
**Statement of**

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**On**

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

**Before the**

**United States House of Representatives Committee on the Judiciary**

**Subcommittee on Regulatory Reform, Commercial and Antitrust Law**

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## Introduction

Chairman Marino, Ranking Member Cicilline, and Members of the Committee, thank you for giving me the opportunity to testify before you today.

The overriding point of my testimony is that the proposed CVS Health/Aetna merger presents a creative effort by two of the most well-informed and successful industry participants to try something new to reform a troubled system. Absent overwhelming evidence that the merger would create an unacceptable risk of harm, the effort should be welcomed and encouraged. And, as it happens, I have seen no evidence of even a *small* risk of harm.

It seems fair to say that the predominant characteristic of the CVS Health/Aetna merger is its prospect of developing, on a larger scale than ever before, innovative approaches to healthcare that could transform our healthcare system. As one analyst noted in an article titled, "Why CVS/Aetna Could Be a Game Changer":

> What CVS seeks to do with this deal is to dramatically accelerate that process, and change the nature of the neighborhood pharmacy. For example, we already know that getting a flu shot at the pharmacy is more convenient than making an appointment with a doctor.
>
> What if an entire array of services was available at the pharmacy? Better yet, what if it would cost less to have those services performed at the pharmacy? The advantage to the provider is clear; send the patients to the pharmacy, and free up the doctors for more pressing needs.[1]

Even this touches on only the tip of the potentially transformative iceberg. The proposed merger has the aim and the potential to demonstrate that it is feasible to provide integrated care with a focus both on both lowering

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[1] Ed Ponsi, *Why CVS/Aetna Could Be a Game Changer — Who Sells Out Next May Shock You*, THESTREET (Dec. 5, 2017), https://realmoney.thestreet.com/articles/12/05/2017/why-cvsaetna-could-be-game-changer-who-sells-out-next-may-shock-you.

costs for therapeutic treatments, such as prescription drugs, as well as enhancing the effectiveness of preventive care in order to reduce the need for therapeutic treatments in the first place.

In this light, I believe that it is important to view this merger not as a combination tending to concentrate economic power in the existing industry structure, but as a significant step toward a reorganization of the industry itself.

## My Background

I am the founder and executive director of the International Center for Law and Economics (ICLE), a nonprofit, nonpartisan research center based in Portland, Oregon. I am also a distinguished fellow at Northwestern Law School's Searle Center on Law, Regulation, & Economic Growth. In April 2017 I was appointed by FCC Chairman Ajit Pai to the FCC's Broadband Deployment Advisory Committee, and recently served for two years on the FCC's Consumer Advisory Committee.

Prior to founding ICLE, I was a law professor at Lewis & Clark Law School in Portland. I have also served as a lecturer in law at the University of Chicago Law School and the University of Virginia School of Law, practiced antitrust law and appellate litigation at Latham & Watkins, clerked for Hon. Morris S. Arnold on the 8th Circuit Court of Appeals, and worked as a research assistant for Judge Richard Posner.

My JD and AB degrees are from the University of Chicago and, not unrelated, I am an expert in the economic analysis of law, specializing in antitrust and competition, telecommunications, consumer protection, intellectual property, and technology policy.

With former FTC Commissioner, Joshua Wright, I am the editor of a volume from Cambridge University Press entitled, COMPETITION POLICY AND INTELLECTUAL PROPERTY LAW UNDER UNCERTAINTY: REGULATING INNOVATION.[2] I a member of the American Law and Economics Association, the

[2] Geoffrey A. Manne & Joshua D. Wright, eds., REGULATING INNOVATION: COMPETITION POLICY AND PATENT LAW UNDER UNCERTAINTY (Cambridge University Press 2011).

Canadian Law and Economics Association, and the Society for Institutional & Organizational Economics.

I have written extensively on antitrust law and economics, and, in particular, on mergers. Much of that work has focused on vertical mergers, including, among others, recent work on the ChinaChem/Syngenta, Bayer/Monsanto, and Dow/DuPont mergers, the AT&T/Time Warner merger, and the Comcast/NBCUniversal merger. I have also studied and written about antitrust and merger issues in the healthcare and health insurance industries. Most recently, I co-authored a paper assessing key economic analyses of health insurer mergers,[3] and I authored two recent amicus briefs opposing the FTC's challenge of the St. Luke's Hospital merger.[4]

## Healthcare Reform and its Discontents

It is difficult to deny the singular importance of private-sector efforts to try something new in the healthcare industry. Everyone is by now familiar with the urgent need to realign the healthcare industry in a way that provides better results at less expense. But the extent of agreement that *something* must be done to fix our healthcare system is outweighed only by the extent of disagreement over *what exactly* should be done.

