Statement for the Record: The National Community Pharmacists Association (NCPA)

United States House Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Hearing: "Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna"

February 27, 2018

Chairman Marino and Ranking Member Cicilline, and Members of the Subcommittee:

Thank you for conducting this hearing on competition in the pharmaceutical supply chain and on the pending merger of CVS Health and Aetna Inc. that is currently under review at the Antitrust Division of the Department of Justice ("DOJ"). NCPA represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion healthcare marketplace and employ more than 250,000 individuals on a full or part-time basis. These pharmacies dispense approximately 40% of all community pharmacy prescriptions and are often located in underserved rural or urban areas.

In this statement, NCPA will highlight how increased consolidation in the healthcare industry may be contributing to higher costs and negatively impacting patient choice. NCPA will also address several potential issues and pose questions related to the CVS Health/Aetna Inc. merger and the broader implications on the healthcare industry. NCPA recommends that the proposed merger between CVS Health and Aetna Inc. be closely examined to determine whether this transaction will lead to lower quality/fewer options for patients, higher costs, and less competition in the healthcare market.

Potential Implications on Pharmacy Choice for Patients

The proposed CVS Health/Aetna Inc. merger raises several questions regarding its impact on pharmacy choice for patients. A recent Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad,* found that just three pharmacy benefit managers ("PBMs") account for 85% of the market.[1] CVS Caremark, the PBM business for CVS Health, is the second largest PBM in the U.S., covering approximately 34% of covered lives.[2] This significant market share allows CVS Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves. Community pharmacies have very little negotiating power when contracting with PBMs like CVS Caremark, and routinely must agree to take-it-or-leave-it contracts to be a part of the PBM's pharmacy network. In some cases, even if a pharmacy is willing to accept onerous contract terms, the PBM will exclude certain pharmacies from their networks altogether, limiting patient choice. Aetna,

[1] Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad*, Feb. 2018, *available at* https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

[2] According to CVS Health, it has 90 million PBM plan members. *See* CVS Health, *available at* https://cvshealth.com/about/facts-and-company-information. The Pharmaceutical Care Management Association testified that PBMs administer drug plans for more than 266 million Americans. *See* Testimony of Mark Merritt, Pharmaceutical Care Management Association, before the United States House of Representatives Energy and Commerce Committee Subcommittee on Health, "Examining the Drug Supply Chain," Dec.13, 2017.

for which CVS Caremark administers the pharmacy benefit, has already engaged in this practice as the 2018 plan year marks the second consecutive year that many independent pharmacies were excluded from the opportunity to bid for preferred status in Aetna's Part D pharmacy networks. Having the opportunity to be a part of a plan's preferred network is critical, as nearly all Part D plans in 2018 include preferred networks that offer lower co-pays to beneficiaries in exchange for lower reimbursement to the pharmacy. Additionally, the opportunity to be in preferred networks allows pharmacies to evaluate a potential benefit of increased volume of consumers from those preferred network patients.

Indeed, Aetna has already engaged in problematic practices with respect to its pharmacy networks. CMS sanctioned the company in 2010[3] and again in 2015[4] for misleading seniors about which pharmacies were in-network. According to CMS:

> *Aetna reported that a total of 6,887 non-network retail pharmacies were erroneously identified by Aetna as "retail in-network" for 2015 on its website and through its call center customer service representatives during the calendar year 2015 Annual Election Period. Beneficiaries that selected a plan based on its in-network pharmacies may have been misled by this incorrect information.*
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> *The confusion created by errors in Aetna's pharmacy network directory on their website led to disruption in the marketplace. After January 1, 2015, many Aetna enrollees presented with a prescription at their usual pharmacy only to discover that the pharmacy was not in their plan's network. These enrollees complained because they either had to pay cash at the point of sale for their prescription (and seek subsequent repayment from Aetna) or to leave the pharmacy without their drug. Aetna's complaint rates for Part D issues were five times greater than the complaint rate for all MA-PD and PDP parent organizations.*
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> *Aetna's 3,767 complaints accounted for 33 percent of all complaints received by CMS. Of those complaints, 2,750 (73 percent) were marketing complaints that beneficiaries were misled about in-network pharmacy coverage.*

Merging a pharmacy/PBM with a health plan will only solidify problems with respect to pharmacy access issue especially in underserved areas. PBMs like CVS Caremark already direct or incentivize patients into certain pharmacies based on prescription benefit design. For example, the PBM can create a design that offers patients a lower co-pay at their own mail order pharmacy or retail stores than at the community pharmacies with which it contracts. An entity that controls the healthcare benefit as well as the prescription drug benefit will give consumers even less control over their choice of healthcare providers.

