grow in value, which over time will expand employment. I would also add that healthcare is local. It will always have a strong presence in the states where we are privileged to serve its citizens.

Aetna has made strong commitments across its employee base, voluntarily raising our minimum wage
and subsidizing our healthcare benefits for employees whose household income is less than 300 percent of the federal poverty level. As part of this transaction, these benefits will be extended to a similar group of 10,000 Humana employees here in Florida, and remaining 40,000 plus across the nation.

How do we fulfill our corporate social responsibility here and throughout the nation? Right here in Florida, Humana and Aetna have made a significant commitment to improving the health and wellbeing of Floridians through our respective foundations, our corporate giving and employee volunteerism.

You can see from this slide that together Aetna and Humana have donated millions of dollars and hundreds of thousands of volunteer hours to important programs and causes. This is a commitment that we stand behind today, tomorrow, and well beyond when this transaction is approved.

In closing, mergers and acquisitions are not just about achieving greater efficiencies and business goals. Both Aetna and Humana share a common culture focused on improving health, not just selling products. Aetna's acquisition of
Humana is about creating positive change in the healthcare market. It's about being a part of an effort to build a 21st century healthcare system built around engaging the consumer and increasing the number of healthy days, and by partnering with hospitals, physicians, and other providers to improve health outcomes. We believe our acquisition will enhance the healthcare market by providing more consumer access to more affordable and higher quality products.

Thank you again for the opportunity to testify today, and I look forward to your questions.

MR. CHAIR: Thank you very much. I believe that we would like -- unless anybody has any specific questions right now, perhaps that we would hold questions until the various presenters --

        Does anybody have anything right now?

MR. SOISTMAN: Okay. Very good. I'll turn it back over to Mr. Whitmer. Thank you.

MR. WHITMER: Thank you, Mr. Soistman.

        The next witness we'd like to present is Dr. Thomas McCarthy.

        EXAMINATION

BY MR. WHITMER:

Q Dr. McCarthy, could you go ahead and start by
providing us with your title?

A Yes. I am a senior vice-president with NERA Economic Consulting. And I'm also the head of our healthcare practice around the world.

Q What is NERA?

A NERA is -- Economic Consulting implies a firm of economists. We're virtually all economists. Probably 400 economists in about 27 offices around the world. We look at economic analysis for various reasons: Competition policy, public policy, litigation, finance, strategy, those sorts of things, but what holds all of those practices together is an analysis of economic data.

Q And approximately how long have you been with NERA?

A 32 years.

Q I'd like to talk a little bit about your education. Where'd you go to college?

A I went to a small school in Worcester, Massachusetts named Assumption College, and got a BA in economics from Assumption College. I then went on to the University of Maryland, got a master's and a Ph.D. in economics, and I wrote my dissertation on a health economics subject.

Q And you've also had some college teaching positions. Could you tell us about those?
A  Yes. While I was finishing my dissertation, I
taught at the University of Maryland. I was an instructor
and taught a variety of courses. When I got my Ph.D., I
then taught at a school called Oakland University in
Michigan. And there I taught a number of subjects to
undergraduates and to MBA students, including health
economics.

Q  I'd like to talk a bit about your professional
background. Could you go ahead and start with your work at
the Federal Trade Commission?

A  Yes. I worked for the Federal Trade Commission
for a while in a division called the Division of Regulatory
Analysis. And the purpose of that division was to look at
regulations before they passed to see whether they would
have positive economic effects in a cost benefits sense or
positive economic effects in terms of competition.

And I focused mainly on certificate of need
loss, home health reimbursement. And the first project
I had there was to evaluate something which is now
routine, which is the DRG system that hospitals use for
reimbursement. But back in early '80s, that was new.
And I worked on that project.

Q  What other health plan mergers have you worked on
other than the one we're talking about here today?

A  I've worked on several. I'll run through a quick
list. All of these had to do with the antitrust review and antitrust analysis. Cigna/Health Spring, that merger. United healthcare/Pacific Care. Blue Cross of Michigan bought a company called MCare, which was the provider sponsored plan for the University of Michigan. Aetna/Prudential, one of the signal events in analyzing health plan mergers. Aetna/Coventry. Blue Cross Blue Shield of New Mexico's recent purchase of the Loveless Health Plan, mostly in the Albuquerque area. Cigna/Great West.

And then there's a company called healthcare Services Corporation, HCSC, which is actually an owner of five not-for-profit Blue Cross Blue Shield plans around the country, and I helped them with their acquisition of -- their fifth that they added, which was Montana. The Blue Cross plan in Montana is now owned by HCSC.

Q Now, Dr. McCarthy, you are also co-editor of a book. Could you tell us a bit about that?

A Yes. That's called Financing healthcare. It actually was about healthcare reform around the world. Financing healthcare is, I think you would guess, has something to do with insurance and how we actually bear that risk. So this had to do with comparisons around the world.
Q I'd like to talk a bit about your prior testimony in other proceedings. First of all, have you had the opportunity to testify before state departments of insurance?

A Yes, I have.

Q Tell us a bit about that.

A Well, for the Florida Office of Insurance Regulation, for the Aetna/Coventry transaction, I didn't appear in person, but I submitted two written affidavits for that transaction to this body. But also I've appeared in person in a number of other departments of insurance. These include Alaska, Colorado, Delaware, Montana, New Jersey, twice in New Mexico, and once in Washington state.

Q Now, you've also appeared previously before the Department of Justice and the Federal Trade Commission. Can you tell us about that?

A In 2003, they held hearings about how to -- it was called a dose of competition in healthcare, how competition relates to healthcare. I spoke at three of those sessions, testified at three of those sessions for those hearings.

Q And finally, you've also testified before state and federal courts. What can you tell me about that?

A Yes, I have. In mainly their healthcare antitrust cases, sometimes patent cases or damages
analyses, but that's serving as an expert witness in the

court setting.

Q And moving on to this transaction, what was your
assignment for this matter?

A Well, I was asked to evaluate whether, in terms
of the NAIC guidelines, whether a merger of Aetna and
Humana was likely to lead to lessened competition or tend
to create a monopoly in any line of business in the state
of Florida, that is to evaluate the competitive effects.
Our shorthand would be the competitive effects of the
merger.

Q I'd like to walk through with you the process you
undertook for your analysis. But let's start with the
information you reviewed. Could you just describe that for
us?

A Well, as you'll see in a few moments, we're going
to look at a lot of shared data. So we looked at premium
data, we looked at enrollment data. And those enrollment
data come from a number of different sources, the parties
themselves, the OIR's research division. The medicare data
are principally from the centers for Medicare and Medicaid
services, which is CMS, federal government. And there's
also another database that we use, and you'll see, from the
InterStudy database. That's a company that collects data
around the country, all the states, tries to categorize all
of the various services that those insurers provide.

Q Now, as part of this process, did you also have
the opportunity to conduct certain interviews?

A I did. We talked to -- at both the national and
the Florida operational level, we talked to Humana
management and Aetna management to make sure we understood
what was going on in the markets.

Q Was the information that you reviewed and the
interviews you conducted, was that collectively sufficient
from your viewpoint to conduct the analysis you're
presenting here today?

A Yes. I definitely think we cast a wide enough
net to understand what's going on in Florida.

Q Now, before we get to the details, let's start
with your overall conclusion.

A I find that the transaction is not likely to
lessen competition or tend to create a monopoly in any line
of business, health insurance business in the State of
Florida.

Q Now, Dr. McCarthy, I understand that this
conclusion is based on four specific facts. Let's take
each of those four in turn.

Now, the first key fact that you've identified
is that Aetna and Humana have complementary strengths.
Could you explain that to us?
A  Yes. And I think you just heard a very complete rendition of that from Mr. Soistman. But the principal complementary is between Aetna as a commercial, particularly large group national account, strong company, and Humana, which is very strong and very able on the Medicare product side. So, what you heard is putting these two together gives you a very balanced portfolio for the merged entity.

Q  Now, the second key fact you've identified is that the proposed transaction will lower costs and provide greater competitive opportunities for both companies. Could you also explain that point for us?

A  Right. Again, I think this was covered in the first presentation. I looked particularly at the efficiencies that will come out of this new organization and the 1.25 billion in annual savings by the year 2018. And I think, to put my role in the context of that number, it is to say that I'm going to describe the competition is sufficient and forceful enough in the State of Florida to make sure those cost savings are passed on to effectively keep price down and keep quality up.

Q  Moving on to the third key fact that you've identified, that's that post-merger shares for the relevant products will generally remain below a 30 percent threshold, I understand that you took a three-step process
and three-step approach to that particular answer. Could you go ahead and explain to us the first of the three steps?

A: Yeah. Much like the NAIC model law, there are thresholds in those guidelines that, if the share for a particular line of business is below that threshold, it's considered a safe harbor. So that's step one. When you look at a particular line of business, is it below that safe harbor.

If on the other hand it is above the number, particularly in the NAIC guidelines, then you have to look a little further. You have to look and say are there other factors and other conventions in a particular industry for a particular review. In this case, an antitrust review. And that's where the 30 percent comes from. In my experience in all of these merger reviews, there's never a magic number, but there's a threshold that you approach about 30 percent share where it acts as if it's almost a safe harbor. It's not literally a safe harbor, it's just the discussion changes are above 30 percent, where you need to look a little more deeply at what's going on to make sure competition will be preserved. So that's the second step in establishing that 30 percent.

And then the third step is if it is above this
30 percent threshold, that's the convention, then
there's a deeper analysis that has to be undertaken,
again, to look at other aspects in the market.

Q And when courts generally are looking at monopoly
power, is there any factors that they're looking at or
percentages that they consider?

A Well, in the end what you care about is monopoly
power, will something advance to the point of monopoly
power. And courts never consider monopoly power to exist
unless the share's at least 50 percent.

Q So that takes us to your fourth key fact,
Dr. McCarthy, and that's that additional factors further
establish why this transaction does not present any
competitive concerns. What are those additional factors?

A We're going to talk a bit about them in a context
of a particular product line. But you look at basically
three things, sort of categories of analysis. One would be
to look at shares. That is, what are current competitors
doing in the market now that gives you an idea. We know
that a current competitor would want to steal business from
Aetna, would want to steal business from Humana. So we
just look at what's going on now. That's pretty much the
share analysis.

But then we also consider opportunities for
expansion. That is, people -- players who are in the
market can expand geographically, they can expand to a
new product line, they can expand by changing their
network strategy, their provider network strategy.
There are adjustments that exist that players in the
market can make to compete more effectively. That would
be the second opportunity to expand.

Then the third would be opportunities for
entry. And there's sometimes a blurry line between
expansion and entry, but the idea would be new players
who might come in or new players who have never
considered being in one product line and suddenly they're in that product line. We'll talk about that
kind --

Q  So could you provide some context for these three
factors you just identified? Why do they matter for the
transaction we're talking about here today?

A  If you think about -- when you focus on share,
you're just talking about what's available today and what
choices can I make, because you're looking at existing
players. That's really only the beginning of a competitive
market analysis, because there's also -- that's the demand
side. That's what buyers can choose from differently.

But on the supply side, there are other
responses we want to look at, like that expansion and
entry. And so you can't really get an idea. The way
markets are supposed to work is consumers express a preference, suppliers notice those preferences, see it as a market opportunity, and respond. And they can respond in big ways, like entry, or they can respond in little ways, like consumers want a bigger provider network.

But the point is, to understand the competitive process, you have to not only understand what consumers want and what's available today, but you have to understand what the market responses could be in maintaining competitive pressures on everybody.

Q So now that we have established these four facts, let's move on and talk about the lines of business that you considered. Can you identify those three lines for us?

A Yes. We looked at commercial, overall commercial enrollment, we looked at Medicare, and we looked at Medicaid.

Q And why is it that you selected those three lines as opposed to others?

A Well, we talked about safe harbors before. These are the three categories that exceeded the NAIC guidelines.

Q So if you could go ahead and look at the screen, Dr. McCarthy, you have up there figure three. Could you explain to us, what is it that this figure tells us?

A Well, you can see that -- well, two things. The
two different companies are up there, but you can see at the bottom that both of these companies have about 1.5 million members in Florida. And so they're roughly the same size, yet they're very different companies. The -- Aetna, you can see 90 percent or so of their membership is in the commercial membership, whereas for Humana, it's only about 37 percent of their membership. Instead, Humana's significantly involved in Medicare business, with about 40 percent of its membership being in Medicare beneficiaries. Aetna on the other hand has less than 10 percent.

I think this is a picture of what Mr. Soistman was saying earlier, that these are two very different companies in a complementary sense. And that's really what I think this figure illustrates is how nicely the two portfolios fit together.

Q So you've identified for us three lines you're going to tell us about. Let's move forward and talk about the first of the three lines or segments, and that is commercial. Let's go ahead and move forward to table one.

And you'll see, Dr. McCarthy, table one that's up on the screen, could you give us some context about what the table tells us?

A Yes. This table looks at total commercial enrollment. In this case, we're looking at individual and
small group and large group. We're looking at them all together. And we're looking at fully insured and self-insured members. These data come from InterStudy. They collect both fully insured and self-insured data. And what you see in that table is that the combined entity post merger would have a 19.3 percent share based on this 2015 data. That's not -- again, looking at the 30 percent threshold we talked about earlier, that's not a threatening level and one would not consider that a significant concern from an antitrust point of view.

Q Continuing with the commercial segment, let's now take a look at table two. What is table two and what is it that it tells us?

A Table two is a similar table, but now we're going to try to break this down into small group, large group, and individual. This is the table reflecting small group data. The data here come from the OIR, because there are very few people who gather small group data separately. This is our only source. It does not include the self-insured, but the -- looking at fully insured small group plans, we see that the post-merger share would be 23.6 percent. Again, well below the 30 percent threshold.

Q So let's move forward then and take a look at table three. What can we learn from this table?

A This is looking at large group. Again, large
group is defined, by the way, as a hundred and above. That is employer groups that have at least a hundred employees. And when we look at the players offering these products, this is, again, OIR data. It's only the fully insured component of it. But the post-merger share would be 22.5 percent in that segment.

Q Again, below the 30 percent number you've been discussing?

A That's right.

Q So you've been describing for us commercial group. Did you also have the opportunity to review the commercial individual segment?

A Yes.

Q And what is it you learned about that?

A Well, this is the only commercial segment where the share is above 30 percent. You can see for 2014, that's the most recent data we have, the post-merger share would be 37.7, 38 percent.

Q And does that present a competitive concern, Dr. McCarthy?

A No. Because -- and I will try to go through why, because of the potential supplier responses that I think will keep this market robust. What we'll find is shares are very volatile in this segment.

Q Does the Affordable Care Act have any impact on
A Yes. As you know, the Affordable Care Act, otherwise known as ObamaCare colloquially, has a mandate to buy health insurance. And so many of the buyers are looking to find the cheapest possible policy with as much of a subsidy as possible to reduce the costs to them of satisfying that mandate. In fact, nationally about 86 percent of those who buy on the exchanges, on the public exchanges, receive a subsidy.

Q So why -- you're focusing on the subsidy, but could you provide us an explanation, why does the subsidy matter with respect to your analysis?

A The subsidy matters because, again, buyers would like to maximize the use of that subsidy. And I don't probably need to go into too much detail with this group, but the subsidy is tied to the two lowest price silver plans in a given area. And, as you know, ObamaCare is organized in terms of these different medal levels: Bronze, silver, gold, premium implying richer and richer benefits.

So the premium -- the subsidy being tied to the price of these two lower plans means that you always would like to be one of those two top spots, because it will mean higher membership, more successful sales if you're among these to get the greatest proportion of the
So, if you could connect the dots for us, why is it that a 38 percent share here still does not present a competitive concern from your viewpoint?

Well, if you look at 2013 on this table four, you see that the share, the post-merger share would have been, in 2013, 22.3 percent of the individual market. But the jump up between 2013 and 2014 is really due to Aetna and Humana's entry into the exchanges.

And so I want to look now at the exchanges to show what the supply responses have been in those exchanges.

Okay. So why don't you explain, what are the implications here?

Well, it's clear that the shares in the exchange are very fluid. For instance, in 2015, Aetna dropped from the second slot in Miami-Dade County, and they lost more than half of their exchange membership. Why? Because you fell out of those two favored spots and therefore lost a lot of membership. So, in some sense, there's an easy come, easy go, unless you bid very aggressively.

So you've been explaining to us that what you call supply responses and that they will ensure competition, but perhaps it will be helpful if you could give us an example of how that works.
A There's a very interesting example going on in Florida and nationally, and that has to do with the company known as Centene. Centene's a good example of the type of supply response that will ensure this competition remains robust. As you probably know, Centene's an important and successful Medicaid managed care company. They've been recently trying to diversify their portfolio by moving into the commercial individual space, mainly through the exchanges. But it's also an interesting note that Centene has already gotten approval from the antitrust -- the federal antitrust authorities to merge with Health Net.

Health Net, as you may know, is a West Coast -- fairly large West Coast health plan that has a full range of commercial and Medicare and Medicaid services. And one of the reasons given for that merger is to leverage the success of Health Net in these markets.

So, Centene is very active. They've now moved into -- when we talk to Aetna and Humana about their -- what they're doing in Florida, we're told that they have a very aggressive exchange strategy developed.

Q Describe for us what you mean by an aggressive strategy. What does that mean?

A Well, the way Centene is going after the exchange market is to, what management calls, they've flooded the
market with low cost plans. So they're on the one hand trying to achieve those first two preferred slots on the silver plan pricing, and they are in effect tying up a lot of the low price slots. So they have the first five slots in 11 counties; they will have for 2016 the first five slots for 11 different counties in Florida. And that's going to make them appealing in two ways: One, they're the low priced carriers; two, they kind of occupy the whole first space. If you get on Healthcare.gov website, you'll see Centene, Centene, Centene, Centene.

Q So you've described the approach that Centene is going to be taking. Are there others that are taking a similar approach?

A Molina is also on the exchange. They're new to the exchange, relatively new to the exchange. They have one of the top two slots in one county. They're well-positioned to follow the Centene model. But also Amerigroup, owned by Anthem, is in a similar position, being an experienced Medicaid managed care company that could expand into the exchanges.

Q So to summarize, Dr. McCarthy, do you have any concerns whatsoever from a competitive standpoint with respect to the commercial lines?

A No. For Aetna, with or without Humana, for Aetna to remain successful in this segment, they're going to have
to price aggressively because of this volatile -- this sort
of volatile shifting of share that occurs when somebody
takes over those silver plans, preferred silver plans.

Q So let's move on now to the second line that you
focused on in your analysis. And you've already explained
that to us. That's Medicare. So let's talk about
Medicare. Let's start, if you could, by explaining, what
are the choices available to Medicare beneficiaries?

A The main choice is to choose between traditional
Medicare and a Medicare Advantage plan that are offered by
the commercial insurers such as Aetna and Humana.

Traditional Medicare of course is historically what we
think of as Medicare. Some people call it original
Medicare. It's sometimes caught up with a Medicare
supplemental plan or prescription drug plan, but it's what
we think of as the original Medicare.

Medicare Advantage plans in effect take the
traditional Medicare benefits, and they require that
those same benefits have to be made available to the
beneficiaries, but they're -- these benefits are made
available through an HMO or a PPO by a private
commercial entity like Aetna or Humana.

Q So are traditional Medicare and Medicare
Advantage considered substitutes for each other?

A Yes. They're choices that have to be made. They
offer the similar benefit structures, and people choose one or the other for a variety of different reasons.

Q So if you could explain to us a little bit more, what is the choice that's presented to a retiree when it comes to these two pieces?

A Well, when a retiree ages into Medicare, they have to make this choice. And usually the retiree will go to the Medicare.gov website, and what you'll find there is the first choice you're asked to make is do you want traditional Medicare or do you want a Medicare Advantage plan?

So, for example, if you enter the Tallahassee zip code of 32301, which I took to be the OIR's zip code, you -- the website lists first, as is typical, lists the traditional Medicare option first. And then, in the case of this particular zip code, it lists the eight Medicare Advantage plans that are available. They're available from five different companies, and the premiums range from $0 to $147 per month. So there's a choice of plans available.