The Department of Justice should closely examine whether this transaction -- that will create a vertically integrated health plan, pharmacy benefits manager, and pharmacy chain -- will result in substantial access issues for patients who want to continue to use their local community

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[3] Manos, Diana, Healthcare Finance, *CMS issues sanctions against Aetna*, Apr. 12, 2010, *available at* http://www.healthcarefinancenews.com/news/cms-issues-sanctions-against-aetna.

[4] CMS, *Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug and Prescription Drug Plan Contract*, Apr. 16, 2015, *available at* https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/AetnaCMP4162015.pdf.

pharmacy or existing healthcare providers. CVS Health operates the largest pharmacy chain in the United States with approximately 9,700 retail locations and has significant share in many markets. Will the merged entity be able to use their dominant position to increase payments to CVS pharmacies? Conversely, will health plan competitors foreclose CVS pharmacies from their plans?

For example, will Aetna adopt a plan design that only allows Aetna customers to access CVS' Minute Clinics (or raise costs to competitors who want access to the clinics for their beneficiaries)? Will Aetna direct patients into CVS Minute Clinics rather than the healthcare provider of their choice? Will those patients also be incented to use the CVS pharmacy where the Minute Clinic is located, leaving the patient with little choice in where they receive their healthcare?

The Department of Justice should also examine whether Aetna will require or strongly incentivize patients to use CVS Health's mail order and/or specialty pharmacies. Forcing patients, particularly those that have more complex conditions that require specialty drugs, to get their prescriptions from a pharmacy with which it has no personal relationship severely limits patients' choice and may impact the quality of care and adherence. Will this transaction force more patients to use CVS retail or mail order pharmacies despite a preference by consumers to use their pharmacies of choice?

NCPA is not alone with concerns about patient access. Recently, several HIV/AIDS patients sued CVS Health, alleging the pharmacy leveraged insurance laws to force patients to fill their prescriptions at CVS pharmacies or CVS Health's mail order company.[5] If the patient chose to obtain their prescription drugs from a different pharmacy, the patient faced thousands of dollars in costs to obtain the drugs. Patients reported a number of other issues with patients being forced into using one pharmacy provider, including that a patient who received drugs from CVS' mail order program, had his drugs left outside his home, "baking in the afternoon sun."[6] NCPA has also received over a hundred photographs of mail order waste from CVS and other mail order pharmacies in which millions of dollars of unwanted prescription drugs have been sent to consumers. These consumers seek out their local pharmacists' help in disposing these unnecessary and often costly drugs.[7]

Thus, there are serious questions as to whether patients will continue to have access to their preferred pharmacies and other healthcare providers and whether quality and service will be negatively impacted to the detriment of patients.

Potential Implications on Patients' Healthcare Costs

The merging parties have stated that the proposed transaction will create efficiencies and save hundreds of millions of dollars for consumers. They have not, however, explained whether those purported savings will be passed on to consumers. The largest PBMs already claim their size

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[5] Herman, Bob, Axios, *HIV patients sue CVS over pharmacy networks*, Feb. 21, 2018, *available at* https://www.axios.com/cvs-pharmacy-lawsuit-hiv-1519160365-c6f5527a-f5f2-429d-b817-6a9ea321335d.html; *see also John Doe One et al. v. CVS Health Corporation*, Case No. 3:18-cv-1031, N.D. Cal. (filed Feb. 16, 2018).
[6] *Id.*
[7] NCPA, *Waste Not, Want Not*, *available at* https://www.ncpanet.org/pdf/leg/sep11/mail_order_waste.pdf.

enables them to achieve significant efficiencies and cost savings. As patients' out of pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers. Will savings from this merger be passed along? Did the 2012 merger of PBMs Express Scripts and Medco result in consumer savings? NCPA suggests the answers to these questions remains unclear but warrant careful consideration by the Department of Justice.

As discussed above, many patients that visit CVS Minute Clinics are likely to pick up their drugs at the CVS pharmacy. NCPA questions whether picking prescription drugs up at a CVS will result in lower costs? Will CVS use the proximity of its store locations within its Minute Clinics to extract higher payments from healthcare plan sponsors?

In addition, will the combined company force more mail order on patients who often pay more for costlier drugs in the mail order program? It is a common misconception that steering patients into mail order will lower drug costs for consumers.[8] Evidence demonstrates that mail order pharmacies consistently dispense costlier brand-name drugs and fewer generics than retail pharmacies. As a "price giver" and a "price taker," mail order firms can manipulate pricing schemes. Plan Sponsors (employers, the federal government, individual purchasers) are often misled into thinking their overall prescription drug costs will be lowered by moving to mail order. At the end of the day, a shift to more mail order will lower the rate of generic dispensing, ultimately raising drug costs. In comparison, community pharmacies dispense generics 88% of the time.

General Questions that Arise from the Merger

Finally, NCPA would like to highlight several additional questions about the proposed merger:

- Will a combined CVS/Aetna limit selling its PBM services to certain health plans or conversely, will health insurance payers exclude CVS/Aetna from its pharmacy network or as its PBM?
- Will the deal essentially "cut out" one of the big 3 PBMs therefore lessening bidding intensity by PBMs offering their services to health plans?
- Will the deal create a potential horizontal issue by eliminating existing CVS Caremark/Aetna bidding competition in the market for provision of PBM services to non-health insurer plan sponsors, including employers and unions?

Conclusion

As the healthcare system continues to consolidate, healthcare costs continue to increase, and patients have fewer choices. Members of this subcommittee should be concerned with this trend and encourage close examination of the CVS Health/Aetna merger to determine whether the transaction will result in significant anticompetitive effects. Thank you for considering NCPA's concerns.

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[8] *A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies*, *available at* http://www.ncpanet.org/pdf/leg/feb13/comparison_costs_dispensing_prescriptions_retail_mail_order.pdf.

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Re: Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna

February 27, 2018

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on competition in the pharmaceutical supply chain and the proposed merger of CVS, the largest U.S. pharmacy chain in the United States and one of the two largest pharmacy benefit managers (PBM), and Aetna, the third largest U.S. health care insurer. We commend the House Committee on the Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law for holding this hearing and urge Congress to closely scrutinize this massive proposed merger and the potential negative impact it poses to American health care consumers. We are concerned that the proposed merger has the potential to worsen competition (or reduce hopes for amelioration) in three poorly performing markets: PBM services; local health insurance markets; and many local retail pharmacy markets.

The Proposed Transaction Raises Anticompetitive Concerns that are Unique to Vertical Mergers

CVS and Aetna mostly operate from different parts of the supply chain where they do not compete. As with all vertical mergers, the proposed CVS-Aetna merger should be rigorously scrutinized because it involves a firm that already possesses market power at one level of competition.[1]

The primary vice of a vertical merger where one firm possesses market power at one level of competition is that the merger may increase barriers to entry or foreclose competitors, especially where, as here, the merger would require an entrant to enter both health insurance and PBM markets simultaneously.[2] Thus, the 1984 Merger Guidelines provide that a vertical merger may be challenged if it may increase barriers to entry or foreclose competitors.[3]

Vertical mergers may also be anticompetitive where, as here, the vertical integration may facilitate collusion among horizontal competitors (see 1984 Merger Guidelines) or where it may reduce competition by enabling the parties to "raise rivals costs."[4] Whether a vertical merger threatens competitive harm requires predictions about the post-merger conduct of the merged firm.[5]

If the resulting combination of CVS and Aetna harms competition in a single market, that would be sufficient to enjoin the entire transaction to protect consumers.[6]

Health Insurance Markets are Highly Concentrated and in Numerous Markets Aetna is the First or Second Largest Health Insurer

It is now well-established that markets for health insurance are highly concentrated with high barriers to entry, and that they are often dominated by one or two insurers, including Aetna.[7]

The AMA's 2017 comprehensive study of competition in health insurance markets finds that nearly 70 percent of the combined HMO + PPO + POS + EXCH markets are highly concentrated. Moreover,