Q Now, let's assume that an enrollee --

MR. CHAIR: Excuse me. Maybe I misheard you. I thought we were discussing the traditional Medicare, as you called it, and then you said there are five Medicare Advantage plans with traditional
Medicare?

**DR. McCARTHY:** What I meant to say is that when you go to the Medicare.gov website you are faced with a choice of both. Traditional Medicare is listed, and then below that are these eight plans I was mentioning as options. So, the typical way that you can research what you would like to do as a new retiree is to go to this website, put in your zip code, and see what the alternatives are. They're both there, traditional Medicare and the Medicare Advantage.

**MR. CHAIR:** Okay. And by traditional Medicare, you mean the med sup plans, as we refer to them? It seems like there are three options. There's the Medicare, you could just go alone, or you could buy a supplement or you can buy a Medicare Advantage plan.

**DR. McCARTHY:** And all of those are options. All of those are options. I was referring to the traditional Medicare, meaning more if I'm a new retiree, I must opt into some Medicare plan. Am I going to opt into what we call original Medicare, traditional Medicare part A, part B, that whole approach, or am I going to opt into a Medicare Advantage plan? All that's presented as options to
a new retiree, which is the point I'm trying to make. But you're absolutely right, that new retiree can -- if they were -- he or she were to choose traditional Medicare, can supplement with what we call a med gap policy, and that and an additional option within those two broad options.

MR. CHAIR: Okay. Thank you.

BY MR. WHITMER:

Q Now, Dr. McCarthy, let's assume that enrollee does not like her initial choice. Is there an opportunity to change or switch?

A Yes, there is.

Q Could you explain that to us?

A Once a year, and curiously enough December 7th, today, is the last day for Medicare enrollees, if they wanted to switch for the calendar year 2016, they have to do it today. Today's the last day. But once a year at least, there's some other conditions where you may get to do it more than once, but once a year at least Medicare beneficiaries can switch to another Medicare Advantage plan, from traditional to Medicare Advantage, from Medicare Advantage to traditional. They can revisit that option.

Q So have you evaluated that? Have you looked at whether enrollees switch from traditional Medicare to Medicare Advantage or vice versa?
A

Yes. We've looked at the last three years of data available to see, for any Aetna member, any Aetna Medicare member who had a Medicare Advantage plan who switched, how many switched to traditional insurance. And 21 percent of the Aetna members who switched, switched to traditional. And with respect to Humana, 25 percent of Humana enrollees who switched during those three years switched to traditional Medicare.

Q

So what is it that we learned from that?

A

Well, we learned that not only can you revisit this choice, but there's a substitution that goes on and the Medicare beneficiaries move between these two products so that they are substitutes. And that Medicare -- traditional Medicare is acting as a constraint on the Medicare Advantage policies.

Q

So let's move forward now to table six. You can go ahead, Dr. McCarthy, and take a look at the screen. Please explain to us what table six demonstrates.

A

Table six looks at the shares of total Medicare enrollees that the players in Florida have. And you can see the post-merger share for Aetna and Humana would be 15.5 percent.

Q

And does that number, 15.5 percent, present a competitive concern from your viewpoint?

A

No. It's well below that 30 percent threshold.
Q So, are there any other additional considerations that you'd want to look at when evaluating this Medicare segment?

A Yes. I think I would just add -- in that case this is sufficient, but I would add that there are a variety of supply responses in the Medicare Advantage segment of the Medicare business. So, during the past six years, there have been four new entrants in Medicare Advantage in Florida. There's another phenomenon that we're seeing which is -- it has been done before, it's not terribly new, but hospital systems around the country as they consolidate sometimes have their own what we call provider-sponsored health plan.

You have one very prominent one in Florida in the Health First System out of Melbourne, Brevard County. And there are others around the country that are these provider-sponsored health plans that have a Medicare Advantage plan. Given the consolidation going on in the hospital system and the vertical integration going on with physicians, et cetera, provider-sponsored plans, I think, are a part of the future and would be another supply response to look at, at least potential supply response.

Q Let's come back to Centene for a moment. You talked Centene when describing the commercial lines. Does
Centene also play a factor here?

A  Yes. I mentioned their purchase of Health Net. Health Net has a well-established Medicare Advantage product line. And the press release for this merger says the following: Health Net's high quality Medicare platform across the combined business is the reason -- is one of the reasons for the merger. In other words, I'd like to take what Health Net knows about Medicare Advantage and move it to other places. And we think for sure in Florida, because in our interviews with the local operations folks, they've heard repeated rumors that Centene is already talking to different providers around the state about starting up Medicare Advantage. You can't count those more than rumors at this point, but certainly they have clear intention of moving into Medicare Advantage with their purchase of Health Net.

Q  So what other developments matter as we're considering this?

A  Well, we've talked mainly about individual retirees choosing a Medicare benefit, but there's also Medicare Advantage plans and Medicare supplemental plans and the like, sold as group policies, that is, to employers who want to provide health retiree benefits. And there's been sort of an interesting development that's starting in the sale, the distribution process of group Medicare
benefits. That's something called the private exchanges.

Q  Describe that for us. What is a private exchange?

A  A private exchange is usually a health -- a human resources kind of consultancy. We'll make an arrangement such that a given employer's retirees can choose between several different Medicare Advantage plans or traditional Medicare instead of the usual process that went on, which is RFPs go out, different companies bid, and they either get all or nothing. They either get the retirement contract or they don't get the retirement. Now, in an private exchange, this pool of retirees is going to be split among different types of plans.

Q  So tie that together for us. How is it that that impacts how Medicare beneficiaries make their decisions?

A  Well, it says, first of all, you're not going to get all or nothing. But it also has had -- at least reported to us from Aetna management, has had an interesting effect. And the interesting effect is that in one instance, when Aetna lost a large retiree group contract, they were only able to retain 8 percent of the members that they had effectively 100 percent of before. And what they've also found out of this is that the real shift goes to traditional Medicare. That's something like 70 percent of those who use an exchange will choose the
traditional Medicare option rather than, you know, one of 
the managed Medicare Advantage options.

This is also coupled with some surveys of 
employers, which show that, by 2018, between 20 percent 
and 33 percent of employers expect to be using private 
exchanges for their Medicare retiree options.

Q So, concluding this segment, what does all this 
tell us about any competition concerns with respect to 
Medicare?

A It says that there's plenty of current 
competition on future competition.

Q Now, I'd like to switch directions a bit and ask 
you whether the analyses that we've been discussing, do 
those consider statewide data?

A Yeah. With very minor exception, yes. We're 
looking at statewide data.

Q What is an MSA?

A MSA stands for metropolitan statistical area. 
It's usually made up of a core urban center, which we 
colloquially call a city, and the -- sort of suburbs in 
areas that are economically integrated with that. In 
total, that's called an MSA. The Tallahassee MSA is made 
up of four counties. It's made up of Leon, Gadsden, 
Jefferson, and Wakulla.

Q So let's assume some were to request a more
granular analysis and, for example, say let's look at the MSA level instead of statewide.

A  Yes.

Q  Have you done that? And if so, have your conclusions been any different?

A  Yes, we looked at that for the overall commercial business and for the Medicare business. And for the commercial business, there is no MSA that's any higher than 26 percent post-merger share for Aetna and Humana. That is 26 percent or less in each of the Florida MSAs. For Medicare, looking at the Medicare shares MSA by MSA, the highest number we get is 24 percent.

Q  Both numbers being underneath that 30 percent threshold we discussed earlier?

A  That's right.

Q  So, in either respect, whether you're looking at statewide data or the MSA level, are there any competitive concerns as we're looking at Medicare?

A  No.

Q  So let's move forward then to your third line, and your final line, and that's Medicaid. What does Medicaid encompass? Let's start there.

A  In Florida, there are two distinct programs. There's one called the managed medical assistance program, called MMA. And there's another program called the
long-term care program, LTC. And both of these are part of
the overall Medicare program. Of course, the MMA is about
40 times larger than the long-term care program, because
the long-term care is really a subset of Medicaid members
who are eligible for nursing home care, long-term care
benefits. So it's a much smaller part of the program.

Q So you just described for us two separate
segments of Medicaid. Let's take a look at each of them
separately, starting with what you referred to as MMA.
Take a look at the screen, Dr. McCarthy, that's table
eight. What is it that table eight tells us about MMA?
A Table eight tells us that the post-merger share
for Aetna and Humana would be only 11 percent,
11.1 percent. And that, of course, given the threshold
we've been talking about, is not a threat to competition.

Q And let's jump forward to table nine. Table nine
is long-term care, or LTC?
A Correct.

Q What can we learn from table nine as it concerns
competition?
A It's 26 percent post-merger share. There are
fewer insurers involved in the LTC that's regulated by the
state. And all of those insurers that are in the LTC
program are also in the MMA program. So presumably there
are other MMA insurers who would be willing to join that
segment if the state felt it was needed.

Q So is there any competitive concern here, table nine?

A No. It's below the 30 percent threshold as well.

Q So now, Dr. McCarthy, you have described for us commercial, Medicare, and Medicaid. You talked about all three lines. I'd like to come back now to the big picture.

In closing here, could you just summarize for us what was the purpose of your investigation?

A The purpose was to look at whether the competitive process is preserved even after this transaction. And my finding is that, yes, it is preserved. And that, again, to use the NAIC language, that there's -- the transaction will not substantially lessen competition or tend to create a monopoly in any line of business in the state of Florida.

MR. WHITMER: Thank you, Dr. McCarthy.

Mr. Robleto, I have no further questions for this witness.

MR. CHAIR: Thank you. I may have just one or two.

It seemed to me when you were asked early on about why did you choose commercial, Medicare, Medicaid, your response had something to do with those were the ones in which the market share would
exceed the 30 percent. Did I mishear you when you spoke?

**DR. McCARTHY:** No. I'm sorry. It was that they would -- that under the NAIC filing and the competitive analysis that was filed, that these were segments, lines of business that called out for greater analysis, that the threshold that was exceeded was an NAIC threshold, not the 30 percent.

**MR. CHAIR:** Okay. I misunderstood.

You spoke a great deal about the number of people every year that have switched from the Medicare Advantage I guess back to traditional Medicare. And yet I think we've seen over the last several years a tremendous overall growth in the Medicare Advantage market. So there's something else going on.