[1] US Department of Justice and Federal Trade Commission, MERGER GUIDELINES (1984) [1984 MERGER GUIDELINES]).
[2] *Brown Shoe v. United States*, at 323 (describing foreclosure of competitors as "the primary vice of vertical merger").
[3] 1984 MERGER GUIDELINES.
[4] See, Michael H Riordan & Stephen Salup, *Evaluating Vertical Mergers: a Post Chicago Approach*, 63 Antitrust L.J. 513 (1995); Press Release, Federal Trade Commission, "FTC Seeks to Block Cytyc Corp.'s Acquisition of Digene Corp." (June 24 2002) (avail at https://www.ftc.gov/news-events/press-releases/2002/06/ftc-seeks-block-cytyc-corps-acquisition-digene-corp) (By purchasing Digene, Cytyc would have been in a position to harm competitors by restricting access to Digene's HPV test, and also to thwart the entry of potential new competitors by denying them access to Digene's HPV test).
[5] Remarks of D. Bruce Hoffman, Acting Director, Bureau of Competition, Federal Trade Commission before the Credit Suisse Washington Perspectives Conference (January 10, 2018).
[6] See *Brown Shoe v. United States*, 370 US at 337 (Section 7 violated "if the anticompetitive effects of the merger are probable in any significant market"); Philip E Arreeda & Herbert Hovenkamp, Antitrust Law: An Analysis of Antitrust Principles and Their Application ¶ 972a (4th ed. 2014).
[7] See *United States v Aetna*, 240 F Supp.3d (D.D.C 2017); *United States v. Anthem*, 835 F 3d 345 (D.C. Cir. 2017).

Aetna's market share is either the first or second largest in 57 of the 389 Metropolitan Statistical Areas (MSA) studied.

The PBM Market is Highly Concentrated and CVS is One of the Two Largest PBMs

The national market for PBM services is highly concentrated, and CVS has a large share that places it as one of the two largest. Northwestern health economist Craig Garthwaite and Yale health economist Fiona Scott-Morton observe that 80 percent of the PBM national market is controlled by three suppliers, including CVS.[8] Given the present structure of the PBM market, CVS may have the ability to exercise market power unilaterally or through coordinated interaction.

The high market concentration has hampered performance. According to Garthwaite and Scott-Morton, the consolidation of the PBM market, combined with opaque pricing, is one significant cause for higher pharmaceutical prices.[9]

The Retail Pharmacy Market is Highly Concentrated and CVS Likely has Market Power in Local Markets

CVS has the status of being one of the nation's two dominant pharmacy chains in a highly concentrated retail pharmacy market.[10] Moreover, in a number of large MSAs, CVS appears to have large retail pharmacy market shares. These shares appear to be large enough to be consistent with CVS possessing market power, especially since CVS's retail pharmacies may be considered must-have pharmacies, and therefore CVS' market share understates its competitive significance. They are "must have" because health plan sponsors prefer geographically comprehensive networks—pharmacies located in close proximity to their patient population. Reportedly, 76 percent of the population of the U.S. lives within five miles of a CVS pharmacy. In its 2015 U.S. Securities and Exchange Commission (SEC) form 10-K filing, CVS disclosed that it operated in 98 of the top 100 United States drugstore markets and held the number one or number two market share in 93 of these markets.

CVS essentially acknowledges that it likely possesses market power. In its form 10-K filed with the SEC for the fiscal year ended December 31, 2016, CVS informs investors of the antitrust risks intrinsic to its appearance of market power. CVS states: "[T]o the extent that we appear to have actual or potential market power in a relevant market or CVS pharmacy or CVS specialty plays a unique or expanded role in a PBM product offering, our business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties."[11]

[8] "Pro Market Blog of the Stigler Center at the University of Chicago Booth School of Business, Craig Garthwait Associate Professor of Strategy and the Director of Kellogg School of Management's Health Enterprise Management Program (HEMA) at Northwestern University and Fiona M. Scott-Morton, Theodore Nierenberg Professor of Economics at the Yale University School of Management.

[9] Id.

[10] See e.g. Corey Stern, "CVS and Walgreens Are Completely Dominating the US Drugstore Industry," *Business Insider* (July 29, 2015) available at http://www.businessinsider.com/cvs-and-walgreens-us-drugstore-market-share-2015-7.

[11] U. S. Securities and Exchange Commission, Form 10-K for the fiscal year ended December 31, 2016, at 20 (February 9, 2017).

Merger Ramifications in the PBM Market

The Merger May Reduce the Likelihood of Beneficial Entry into the Highly Concentrated PBM Services Market

Removal of Aetna as a Likely PBM Market Entrant

By acquiring Aetna, CVS could prevent Aetna from entering the PBM market as a CVS competitor. National health insurers either have, or are in the process of, bringing PBM services in-house. But to achieve that goal, a large insurer such as Aetna need not resort to PBM acquisitions that would deprive the marketplace of a new PBM competitor. Instead, it could develop its own in-house PBM services—e.g., Aetna could follow Anthem's strategy of developing its own PBM capabilities with the help of a standalone PBM. Aetna might also partner with another company, such as Amazon. Aetna would likely find it much easier to enter the PBM market, as compared to de novo PBM market entry by another firm. Consequently, the CVS-Aetna merger may be deemed anticompetitive because it would arguably deprive the market of one of its most likely entrants—Aetna.

Crucial evidence for the fact finder here, and on other issues, is in the possession of the merging parties (e.g., documents reflecting business plans to enter the market).

Foreclosure of Aetna as a PBM Customer Significantly Diminishes the Prospect of Needed PBM Market Entry

To be competitive, a PBM market entrant needs covered lives—contracts with insurers—to negotiate volume discounts on drug prices. But if a major insurer essentially exits the client market by merging with a PBM, then a new entrant's chances of gaining the covered lives necessary for negotiating discounts is diminished. This in turn makes it less likely that the new entrant can attract health insurers. Accordingly, having a large insurer/customer is critical to successful PBM market entry.

A much needed new PBM market entrant, which could include, but certainly need not be limited to, Amazon, today finds that Aetna is the sole Big Five insurer that neither has its long-term PBM supply needs served in-house nor is transitioning to in-house as in the case of Anthem. A CVS acquisition of Aetna would foreclose the one remaining major customer opportunity for would-be CVS competitors. Indeed, there are reports in the *Wall Street Journal* that CVS is acquiring Aetna to tie up that business before Amazon can enter the market.[12]

The Highly Concentrated PBM Market is Poorly Performing and Urgently Needs a New Innovative Entrant

Depending on the size, sophistication, and scope of the potential PBM entrant's book of business, the availability of Aetna as a PBM customer could enable a new PBM entrant to ultimately acquire the sort of bargaining power that would enable the new entrant to compete with CVS or Express Scripts directly on price. But even if the availability of Aetna as a PBM market entrant or customer did not produce a new PBM with the sort of bargaining power to drive drug discounts that a CVS or Express Scripts possesses, a new entrant would likely be forced to compete on non-price dimensions that are critically important to consumers.

[12] *See, e.g.* "A Force behind the Aetna Bid: Amazon," the *Wall Street Journal*, (October 27, 2017).

For example, a new PBM entrant could compete on transparency and service efficiencies in an environment that is currently plagued by the black-box nature of PBM activities, as evidenced by the numerous state bills on PBM transparency and at least one on-going lawsuit alleging PBM overcharging. Northwestern Professor Craig Garthwaite and Yale Professor Fiona Scott-Morton observe that " when only a few PBMs exist, it is all too easy for them to stop functioning as brokers that increase market efficiency and start looking for win-win arrangements [with pharmaceutical firms] in which consumers are the ultimate losers."[13] Another expert has written that "most of the increase in drug pricing were rebates pocketed by PBMs."[14] Unfortunately, a CVS acquisition of Aetna would reduce the likelihood of needed PBM market entry, thereby diminishing the chance of new efficiencies and improved market performance.

Merger Ramifications in the Market for Retail Pharmacy

As discussed above, CVS owns "must have" retail pharmacies. Its PBM also contracts with independent pharmacies to be in its pharmacy network, promising access to plan subscribers in return for discounting fees for filling prescriptions. Thus, CVS is both a competitor and a critical customer of independent pharmacies.