Are there equal numbers of switches coming over from the traditional Medicare? Or, as I said, the med sub -- well, let me start there.

**DR. McCARTHY:** I think you're right. The trend since I think 2004 has been a fairly consistent upward penetration of Medicare Advantage plans. And I do think there are a number of different things going on, and a number of different adjustments going on having to do with
what the subsidies are and whether they're going to taper off, having to do with the baby boomers that are aging in and whether they're more comfortable in a managed care type setting. And all of this kind of varies state by state, but I think the point I want to -- would like to have us all take away is that the traditional Medicare puts a constraint on managed -- or Medicare Advantage programs by being this alternative that caps what -- you know, what Medicare Advantage plans can do. And that's what I need to establish to understand that there's no competitive problem that's going to occur.

**MR. CHAIR:** You broke the Medicare market down into MSAs at one point. Is there any reason not to have looked at it as the Medicare Advantage market on a standalone basis, which of course would significantly increase the overall shares to somewhere close to 50 percent, I believe, post merger?

**DR. McCARTHY:** I don't know that it's that high, but the answer is that our analysis in the position that we think is supportable, and there's evidence for, is that both of these types of approaches constrain each other. Traditional
Medicare constrains the Medicare Advantage plan and that's why they're put together. It's because of the theory that they affect each other, that they're substitutes for each other.

**MR. CHAIR:** Okay.

**MR. JOHNSON:** Just one followup to that.

Did you consider all the changes that are going to happen in 2020 to traditional Medicare? You're actually looking at no first dollar coverage and, you know, greatly, I guess, shift in the dynamics of what we were getting with traditional, and how it would impact the competition between MA and --

**DR. McCARTHY:** I have not looked at that. 2020, that happens, I have not looked at that.

**MR. CHAIR:** I would like to remind all of us, which I violated a number of times now, that since we are being recorded and people are listening in, we're supposed to introduce ourselves. So I apologize to the general public that didn't know. I was speaking -- this is Rich Robleto speaking to Dr. McCarthy. And Eric Johnson, followup question.

**MR. WHITMER:** Any other questions, Mr. Robleto?

Thank you.
At this time, Aetna would like to call
Mr. Gregory Martino as its next witness.

EXAMINATION

BY MR. WHITMER:

Q  Mr. Martino, could you go ahead and explain, what
is your current title?

A  Yes. Currently I am employed by Aetna as an
assistant vice-president for state government relations for
Aetna, Inc.

Q  And what are your responsibilities, what's your
role in that capacity?

A  Working in the state government relations area,
it's a broad area, including legislative regulatory NAIC
issues. I am spending a significant amount of time on
mergers, acquisitions in the regulatory side, dealing with
state regulators as well as other duties I have.

Q  Now, before you came to Aetna, you spent many
years in the insurance industry. Could you tell us what
you were doing?

A  Yeah. I spent 10 plus years with the
Pennsylvania insurance department in various capacities. I
was director for market conduct when I first began at the
Pennsylvania insurance department. I then moved on to
deputy insurance commissioner for consumer services and
market conduct. I also played a role and was actually, for
the longest period of time, was there as deputy insurance commissioner for insurance regulations, which oversaw tax in the health industry, the PNC industry, and dealt with the impact of rates and forms and market penetration.

And then lastly, I did serve as acting insurance commissioner for a brief period of time at the Pennsylvania insurance department.

Q Let's move on now to this transaction that we're here to talk about today. Just describe for us, what's your role been?

A I've been involved with the transaction here since its initial announcement on July 2nd, and have been very much involved in the forming proper applications that we've done for other states for the application for Florida. Have been very much involved in getting the forms filed with the states. I've been involved with meeting with the states. I have met with all the state insurance departments where we have filed and need approvals. Met with a number of insurance commissioners, senior staff and all those folks, talked to them, explained to them the transaction. I worked with various parties on preparing followup questions, responding to state insurance regulators. And obviously am preparing for hearings such as this one here today.

Q Now, is one aspect of your preparation with
respect to this transaction a review of the Florida statutes, and more specifically, the ten requirements set forth under Florida law with respect to this transaction?

A Yes. As part of my preparation for the application that we submitted towards the end of July as well as this hearing, I familiarized myself with those statutes.

Q Now, Dr. McCarthy just testified about one of the ten requirements, and I won't ask you any questions about that one, but I do want to ask you about the other nine.

A Okay.

Q Let's start with requirement number one. This requirement provides that the domestic insurers will continue to satisfy the requirements for issuance of a license in Florida. Now, there are four domestic insurers. Mr. Robleto identified them at the beginning. Mr. Ventura will be providing some more specific testimony on each of the four. What I'd like for you do, sir, is to just confirm that the licensure requirements for all four of these domestic insurers has been satisfied.

A Yes. The licensing requirements for those four domestic insurers, they all currently are licensed under the Florida statutes, currently meet those requirements and continue to do so and are in good standing today.

Q I'd now like to direct your attention to a
post-transaction period. What assurances can you provide for us that these four domestic insurers will continue to satisfy licensing requirements on a going-forward basis?

A  Post transaction, Aetna currently has no plans to make any material changes to the operations of the business of these four domestic insurers, really nothing that will adversely affect their maintaining a license in good standing in the State of Florida.

Q  Does the Aetna compliance department have any weigh-in there?

A  Aetna has a very strong, robust, very active compliance department. As part of that, we monitor and the compliance department works on all of these what I'll call the family of legal entities that Aetna has throughout the country. And post transaction these four domestic insurers will be part of the Aetna family, legal entities, and the same robust, proactive compliance that applies to those individuals, to those other Aetna life -- Aetna insurance companies will also apply to these four domestic insurers.

Q  Moving forward to requirement number two, Mr. Martino. This concerns whether the financial condition of Aetna will jeopardize the financial stability of these four domestic insurers, or prejudice the interests of their insureds or the public. Now, Mr. Robleto at the beginning provided some background information on both Aetna and
Humana. What I would like for you to do is confirm for us that Aetna has the financial strength to meet this requirement.

A Yes. Aetna has a very strong financial strength and will meet this requirement. Aetna is a very longstanding insurance company, dating back to 1853. It is a Fortune 50 company. It is a large national insurance company. And in 2014, it had a revenue of approximately $58 billion.

Q So you can confirm for us that requirement number two has been met here?

A Yes, I can.

Q Then let's move forward to requirement three. This concerns whether this transaction is fair and free of prejudice to the insureds, of these four domestic insureds, and to the public. Has that requirement been met here? And if so, could you explain why?

A Yes, that requirement has been met, as Mr. Fran Soistman discussed earlier through the presentation, a number of the benefits that would occur to the current insureds, to the providers, to the employers, and to the state. So he really laid out very well in the presentation. We hope you can pick up some of those pieces that really would benefit the overall insured's -- and the general public.
Q Can you confirm for us, Mr. Martino, first that -- whether there are any intentions to declare extraordinary dividends with respect to these --

A There are no current plans to declare any extraordinary dividends, liquidate the company, or to make any material changes to its business.

Q Can you also confirm for us, on a going-forward basis, all four domestic insurers will continue to maintain their separate corporate existences?

A Yes. As a result of this transaction, post transaction, Humana will be a separate legal entity. Humana, LLC, will be a direct subsidiary of Aetna. And as a result of that, these four domestic insurers will continue to operate independently under the Humana, LLC.

Q What can you tell us with respect to whether any material changes are anticipated with respect to the boards of directors or the senior management for these four companies?

A There are no plans to make any changes to these board of directors at post closing or at closing, except through replacement that will occur as a result of resignations.

Q Let's move forward now to requirement number four. This concerns the competence, experience, and integrity of those who will either directly or indirectly
control the operations of these four domestic insurers following the transaction. Now, have you had the opportunity, sir, to review the makeup of what the new board will be?

A  Yes, I have.

Q  Could you tell us about that?

A  Sure. At the close -- upon closing this transaction, the Aetna board will be at 12 members. Part of the acquisition agreement is that board of directors will expand from 12 members to 16 members. The four additional members will come from the Humana board. And I think that's important to note because it kind of plays into the fact that we really are valuing their expertise and their knowledge in the Medicare world. So as we talk about these complementary benefits, it's important to bring on the board of directors as well as others, the skill and expertises.

Q  I'd like to direct your attention to the 13 directors for Aetna, Inc.

First of all, do you have familiarity with those 13 individuals?

A  Yes, I do. I've reviewed their biographical affidavits.

Q  And having reviewed the biographical affidavits for all 13, what can you tell us concerning the competence,
experience, and integrity of those individuals?

A They are individuals of high competency, very experienced, and very high integrity.

Q There are currently seven executive officers of Aetna, Mr. Martino. Is that right?

A Yes, there are.

Q What can you tell us about your familiarity with those seven individuals?

A I worked with them, most of those if not all of those individuals, over my 15 years at Aetna and gotten to know them. And I will tell you, in addition to working with them on a number of different projects, I've also reviewed their biographical affidavits.

Q And having reviewed that information and with your knowledge having dealt with many of those individuals, what can you tell us about them with respect to the knowledge, experience, integrity?

A Based upon my experience and their biographical affidavits, I would indicate that they -- state that they are individuals of high competency, integrity, and experience.

Q Now, jumping forward, requirements five, six, seven, and eight, all of those concern the background, the experience, the trustworthiness of the individuals who will be controlling the domestic insurers. And I'm going to put
all those together.

Have those requirements been met here? And if so, can you tell us why?

A As I mentioned earlier, I have reviewed the biographical affidavits and worked with a number of the executives in the committee -- excuse me -- the company, and, as a result of that, I can tell you that they are individuals with very good backgrounds, experience, knowledge, expertise, and would meet the requirements of 53.

Q Now, with respect to the individuals who are the directors and the executive officers of the four domestic insurers, we're going to have Mr. Ventura address that, but for right now, I'd like to move on with you to requirement number nine. And that requirement provides that this transaction is not likely to be hazardous or prejudicial to the insureds or the domestic insurers or to the public.

Has requirement nine been satisfied here? And if so, could you explain why that is?