If CVS were to acquire Aetna and the latter were to require that patients use CVS-owned pharmacies, independent pharmacies may be foreclosed from the market and drug prices may rise. Indeed, there is some evidence that CVS has already used its market power in the PBM market to disadvantage independent pharmacies that compete with CVS-owned pharmacies. A January 23, 2018, *American Prospect* article entitled "Abusing Drugs: How CVS Uses Its Market Power to Destroy Competing Independent Pharmacies," authored by David Dayen,[15] reports that "CVS's existing combination of a pharmacy (which dispenses drugs) and a pharmacy benefits manager (which reimburses other pharmacists for dispensing drugs) is a disaster for competition and access, particularly in underserved communities. Adding a health insurer like Aetna would further concentrate market power and narrow the networks people depend upon for medical care".[16]

The *American Prospect* article says that beginning around the time the CVS-Aetna merger was announced in the press, independent pharmacists began to notice significant cuts to reimbursement rates for prescription drugs on plans managed by CVS Caremark. The cuts reportedly were to levels below the independent pharmacy's cost of acquiring the drugs and were concentrated in Medicaid managed care plans that constitute a disproportionate share of independent pharmacy income. At the same time of the cuts, says the article, CVS' acquisitions department sent letters to the independent pharmacists inquiring about buying their stores.

Antitrust enforcers should investigate whether CVS has engaged in predatory behavior, as reported in the American Prospect article. If accurately reported, antitrust enforcers should weigh this prior conduct and the dominant market positions that CVS now possesses in PBM and retail pharmacy markets. Antitrust enforcers should consider whether by locking up all of Aetna's prescription volume, CVS would have a dangerous probability of acquiring and exercising market power in retail pharmacy markets.

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[13] See footnote 8.
[14] "Robert Goldberg, "Drug Costs Driven by Rebates," Center for Medicine in the Public Interest, http://bionj.org/wp-content/uploads/2015/11/drug-costs-driven-by-rebates.pdf.
[15] See http://prospect.org/article/abusing-drugs.
[16] David Dayen, "Abusing Drugs: How CVS Uses Its Market Power to Destroy Competing Independent Pharmacies," *American Prospect* (Jan 23,2018) at https://urldefense.proofpoint.com/v2/url?u=http-3A__prospect.org_article_abusing-2Ddrugs&d=DwIFAg&c=iqeSLYkBTKTEV8nJYtdW_A&r=YXZfhuF5LazfglWur9aEAPmfrPHSGcBoFhGKGQuxCJY&m=FDJ9rI1hwFVMepr1zb2N4aRTip5sKlsAHo7J4GPO4zU&s=y9khpj6sXs3L6fNCKrAjuMTWgN80081bnBGd6PvwZrw&e=

Merger Ramifications in the Health Insurance Market

Post-Merger, CVS May Refuse Either to Supply PBM Services to Aetna Rivals or May Provide These Services on Disadvantageous Terms

Given the present structure of the health insurance market, health insurers have the ability unilaterally or through coordinated interaction to exercise market power by raising premiums, reducing service or stifling innovation. Accordingly, health insurance markets require more, not less, competition. As the very recent successful Aetna-Humana and Anthem-Cigna merger challenges have illustrated, mergers that effect competitive conditions in the health insurance marketplace must be carefully scrutinized. [17] CVS' proposed acquisition of Aetna is such a merger.

Small and would-be sellers of health insurance who are competitors of Aetna need to be able to purchase essential PBM services. These insurers typically do not have the capacity to successfully enter into both the health insurance and PBM markets. Most desirable sources of PBM services are firms like CVS that are large enough to drive the biggest discounts in drug prices. In recent years, as already noted above, nearly all of the large PBMs either have been acquired by the Big Five insurers or have otherwise become an in-house service of these insurers. United Healthcare now operates Optum RX2; Humana has Humana Pharmacy Solutions; Cigna operates Cigna Pharmacy Management and Cigna Pharmacy Management also serves numerous Blues plans, including Anthem, which had hoped to acquire Cigna Pharmacy Management but now is developing its own PBM service with the help of CVS. Consequently, there are now only two large PBM supply sources that are independent of insurers and to which smaller health insurers or new market entrants can turn. They are Express Scripts and CVS. The merger will eliminate CVS as an independent source of PBM services, leaving Express Scripts as the sole PBM independent of an insurer. Thus, this merger will exacerbate the PBM market power evidenced by the poorly performing PBM market identified by Professors Garthwaite and Scott -Morton, the economists referenced above.

Smaller insurers that decide to rely on drug rebates from a merged CVS-Aetna, and faced with competing with Aetna, may be hurt by the merger. For example, CVS could have less of an incentive to give these insurers aggressive bids that would strengthen them as Aetna's rivals. Also, with only one independent PBM left in the market (Express Scripts), small insurers could easily fall victim to a strategy known in antitrust parlance as "raising rivals costs." The PBMs owned by (or that own) a health insurer could refuse to deal with other health insurers except on discriminatory terms that lessen competition in the health insurance market.

The Merger May Lead to Anticompetitive Behavior Due to Information Sharing Among Competing Health Insurers

If CVS were to merge with Aetna, then health plan entrants and smaller insurers seeking PBM partners would essentially be forced either to deal with Express Scripts or to share sensitive information with insurer competitors—something they may be loath to do even with the promise of information firewalls.

For example, if the merger were approved, Aetna could potentially have access to the prescription experience of Aetna's competitors. From that information Aetna could determine the illness profile of its competitors' covered populations. If Aetna determines that those populations consist of desirable insureds, Aetna can design formulary profiles and other health insurance benefit design features to draw away the smaller insurers' customers. If, on the other hand, Aetna determines that the smaller insurer has

[17] See *United States v Aetna*, 240 F Supp.3d (D.D.C 2017); *United States v. Anthem*, 835 F 3d 345 (D.C. Cir. 2017).

a big spend on expensive drugs, Aetna could make an effort to steer away from the smaller insurer's customers.

Aetna's potential post-merger access to competing health insurer confidential business information could also create opportunities for monitoring competitors' costs and for health insurer collusion that could be additional reasons for opposing the merger.

Post-Merger, CVS' Retail Pharmacies May Either Refuse to Supply Retail Pharmacy Services to Aetna Rivals or May Provide Those Services on Disadvantageous Terms

Just as a merged CVS-Aetna is likely to disadvantage insurer competitors needing PBM services, the merged firm may also foreclose competing insurers from access to CVS " must have" retail pharmacies, either entirely or by offering terms that are not competitive with those offered Aetna.

The Merger May be Anticompetitive Because it Would Allow CVS-Aetna, the Third Largest Health Insurer, to Control the PBM Services of Anthem, the Second Largest Insurer

CVS recently entered into a contract effective January 1, 2020, with Anthem to supply PBM services to Anthem as it transitions to supplying PBM services in-house. For CVS to operate a PBM with Anthem, the second largest health insurer, while owning Aetna, the third largest U.S. health insurer, could be highly problematic. It could facilitate price fixing and the anticompetitive sharing of competitive information—the kinds of horizontal market issues that have appropriately attracted close scrutiny by the Federal Trade Commission and the U.S. Department of Justice and condemnation by the courts.

The Merger May be Anticompetitive in the Market for Part D Medicare

Both Aetna and CVS have sizable footprints in the Medicare Part D prescription drug plan. Thus, for example, Aetna and CVS compete in the Connecticut Part D market. According to the companies' competitive impact statement filed in the Connecticut Department of Insurance in connection with this merger, CVS Health has a 30.1 percent share of Part D enrollees in that state and Aetna's share is 7.6 percent. While we do not have market concentration and market share data for Medicare Part D, we urge antitrust enforcers to examine the horizontal merger ramifications in Medicare Part D.

Alleged Efficiency Justifications for the Merger

Alleged Efficiency in PBM/Health Insurance Markets

Proponents of the Aetna-CVS merger argue that combining drug and health insurance under the same corporate roof will enable the new company to decide whether increasingly expensive new drugs are actually making people better and to design the drug benefit to lower overall health care costs that the Aetna portion of the new merged company would insure. Thus, proponents claim, consumers would benefit in the form of reduced health insurance premiums.

However, it is not clear that a combined Aetna and CVS has a strong incentive to reduce overutilization of prescription drug use or prices. While the health insurance side of an Aetna-CVS entity has an incentive to lower utilization and prices, the PBM side of the business has a diametrically different incentive. It cannot be determined, at this time, which direction the overall incentive would point.

Moreover, and most importantly, professors Garthwaite and Scott-Morton correctly observe that consumers will only benefit from lower Aetna health insurance costs that might result from the merger if

there is a competitive market in health insurance. [18] This is rarely present, and thus health insurers generally have very little incentive to pass savings along to consumers rather than pocket the total reduction in healthcare costs. "If past is prologue," notes Professor Leemore Dafny, "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums."[19]

Therefore, the adverse ramifications in the health insurance market of a combined CVS-Aetna, discussed earlier, are likely to swamp any expected cost benefit, rendering those alleged benefits at best speculative.