A Yeah. Requirement nine has been satisfied, as I think Mr. Soistman discussed earlier and explained the various benefits. We can clearly see how this will be a benefit to the various stakeholders and the various parties of the domestic insurers as well as Aetna. And as a result of that, we believe -- I will tell you that we have met
that requirement.

Q Now, the tenth factor is the one that Dr. McCarthy already addressed. I'm not going to ask any questions on that. But before you complete your testimony, are there any additional comments that you'd like to make to Mr. Robleto and this panel?

A The last and concluding statement I'll make is really, as we look at this, this is really a transaction of bringing together two complementary companies. And it really -- Aetna, who really is focused on the commercial side, and Humana, who is focused on the Medicare side. Bringing these two complementary companies together really will bring together and allow for both policyholders on both sides and future policyholders and the public to have access. And the combination will provide high quality healthcare services, more consumer-centric services, more consumer-centric affordable products. The folks at Aetna will have access to the expertise and best of class services that are really out there with Humana now for their Medicare policyholders. And vice versa, where Humana, who has a smaller piece of commercial business, really will have the access and ability to reach into Aetna's whole investment class services. And that's why we really do believe this is really a good opportunity to bring this together for the public and the policyholders.
Beyond that, I would simply ask for -- thank you for your time and ask you for approval on the transaction.

Mr. Whitmer: Mr. Robleto, I have no further questions for this witness, but I want to give you an opportunity, or the panel.

Mr. Chair: Again, we may come back with some questions, but for now, thank you.

Mr. Whitmer: With that, I'm going to ask that we now call Mr. Joseph Ventura as our fifth and final witness to be presented today.

EXAMINATION

By Mr. Whitmer:

Q  Mr. Ventura, could you go ahead and explain to the panel, what is your current role?

A  Sure. Good morning. I'm the associate general counsel and assistant corporate secretary for Humana, Inc., and for each of our subsidiaries.

Q  And in that role, could you describe for us what are your typical responsibilities?

A  Sure. Since I joined Humana in 2009, I've been involved in a variety of legal endeavors. Typically provide mergers and acquisitions, activities, securities laws advice. Advise our board and our management team in upholding the fiduciary duties and the strategic direction
of the company.

Q Now, sir, you're also involved with the transaction. Could you explain to the panel what that involvement has entailed?

A Yes. I first became involved with the transaction in March when it first came to the attention of our board of directors. And, since that date, have worked to advise and provide legal advice to our board, to the management team of Humana, and evaluate the transaction, negotiating the transaction and the strategic merits of the transaction.

Q Now we're going to move over to the four domestic insurers. We heard a little bit about them. Now, we don't need to know a lot of facts about them, but I would like a little bit of general background information on the four domestic insurers we're talking about here today.

Let's go ahead and start with CarePlus Health Plans, Inc. Could you give us a little information?

A Absolutely. I'll rattle off some figures that I know you all are very familiar with. CarePlus was founded in 1985. Became part of the Humana family in 2005. Offers Medicare Advantage products. And today we have about 112,000 Medicare Advantage members.

Q The second domestic insurer is Comp Benefits Company. Tell us a little bit about that.
Sure. Comp Benefits is a specialty insurer licensed as a prepaid limited health services organization in Florida. Has about 1.1 million members that's grown over its life. Founded in 1984. Became part of the Humana family 2007 through an acquisition. Today, as I said, 1.1 million members. About 600,000 of those are vision members and 500,000 have dental products with us.

The third domestic insurer is Humana Health Insurance Company of Florida, Inc. Tell us --

Sure. HIC Florida, as we call it. Humana Health Insurance Company of Florida, also founded in the '80s, provides a wide range of products. Today we have about 84,000 members. Approximately 61,000 of those are commercial HMO members. The entity is licensed as a life and health insurer in the state. And the balance are med sup and Medicare Advantage members.

Now, the fourth and final domestic insurer is Humana Medical Plan, Inc. What information can you provide us on that company?

Humana Medical Plan, similar to CarePlus, is licensed here as an HMO, health maintenance organization. Offers a broad range of products. Today about 1.2 million members. 440,000 of those are Medicare Advantage members. Similarly, 440,000 approximately are commercial HMO members. And the balance, 320,000 or so, are -- we assist
through our Medicaid contracts with the state.

Q  Now, you just heard Mr. Martino testify about nine of the ten requirements under Florida statutes. I'm going to go ahead and move on and ask you questions about those same nine. Are you prepared to provide testimony on them?

A  Yes, I am.

Q  Let's start then with requirement number one. This concerns whether those four domestic insurers continue to satisfy the licensure requirements here in Florida. Can you confirm for us that all four of those entities currently satisfy all the requirements?

A  Yes, they do. As I indicated, two of the entities, CarePlus and -- I've gone totally blank. Two of the entities are licensed as an HMO and are in good standing. The other two are prepaid life and life services limits, health services company and a life and health insurer. And all four are in good standing.

Q  Okay. Let's move on then to requirement number two. Mr. Martino talked about the financial condition of Aetna. What I'd like to ask you about is the financial condition of the four domestic insurers and their relative strength. The first one being -- go ahead with CarePlus. What can you tell us?

A  Sure. I would say that each of these four
domestic insurers are very adequately capitalized and
demonstrate tremendous financial strength in accordance
with the way that Humana typically handles our licensed
insurers. CarePlus has approximately $150 million of
statutory capital. Comp Benefits has a little over
13 million. Humana Insurance Company of Florida has over
70 million. Humana Medical Plan has over $458 million of
statutory capital. We well capitalized our insurance
subsidiaries. We expect them to remain that way through
closing.

Q And does this information establish, from your
viewpoint, that requirement number two is met here?
A Yes, it does.

Q Then let's move forward to requirement three.
Again, this requirement provides that this transaction is
fair and free of prejudice to the insureds of the Florida
domestic insurers and to the public. Has that requirement
been satisfied here? And if so, could you explain why it
is?

A Yes, it has. We have heard a great deal today
about this transaction and how it brings together
complementary capabilities really to create a new kind of
healthcare company that can offer value-based
consumer-centric care. This new type of healthcare company
will be in a position to offer a broad range of products
for consumers at large, which can only have a beneficial
effect for policyholders and for the broader public.

Q Moving on to requirement number four, Mr. Martino
provided testimony about Aetna directors and Aetna
executive officers. What I'd like to ask you about are the
directors and the executive officers of these four domestic
insurers. But let's start with the directors. Can you
tell us, what is your familiarity, what is your knowledge
with respect to the directors of these four domestic
insurers?

A I know each of the directors of each of the four
domestic insurers personally through working with them over
their careers and my career at Humana. In addition, I've
also familiarized myself with their biographical
affidavits.

Q And based on that information and knowledge, what
is it you can tell us of these individuals?

A I can tell you that, without question, each of
them is of the utmost integrity, tremendous experience with
the insurance industry, and they're extremely competent.

Q With respect to the executive officers now of the
same four domestic insurers, could you also explain what is
your background or knowledge concerning those individuals?

A Sure. Similarly to our directors, I know each of
the executive officers, with very few exceptions,
personally through interactions with them over a number of years. Those exceptions are only due to geographic locations in a couple of instances. And one of the gentlemen recently joined Humana, so I'm not as familiar with them. I have, however, reviewed all of their biographical affidavits, including the recent hire. So I can tell you that each of them is also of the upmost integrity. They each have a number of years experience in insurance industry and they're all extremely competent.

Q As with Mr. Martino, we went through requirements five, six, seven, and eight, and we're going to put them together for you as well. These requirements as we discussed collectively concern the background, the experience, and the trustworthiness of these same individuals. Have you had the opportunity to review, first of all, those requirements?

A Yes, I have.

Q And can you tell us whether you believe those requirements have been met? And if so, explain why.

A Yes, I do. Knowing these individuals as I do, I have no reservations testifying that they are each of the upmost integrity, trustworthiness, they all have tremendous experience and background in the industry.

Q That takes us to the final requirement we're going to discuss with you. That's requirement number nine.
And, again, requirement nine provides that this transaction is not likely to be hazardous or prejudicial to the insureds of the domestic insurers. Has that requirement been satisfied here? And if so, could you explain why it has?

A Yes, it has, for the same reasons that I articulated earlier. The bringing together of these two companies will be bringing together complementary capabilities to provide a broader choice that will only benefit the insureds of the domestic insurers.

Q And, again, Dr. McCarthy has addressed requirement number ten, and so that concludes the ten requirements.

But before we complete your testimony, I'd also like to give you an opportunity to provide any additional information that you believe that the panel, you believe, should hear at this point.

A Sure. I have to go last, so challenging the eloquence of the panelists here, it will be difficult. I will keep it very simple. Thank you for your time today. I want you to know that we at Humana are very excited about this transaction. We are excited about what this transaction could do for our bold goal to make all the communities we serve 20 percent healthier by 2020.

I think of this very simply. We have a
Diagram of our integrated care delivery model, and at the center of that diagram is the member. Wrapped around that member are clinical capabilities, the data analytics, the member experience, all of the things that we bring to bear to help that member achieve their best health. And I think of this transaction as wrapping more things around that member, taking the best things that Humana does, taking the best things that Aetna does, combining them, and creating more healthy days for our members.

MR. WHITMER: Thank you, Mr. Ventura.

Mr. Robleto, with that, that concludes the direct examination of our five witnesses. And certainly we'll make them available now for any questions or however you'd like to proceed.

MR. CHAIR: Thank you all very much for very informative presentations. I think what I would like to do is to perhaps take about a ten-minute break at this point. Let the panel and I get together and talk over questions we may want to come back and ask your witnesses.

So, if you don't mind, we will take a ten-minute break, I hope.

MR. WHITMER: Thank you.

(Brief recess.)
MR. CHAIR: Didn't think we'd make ten minutes. I apologize it took a little bit longer, but I think we all could have used the potty break.

Well, I would like to thank the witnesses for a very comprehensive presence today. I think you answered an awful lot of our questions. We may touch base on a couple of things that you have already discussed just to make sure that we completely understand. We have prepared some questions that we would like to direct -- Mr. Whitmer, would you like me to direct them to you and you farm them out, or how would you like us to --

MR. WHITMER: Mr. Robleto, that sounds like a good idea.