In addition, the market can achieve the claimed efficiency gains without the decrease in competition caused by the merger. Aetna already contracts with CVS for PBM services. To proceed with the merger Aetna would have to explain why it could not achieve the claimed efficiencies by modifying its contract with CVS. This is likely to be a heavy burden given the preference among antitrust enforcers for integrations via contract rather than through mergers because the latter are more difficult to unwind in the event the integration proves to be anticompetitive.

Finally, if it is most efficient to internalize into one firm PBM and health insurance functions, then why not follow the course taken by Anthem? It is developing its own PBM capabilities. There is apparently no need for Anthem to merge with an independent PBM in order to acquire PBM capabilities and to deprive the marketplace of an independent source of PBM services.

Alleged Efficiency in Retail Pharmacy/Basic Urgent Care

Aetna/CVS claim that under a combined roof, the insurance arm of CVS-Aetna could help keep costs down by routing patients needing basic urgent care to CVS-owned pharmacies offering walk-in clinics. This, the merging parties say, would keep patients out of expensive hospital emergency rooms. CVS has 1100 "minute clinics" in its pharmacies. The clinics are staffed by nurse practitioners and physician assistants who provide routine care such as flu shots. "Think of these stores as a hub of a new way of accessing healthcare services across America," says CVS Chief Executive Officer Larry Merlo. "We're bringing healthcare to where people live and work." [20]

This claim that the merger would create strong efficiencies with respect to primary care services is wildly speculative. David Blumenthal, President of the Commonwealth Fund observes in the December 14, 2017, Harvard Business Review:

> To become a Geisinger or at Intermountain equivalent, Aetna-CVS would have to acquire-or develop-seamless relationships with legions of primary care and specialty physicians and hospitals. It would have to turn its stores into medical clinics, with exam rooms, diagnostic laboratories, and x-ray suites. And it would have to install and link electronic health records and other providers in its communities. Having done all this, CVS would have to excel at the very challenging task of managing physicians and other health professionals-something that daily confounds even the most experienced, long time, care-delivery systems. The challenge would be unprecedented, the expense considerable, and the outcome uncertain.

[18] See footnote 8 supra.
[19] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?", Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.
[20] "CVS to Buy Aetna for 67.5 Billion, Remaking Health Sector," *Bloomberg Markets* (December 3, 2017), available at https://www.bloomberg.com/news/articles/2017-12-03/cvs-is-said-to-buy-aetna-for-67-5-billion-remaking-industry.

It is not clear that adding a new stopover will be anything more than a return to fragmented care, unless more is done. A recent study of 1.3 million Aetna enrollees found that retail clinics result in higher healthcare spending.[21]

A Bloomberg news article entitled "CVS's Megadeal to Change US Healthcare Faces Stiff Challenges" cautions: "There are serious challenges to CVS's proposal. Revamping the stores could cost several billion dollars"[22] Also noteworthy is that reputable financial analysts covering the health care industry have dismissed claims of efficiencies in this merger and see the merger as "defensive." For example, Leerink analyst Anna Gupta writes that the "Aetna/CVS deal is still viewed as primarily a defensive play."[23] Bloomberg reports that "Jeff Goldsmith, who runs the healthcare consulting firm Health Futures Inc. is skeptical of the strategy behind the deal, calling it 'flat out baffling', and says that the minute clinics 'lack the clinical acumen or trusting relationships with patients to effectively manage care' and does not 'see it generating new customers for the acquirer or the acquiree, or leverage to lower health costs' "[24] MorningStar points out that "CVS has significantly overpaid for Aetna", roughly double its standalone fair value. Antitrust enforcers should consider whether the price paid for Aetna reflects an anticompetitive defense of CVS market power and increases the likelihood that the merger will have anticompetitive effects.

Conclusion

The AMA appreciates the Subcommittee's consideration of our comments. For the reasons discussed above, and to protect consumers, we urge the Subcommittee and Congress to ensure that a rigorous review of this merger is conducted.

[21] See, Ashwood, Gainer et al. "Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending," *Health Affairs* (Millwood) 2016; 35:449-455.
[22] "CVS's Megadeal to Change US Healthcare Faces Stiff Challenges," *Bloomberg News*, December 22, 2017). See also, "A Force behind the Aetna Bid: Amazon," the *Wall Street Journal*,(October 27, 2017).
[23] "Aetna-CVS Deal a Defensive Play As Amazon Threat Looms" Bloomberg First Word Dec 15, 2017.
[24] See, note 19.