MR. CHAIR: Okay. I think early on Mr. Soistman focused on the concept of part of the rationale behind this acquisition was to simplify Florida policyholder transactions with the companies. And I wonder if he could explain that just a little bit. And then at the same time, perhaps expand on -- I don't think we touched on the impact that we're seeing for providers or for agents if the acquisition goes forward. So I wondered if somebody could better explain,
simplify, and tell us a little bit about the impact on providers and agents.

**MR. WHITMER:** Sure. I'm going to direct that question to Mr. Soistman. And if you could go ahead and make sure the microphone's turned on, that would be great. Thank you.

**MR. SOISTMAN:** Thank you. Simplification is probably a description that does need some further explanation.

**MR. CHAIR:** Complicated.

**MR. SOISTMAN:** Exactly. But, you know, our vision is that we want to give our members, consumers, the citizens of Florida a better experience from the very beginning, from shopping experience for health insurance, the shop buying world, all the way through the administration of those benefits, accessing providers. It's a complex environment today. We want -- when you think of the average consumer today, when he or she makes purchasing decisions online, you know, shopping through Amazon or one of the other online organizations, they have a very predictable experience almost every time, something that leads to a high level of satisfaction. That's what we're striving for for everything, from the very
beginning all the way through the end, and making
the experience more understandable, less
error-prone, so that that end-to-end experience --

In fact, one of our biggest initiatives that
we've been working on is achieving business
excellence. And it's an end-to-end commitment to
having a very streamlined process of everything
that touches the consumer, because we know that, in
a consumer-centric world, consumers will vote with
their wallets. And if we're not taking care of
them, they're going to leave us. And that's not a
good outcome. That's a very bad outcome. So
everything about simplification is making sure the
consumer's experience is one that they feel -- they
feel good about. They make the determination.

So I hope that provides a little clarification
in terms of what we're striving for.

MR. CHAIR: I think it does as far as the
simplify. We use words kind of loosely here. We
keep talking about this as an acquisition, and yet
there were many times where we talked about post
merger. And I think, when consumers hear the idea
of merger, there can be concerns raised, you know,
am I going to have to terminate my coverage with
the Humana entity to be a part of an Aetna entity
or something like that.

So can you expand a little bit more on what impact the typical consumer that hears my company's merging together with another company that would provide some comfort level to them or some reasonable expectations of what they can expect?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: Sure. I think we have to acknowledge that bringing these two organizations together will take time, many years to bring everything together, so I think of it sequentially. And we want to minimize, to your point, any kind of hassle, disruption, additional burden or work depending on the commercial segment where employers may be doing a lot of that already for them or the Medicare Advantage or Medicaid. Each of those may be a little different, but the overarching goal is to make sure that our consumers have minimal impact over a period of time.

For example, with the Medicare Advantage program, CMS gives us three years to essentially consolidate our contracts. And that is ample time to make sure that we can do this in a way that is minimally disruptive to our current members and prospective customers. So that's --
MR. CHAIR: So for Medicare, it's actually a federal requirement that you merge the two?

MR. SOISTMAN: We would have to bring the contracts together over three years. For example, on the Medicare Part D, we're only allowed to provide, under current regulations, three different product options. For those three years, we'll be able to each offer our three. But by the end, we would have to have what might be six down to three.

MR. CHAIR: And might a consumer not expect that we would have something similar taking place in at least the commercial markets as well?

MR. SOISTMAN: Absolutely. And again, reminding that this is a very complementary transaction, where Aetna's commercial business is substantially larger than Humana's nationally and here in Florida as well. We would do that based on the individual, individual market, the small group market, the large group market. They might each have a different experience depending on whether it's an employer-based decision or a consumer decision.

MR. CHAIR: Okay. Let's talk about providers or provider network, which was not necessarily discussed a great deal, I think, in any of the
presentations or on the agents. Can you tell an
agent what he might expect to see as a result of
this transaction? Can you tell providers what they
might expect to see as a result of this
transaction?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: Sure. Let me begin with
providers. Providers are -- when we describe a
health insurance product, I think often we think of
it in terms of the benefits themselves, but in fact
the product has as much to do with the providers
that are available to provide those benefits. So,
providers are, you know, front and center in terms
of how we will bring these organizations together
and preserve those relationships. But, as I
mentioned in my comments, we're evolving from a
fee-based or paying for volume of services to
paying for value to more value-based care,
value-based payment. And we're looking with -- to
providers to embrace that as well and will work
with us to achieve that so that we are paying to
achieve better quality outcomes for their patients,
our members.

So providers -- and I should also say that one
size network doesn't fit all. So I envision that
we'll continue to offer a variety of networks, be it an HMO, a PPO, a point of service, an ACO, they'll be choices, and those choices will be dependent upon whether the employer has something specific to their needs or the individual market, they'll have options as well. So, you know, working with providers is paramount to our success, and having the right partners to -- who share our vision of a consumer-centric model and a value-base model.

With respect to brokers, I would say the same occurs. They're an important part of our distribution system today, and I believe they'll be an important part in the future, though I think consumers are becoming much more comfortable shopping online, for example. So their role may diminish over time, but nevertheless there will be certain consumers and certain groups who will always want the advice and counsel of a broker or an agent. And we'll, you know, continue to have them as a part of our distribution system in the future.

**MR. CHAIR:** Any additional questions?

**MS. MOSTOLLER:** Yes. Mary Mostoller.

I want a little clarification, if I may have.
If I'm currently a Humana policyholder, primary care physician already have, use my hospital in the neighborhood and so forth, as a result of this transaction, am I going to possibly lose access to those doctors or that hospital or that clinic, or are they still going to be there for me through this transaction?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: It's a great question. And, yes, I think it's fair to say that we have a couple different models here, because Humana owns or has strategic relationships with many provider groups, and those models will continue well into the future. Likewise with Aetna, with our ACO relationships, we would preserve those. So, there is no intention here of somehow blowing up the current networks that we have today. Back to my point, that they're as much a part of the product that we offer as the benefits themselves. So having those relationships is very critical.

We want to evolve those relationships, though. I want to emphasize that we have to move to a value-based care as a nation, as a state here in Florida, particularly with 19 percent of your population being Medicare eligible. And that
number's going to continue to climb. We have to get value-based care and providers are critical partners to make that happen.

MR. CHAIR: Thank you.

We have one open question regarding competition and Dr. McCarthy's presentation. Dr. Johnson would like --


I just wanted to have a quick followup on the individual market, Dr. McCarthy. I guess one of the things you talked about was the ease of access and getting into the exchanges and being a little -- new competitors and that kind of thing. I wondered if you have any thoughts on, if you had looked at what would happen if people started to leave that market? I know, for instance, recently there's a major carrier nationwide that has expressed a concern about the performance of that market for them and maybe talked about withdrawal. So I want get your thoughts on any competitive influence that has on your analysis.

DR. McCARTHY: Sure. That one insurer who has threatened to leave is only saying, I think, that while their experience has not been good to date,
that they'll reconsider and they'll evaluate the different options that they have. I would steer away from that side of the group that's offering services and look more at the Centene side that we talked about.

There's this logic about a churn that can go on between an exchange where subsidies are given and a Medicaid market where some people, some low income people are in and out of work, they're in and out of -- whether they're eligible for Medicaid, whether they're -- but yet still eligible for a subsidy. And there's a thought that that churn presents an opportunity for the Medicaid managed care providers or insurers to actually keep that patient or keep that member, whether they're in Medicaid at that moment or whether they're on the exchange. So, I think that's part of what triggered a lot of the Medicare -- Medicaid managed care companies to look at the exchanges.

And so you've got Centene aggressively pursuing it and being -- apparently successfully pursuing it. They've got a different cost structure than United, the one that you're alluding to. And you've got other Medicaid managed care companies that are similarly positioned, Molina
being the one that's already entered the exchange market and Amerigroup being a pretty logical example of one who would follow on, too.

So, on the one hand, you talk about those that may be reconsidering it from year to year have to make a business decision whether to stay in the exchange or not. And you have those that are positioned to be successful in the exchange. I think that's got to be sorted out. I don't -- I think that's one of the reasons these shares are very volatile.

**MR. JOHNSON:** Thank you.

**MR. CHAIR:** As a part of your application, you presented a statement that the merger of Aetna and Humana will enable the company or their combined entity to offer consumers a broader choice of products, access to higher quality and more affordable care, as well as a better overall experience. And I think we've touched base on much of the -- you've described much of what we're talking about there.

Perhaps we didn't talk about the broader choice of products, or is there anything else that you would like to add substantiating the statement that was made in the application?
MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: Thank you, Mr. Robleto. I'd like to maybe touch on two of those aspects. First, broader choice of products. We know that consumers have a broad range of needs, and there isn't a one-size-fits-all solution. And we know that someone who is part of the millennial generation or generation -- or baby boomers or everything in between, their needs are different. And we have to have products and services that respond to those needs. So our portfolio will always be ever-evolving to meet those changing needs.

I also want to touch on quality, because quality can take on a different meaning to different people as well. And I can't emphasize enough how committed Humana and Aetna are. And it's not just in words, it's in actions. If you look at our Star ratings, which I think is just a great example of, you know, demonstrating actions and results for what you really intend to do. And there is a correlation between driving quality results and driving down costs and improving member satisfaction, which is why I like the Stars Rating System so much, because it brings all of that
together. And it holds us accountable, as we should be.

And I think the way we operate, we -- even though we may not have an official Stars rating for our commercial business and some other lines of business, we operate as if we did. And it brings those same quality goals across all of our business. And that, too, is an evolving process.

Technology allows us to get better at things. Just thinking outside the box and solving problems, data informatics, and being able to understand root cause of, you know, why people are going to the hospitals more often or going to the ER facilities more often when they really don't need to be there. How do you solve for that?

So both organizations, I think, have demonstrated high levels of commitment, but also I would say great passion for, you know, bringing about better outcomes for the consumer in satisfaction as well as the quality of their life. It's back to our healthy days. It's not just a slogan, it really is how we view the world, giving our members more healthy days.

MR. CHAIR: Thank you.

My next written question may be what you just
answered, but is it expected the proposed combinations of the organization, subject to this acquisition filing, will result in products, services, or technology the acquiring entity does not currently possess? Maybe the synergy or some access? Just -- you may have already addressed that, but --

MR. SOISTMAN: I probably have, but I'll emphasize, in fact, even in my remarks, you may recall me talking about how we will look for best practices, best systems, best products, procedures, everything that is going to affect our operation is now fair game. Meaning, we'll look at this across both organizations and we'll have leadership from both organizations working together to truly identify this is, indeed, the best practices, whether it's on the Humana side or the Aetna side. And it's going to vary from initiative to initiative. And that's how we approached the Coventry transaction, by the way, and we got a very good outcome. We would approach Humana in a very similar fashion.

MR. CHAIR: I think you've made it clear that the acquisition is not going to result in any changes in management, at least where it stands,
there were no changes in management. Can you share anything about how management is affected by this transaction? How does management benefit? How does management lose? Just anything about the impact. We've talked about consumers and providers and the agents. What about the impact on management of the companies?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: Sure. I would say that our jobs get much more challenging. They're challenging already, as you might appreciate, but bringing these two organizations together, you know, the bandwidth requirements are certainly greater. And, you know, I think we're up for that challenge to run these -- this business, the new combined business, to the highest standards and get the, you know, best possible results over the long term.

There really are, I would say, no other benefits that I could think of in terms of just having an opportunity to play a role in a much larger combined organization, and it's going to test all of us in terms of our ability to step up and operate in a much larger organization.

MR. CHAIR: You talked a little bit -- I
believe it was referenced that Aetna will become a stronger, financially stronger company as a result of the acquisition. Certainly it's a very expensive transaction. Certainly going to be a boatload of debt. Can you talk at all about how Aetna will become a stronger financially -- a stronger company financially as a result of the acquisition?

MR. WHITMER: Mr. Soistman or Mr. Martino, feel free to go ahead and answer. I think both of you --

MR. SOISTMAN: I'm happy to start --

MR. WHITMER: Why don't you start.

MR. SOISTMAN: -- and ask Greg to supplement.

Again, this is a complementary transaction of bringing the existing commercial strength and capabilities of Aetna together with Humana's world class Medicare managed capabilities. And you're right, initially, there is more debt involved, but we have a plan to work that debt down over two years to -- you know, within a established target. And I think, if you look at the history of Aetna, we have been a very physically sound organization. We're very mindful of our ratings and very mindful to meeting our regulator's requirements, be it at
the RDC levels, and that won't change. We will -- as the organizations come together and we recognize some of the synergies, that will help our financial performance as well.

MR. MARTINO: The only thing I would add is obviously as we bring -- begin developing broader products, looking towards the quality, looking towards all the things we've talked about, the benefits, we really think it will help drive growth, drive membership. Our goal is to grow our membership, grow healthy days for our membership, which will all make us a stronger company from a financial perspective, but also from an operational perspective.

MR. CHAIR: Thank you.

Within various affiliates of Aetna or within various affiliates of Humana there are a number of types of contracts between the affiliates. Are there any types of contracts not previously discussed involving Florida domestic companies that would be canceled post acquisition or some new initiative regarding relationships between the entities?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: Mr. Robleto, I'm not aware of
any such contracts that would be eliminated or terminated.

**MR. CHAIR:** Okay. Aetna is a stock insurer, so they have a fiduciary responsibility or fiduciary duty of profitability that can often -- well, I don't know if it can get in the way, but that often can raise questions about the interest of investors balanced against the interest of policyholders. And can you assure us in any way, is there anything that you would like to talk about about that very difficult balance of satisfying investors, often on a short return timeline, and taking care of the consumers?

**MR. WHITMER:** Mr. Soistman?

**MR. SOISTMAN:** Well, I think our shareholders would expect us to take care of our customers first. Without taking care of our customers, nothing else is possible. So that is always our number one objective.

When you look at the businesses, the lines of businesses, more of them, if not most of them, now have some kind of minimum loss ratio requirement, which by design really does limit the amount of profitability one can achieve.

And to Dr. McCarthy's comments earlier about
just the competitive nature of the Florida market, markets across the country, there's always those checks and balances. Our job is to continue to be mindful of how can we do things more efficiently and eliminate waste and unnecessary redundancy. And bringing these organizations together, in fact, that's where a lot of the savings come back is eliminating unnecessary redundancies.

And then we have to -- talked about simplicity. Simplicity does take out a lot of waste when you do it right. So that's how we'll take care of our shareholders, two ways, you know, how we run our business, but also Mr. Martino's comments, many of the areas we're focusing on are growth businesses.

Back to my comments about Medicare and the -- what we're seeing in America right now with 10,000 Americans aging into Medicare eligibility every day, that continues out for the next 25 years. So there are growth opportunities, Medicaid growth opportunities, individual public exchange growth opportunities. That's how we'll take care of our shareholders in terms of growing our top line, but being very mindful of being lean and efficient so we can offer competitively affordable price
products to our current and future members.

MR. CHAIR: So, if this acquisition is approved, is it your intent to comply with the provisions of Sections 624.318 and 641.27 of Florida statutes, which require cooperation with examinations conducted by the Office, which require making accounts, records, documents, files, information, assets, and any other matters in your possession freely available to our examiners?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: I can say definitively that if you look at the history of the relationship that we've had with the OIR, we have held ourselves to the highest standard. We've made sure that we've lived up to that standard, and I don't expect that to change. So, yes, we will continue to be good stewards and remain in compliance with all of the requirements set forth in regulation.

MR. CHAIR: Thank you.

Was there an independent valuation of the assets being acquired? Did you obtain an independent valuation of the assets being acquired? And can you tell us who conducted it and what opinion there was?

MR. WHITMER: Start with Mr. Soistman. Or if
not, Mr. Martino can follow up.

**MR. SOISTMAN:** I can tell you that, yes, there were independent valuations performed by, I believe, more than one organization at the Board's request. I don't have here today the specifics, but I can tell you that, yes, there were independent valuations performed. I don't know if Mr. Martino would like to supplement that.

**MR. MARTINO:** I'll obviously try to help you out with that. The arm's length negotiation and the arm's length, really, review and analysis done in additional -- firms by independent -- independently reviewed. And I believe one of the organizations was CitiBank who did one of the reviews.

**MR. CHAIR:** Thank you.

Are there material tax implications expected as a result of the proposed acquisition?

**MR. WHITMER:** Mr. Soistman?

**MR. SOISTMAN:** I'm not aware of any, but I will check with my colleagues here to see if anyone has information that I'm not aware of. But otherwise we would come back to you with it.

**MR. MARTINO:** I'm not aware of one either.

**MR. CHAIR:** To date, have any regulatory
decisions been received by the company relative to the proposed acquisition transaction?

MR. WHITMER: Mr. Martino?

MR. MARTINO: Yes. We've received approval from Michigan for our Form A in Michigan. We also received change of control approval in Vermont. In addition to that, we have had additional Form Es approved and others are being worked on. So we have had several approvals from states.

MR. CHAIR: May I ask, are they blanket approval or is there any qualifications to the approvals thus far?

MR. MARTINO: In Michigan, there was. One of the conditions was approval from other regulatory bodies, including state insurance departments that are necessary to review this filing, as well as clearance from the federal bodies necessary to review this.

MR. CHAIR: Okay. Thanks.

One of the things that we're certainly always interested in in Florida is bringing jobs to Florida. And one of the things we're always afraid of is losing jobs in Florida. Can we talk about the workforce? I think you've mentioned about 15,000 employees between the two companies here in
Florida. Will this transaction bring additional jobs to Florida? Is it anticipated that ultimately this transaction will reduce jobs in Florida?

**MR. WHITMER:** Mr. Soistman?

**MR. SOISTMAN:** Sure. I think with -- if you refer back to my remarks, I acknowledge that any time you have a merger and acquisition, there is some risk of dislocation. Where that occurs, we don't know. But I can reemphasize my comments about the importance of Florida. Florida is Aetna's third largest market with respect to employees. It's a great market. We have great employees here in Florida. And I think that holds true for Humana as well.

I mentioned our focus on growth businesses. And when you are successful capitalizing on those opportunities in growth businesses, the jobs will follow. Healthcare is local. So we envision that our local presence will continue to be strong and employment will grow as we grow.

**MR. CHAIR:** Thank you.

Can you provide any update on litigation that may have been settled or is pending or threatened as a result of the proposed acquisition?

**MR. WHITMER:** Mr. Martino?
MR. MARTINO: Yeah. The last piece of litigation up against Aetna was dismissed on -- I believe last week it was dismissed by the parties -- by the party.

MR. CHAIR: Have there been any amendments to the agreement and plan of merger document that you presented to us? I think I quoted from that earlier. Are there any other significant changes between the date of application and today?

MR. WHITMER: I'm going to give Mr. Soistman and Mr. Ventura an opportunity to respond.

MR. SOISTMAN: To my knowledge, no, there have not been any changes.

MR. VENTURA: That's correct from our perspective, no changes.

MR. CHAIR: Okay. Thank you.

So if a policyholder or a stockholder has a specific question, can you provide us with a contact before we conclude our hearing today that we can share with those or make available to those inquiries?

MR. WHITMER: Mr. Soistman?

MR. SOISTMAN: We would be happy to do that, yes.

MR. CHAIR: Okay. Does anyone on the panel
have any additional questions, need clarification on anything that we've heard?

**MS. MOSTOLLER:** Mary Mostoller. You talked about your cost savings today. But is there any of the cost savings that will actually be passed on to Florida consumers in any type of monetary fashion through, you know, just lower out-of-pocket expenses? Anything that you envision?

**MR. WHITMER:** Mr. Soistman?

**MR. SOISTMAN:** We are very mindful of that in Florida and in all of our other markets. When we talked about the 1.25 billion that we expect to achieve in cost savings beginning in 2018, we see that being returned substantially to the benefit of consumers in the form of coverage that they have, lower copays and so forth. But it's also through an investment in how we make products and programs available in the future. So it's really a combination.

But I think it's important to note that reducing the costs is sort of relative, because we also have this medical trend that goes -- continues every year. So I'd like to think of those cost savings as mitigating what otherwise would be a higher -- potentially a higher increase in the cost
of the premium, so this actually defrays some of that.

**MR. CHAIR:** Please.

**MR. JOHNSON:** You mentioned the medical trend and the cost curves, so I have to bring this up. I guess one of the things I hear about when we talk about getting bigger as health companies is you want to try to bend the cost curve and then actually stop that trend or at least significantly slow it. So I guess what is your -- I guess, is this through the -- what is it you see is the most likely area of this change that you're going to -- the process of merging you're going to go through that will help you do that?

**MR. WHITMER:** Mr. Soistman and perhaps Dr. McCarthy as well.

**MR. SOISTMAN:** Mr. Johnson, we look at every element of medical costs continuously, whether it's the unit cost, utilization. We look for areas for waste and abuse. You have to remain vigilant on all of those fronts to really make an impact. And we do that through a lot of data science work, a lot of data mining. And we continue to identify opportunities.

But when I referenced in my remarks Humana at...
Home, for example, a program that is really aimed at the chronically ill population, and it's changing, not just the cost curve, but it's also making a difference in people's lives. And you've got to do those simultaneously. I mean, achieving one without the other frankly would be failure.

So, we -- I point to that program just to illustrate one of many unique programs between our respective organizations that are really aimed at bringing about a better outcome of quality outcome for a unique part of the population, because populations have different challenges.

You know, we look at the health disparities and we have to be mindful of a very diverse population and have initiatives that really reflect the differences in populations and programs that are specific to one group versus another group. That's how we will achieve quality and bend cost curve.

MR. WHITMER: Did you want to add anything, Dr. McCarthy?

DR. McCARTHY: I would only add that competitive pressures are going to guarantee that sort of thing, that Aetna and Humana and all the others in the market are going to listen to what
consumers are doing -- what they need, what they
want, what will improve their health status, what
will be a way to manage their utilization that
helps them, not just takes something away. I mean,
I think we heard Dr. Hernandez talk about the
model, and you just talked about another model that
says managing utilization is something that keeps
people healthy.

I think it's competitive pressures across the
spectrum of all these players that will have all of
them asking what can they do better to sell and to
gain more members.

MR. CHAIR: I think that completes our
questions at this time. I would now like to switch
to the opportunity for public comment. I have
received three public comment request forms. I
will call the individuals. I believe for some
reason I'm going to do it in the order that they
were provided to me.

So, I would like to start with calling Kyle
Sanders. He's from Duval County and represents
St. Vincent's healthcare.

Mr. Sanders?

MR. SANDERS: Good afternoon. Thank you for
having us. My name is Kyle Sanders. I'm the
president of Population Health and Care Continuum at St. Vincent's healthcare in Jacksonville. And I'm honored to be here to advocate on behalf of this acquisition.

St. Vincent's healthcare is a fully integrated network that exists within Jacksonville. We have hospitals, represent about a thousand beds, approximately 200 employed physicians. And we really feel like we're on the leading edge within our community in moving towards a value-based care. And we really like to talk about it around patient-centered holistic care for our patients.

St. Vincent's is also part of Ascension healthcare, which is the largest Catholic and the largest not-for-profit system that exists within the United States. We've really enjoyed an exceptional relationship with Aetna. We've had a collaborative relationship where we've gotten together on many products. We worked together on a Medicare Advantage product. We worked together on some of the exchange products as well as commercial that they have.

And what we've enjoyed is the fact that we've been able to sit together and share data, talk about how we're doing both on the costs and the
quality side. We've been able to look at it all the way down to our individual provider level. We've been able to actually move the needle both on the cost side as well as on the quality indicator side, as we've looked at individual providers and how we've talked about how we changed the lives of some of those patients that have been in that area. Recently actually got to celebrate some successes that we had with some of our state and local executives with that. So we were very proud, because we felt like that made a difference in the lives of the patients that we serve. So, as a partner with Aetna and as a partner also with Humana, we feel that this merger will actually provide a stronger company.

We agree on the collaborative nature and on the complementary nature of their products, and that this is something that's going to help benefit our patients in our community within Jacksonville. And I appreciate the opportunity to advocate on behalf of the organizations.

**MR. CHAIR:** Thank you very much.

Does anyone on the panel have any questions for Mr. Sanders?

**MR. SOISTMAN:** Thank you.
MR. CHAIR: Next I'd like to call Mr. Jay Wolfson, representing University of South Florida Health, USF Health.

MR. WOLFSON: Good afternoon.

MR. CHAIR: Good afternoon, Mr. Wolfson.

MR. WOLFSON: Pleasure to be here. Thank you for giving me the opportunity. My name is Jay Wolfson. I wear a bunch of different hats. I'm a professor of public health, medicine, and pharmacy at the University of South Florida. I'm the associate vice-president for health -- policy at USF. And I'm also the senior associate dean for the Morsani College of Medicine.

And in those capacities for the last 30 some odd years, I've worked closely with the state, conducting collaborative studies with colleagues at FSU and Gainesville on health services research issues, quality, outcome safety, costs, trying to find out how we can measure it, how we can improve it.

I spend an awful lot of my time conducting those studies, engaging in the management of professional education and health services across all those colleges, engaging in clinical services, measurement and management, writing a bunch of
grants to support it, federal grants, private grants.

I've had the privilege of working with Humana for several years in our community and I've watched them develop community-based systems of care and focusing on a few special communities. They've done some things in San Antonio and they've come to Tampa now to develop a healthy communities perspective. Their health days count, really a public health concept. Population-based health management. They're not the only ones who are doing this, but the extent to which they're doing it openly and notoriously in some respects in bringing together all the different characters and players in each community makes a real difference.

The complementary strengths of Aetna with its massive financial services and analytics capability, and the strength and experience of Humana in the public health services marketplace come together to make them both stronger. And as we move forward after the Affordable Care Act has been introduced, transparency in what we do, how we measure it and how we report it is going to make a difference in terms of who buys what and how you regulate all of it. It will be a lot more useful
Twenty years ago data weren't very good, even ten years. They're getting much better. And we're all using them. We're using them as consumers, we're using them as regulators, we're using them as researching, and as clinicians to make better decisions. And if we have a larger entity that's capable of synthesizing what they do and structuring it better to improve the data they have to leverage the services that they have, it creates a complement for the community in terms of being able to focus more on outcomes and value. Everybody's going to have to do that. And this is a cool example of doing that.

And it creates what I think is going to be more regulatory transparency, more transparency for consumers, and more of an opportunity for all of us to collaborate more together, which we expect to do at USF with Humana. And I was glad to learn that they're not going to turn the Humana name off, consume it, and simply make a giant Aetna. They're going to maintain the structural and quality integrity of what Humana has done.

And I just made the three minutes.

MR. CHAIR: Thank you very much.
Any questions?

Thank you. Our third speaker request form comes from Bill Herrle, the National Federation of Independent Businesses. Mr. Herrle?

MR. HERRLE: Thank you, Mr. Robleto. Glad to see you. Bill Herrle with the National Federation of Independent Business. We represent independent business owners across the state, about 10,000, as you know, Mr. Robleto. I've been doing that for quite some time. My history in advocating for the business community started in 1989 with -- and I've been proud to do that ever since.

I noted that, at the start of the meeting, you pointed out that this is not an adversarial process. That's kind of unusual for this room right here in the Senate, but we'll try to accommodate that by not being adversarial, Mr. Robleto. So, we are neither taking a formal position advocating the approval or disapproval of this merger, but I would like to offer to you my personal testimony in working as an advocate for small business owners for many years.

The corporate culture that I have found, out of both of these organizations when it comes to voicing the concerns of the consumer and as it is
so often in healthcare, the consumer is the
independent business owner, and their dialogue and
their constant work with us on many, many issues,
not in the least of which is just reminiscing over
the many years. As I was sitting in the audience,
remembering that Humana was a tremendous leader in
bringing transparency issues forward before the
legislature, even this year.

NFIB is working very closely with Aetna on the
balance billing issue, which is very much a
pro-consumer issue. And we find a beneficial
alliance in the corporate culture of both these
organizations and wanted to take the opportunity to
relay that to you, Mr. Robleto, and the Office of
Insurance Regulation.

MR. CHAIR: Thank you, Bill. Thank you very
much.

My plan was to suggest that if Aetna
representatives wanted to respond to any of the
public testimony, I'll give you that opportunity.

MR. SOISTMAN: I would like to respond with
just a heartfelt thank you.

MR. CHAIR: I guess, before I did that, is
there anybody else present that would like to come
up and speak?
Okay. Are there any final questions from the panel members?

Well, I again would like to compliment you on the tremendous presentation that you provided. Very comprehensive information, your ability to answer all of our questions. So, again, I thank you very much for your presentation.

As I mentioned earlier, we are not going to make any decisions today, but we will take into account in our decision-making all of the information that we have received today and any information that we receive from the public over the next ten days.

So, again, reminding the public that, to make a comment, send an email to Aetnahearing@FLOIR.com. And we will take into consideration whatever additional comments we have.

Again, thank you very much. Thank you all in the audience for participating and being with us. And hope you all have a great afternoon.

(Hearing concluded at 1:00 p.m.)

*   *   *

ACCURATE STENOTYPE REPORTERS, INC.
CERTIFICATE OF OATH

STATE OF FLORIDA:
COUNTY OF LEON:

I, the undersigned authority, certify that said designated witness personally appeared before me and was duly sworn.

WITNESS my hand this day of , 2016.

--------------------------------------
TRACY L. BROWN
NOTARY PUBLIC
2894-A Remington Green Lane
Tallahassee, FL 32308
(850) 878-2221
tbrown567@comcast.net

My Commission Expires: July 24, 2016
CERTIFICATE OF REPORTER

STATE OF FLORIDA:
COUNTY OF LEON:

I, TRACY L. BROWN, court reporter and Notary Public do hereby certify that the foregoing proceedings were taken before me at the time and place therein designated, and that the foregoing pages numbered 1 through are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the foregoing action.

DATED THIS day of , 2016.

________________________________________
TRACY L. BROWN
2894-A Remington Green Lane
Tallahassee, FL 32308
(850) 878-2221

ACCURATE STENO TYPE REPORTERS, INC.