The proposed CVS Health/Aetna combination emerges from broader market dynamics including especially technological evolution and a growing movement in healthcare away from fee-for-service medicine and toward value-based care. If for no other reason than its risky undertaking to try to

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[3] Geoffrey A. Manne and Ben Sperry, *When Past Is Not Prologue: The Weakness of the Economic Evidence against Health Insurance Mergers,* ICLE Antitrust & Consumer Protection Research Program White Paper 2016-4 (2016), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2881616.

[4] Brief of *Amici Curiae* ICLE and the Medicaid Defense Fund, *St. Alphonsus Medical Center, et al. v. St. Luke's Health System* (9th Cir. 2014), *available at* https://www.ftc.gov/system/files/documents/cases/140619stlukemedicaidamicusbrief.pdf; Brief of *Amici Curiae* ICLE and Professors and Scholars of Law and Economics in Support of Rehearing *En Banc, St. Alphonsus Medical Center, et al. v. St. Luke's Health System* (9th Cir. 2014), *available at* http://laweconcenter.org/images/articles/icle_st_lukes_profs_amicus.pdf.

further these dynamics, the transaction holds out the promise of substantial consumer benefit.

The move away from the traditional, fee-for-service model changes how healthcare and health insurance firms do business. It requires large investments in technology, comprehensive tracking of preventive care activities and health outcomes, and more-holistic supervision of patient care by insurers. Arguably, all of this may be accomplished most efficiently and effectively by larger, more tightly integrated firms with significant resources, comprehensive data, large-scale administrative capabilities, and diverse contact points with consumers.

Unfortunately, this transition is stymied significantly by a difficulty observing and assessing consumer activity and health outcomes. A combined CVS Health/Aetna, however, should have the ability to do so more effectively by integrating CVS's large retail footprint — with frequent traffic and multiple current and future services — with Aetna's large subscriber base and related healthcare data.

## CVS Health/Aetna as Part of a Bigger Movement in Private-Sector-Driven Healthcare Reform

It is interesting to note that the proposed CVS Health/Aetna merger arises amidst a veritable wave of innovative, vertical healthcare mergers and other efforts to integrate the healthcare services supply chain.

In the past, the most significant healthcare industry mergers have been horizontal — *e.g.,* between two insurance providers, or two hospitals — or "traditional" business model mergers — *e.g.,* between provider groups and hospitals or aimed at building managed care organizations. This suggested a sort of fealty to the status quo, with insurers interested primarily in expanding their insurance business or providers interested in expanding their capacity to provide medical services.

Today's mergers seem more frequently to be different in character, and they portend an enhanced industry-wide experiment in the provision of integrated healthcare that we should enthusiastically welcome. Most of the current proposed mergers would bring together various players in the healthcare/health insurance/pharmacy chain in unique ways, and/or in ways that double down on the value-based care approach:

Some of the other relationships and business models being explored center around pharmacies and PBMs, and minimize the role of insurers. **Walmart's generic drug program**, for example, offers low-cost prescriptions to customers at the same price regardless of insurance, and Walmart does not receive reimbursement from health plans for these drugs. Meanwhile, both **Express Scripts and CVS Health have made moves toward direct-to-consumer sales**, establishing drug pricing for a small number of drugs independently of health plans.[5]

Also seemingly focused on pharmacy services, in addition to announcing its intent to enter the healthcare industry in collaboration with JP Morgan and Berkshire Hathaway, **Amazon has sought pharmacy licenses in a number of states**,[6] thus putting competitive pressures on pharmacies and PBMs.

Whatever its role in driving the CVS Health/Aetna merger (and I believe it is far smaller than most reports like to suggest), Amazon's interest demonstrates the fluid nature of the market, and the opportunities for a wide range of firms to create efficiencies in the market and to lower prices.

At the same time, the differences between Amazon and CVS Health/Aetna highlight the scope of product and service differentiation that will contribute to the ongoing competitiveness of these markets following mergers like this one. While Amazon inarguably excels at logistics and the routinizing of "back office" functions, it is unlikely for the foreseeable future to be able to offer (or to be interested in offering) a patient interface that can rival the service offerings of a brick-and-mortar CVS pharmacy or clinic and its staff, coupled with the capabilities of an insurer like Aetna. To be sure, Amazon may put price pressure on important, largely mechanical functions, but like

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[5] Adam Rubenfire, *New PBM programs bypass insurers to offer drug discounts directly to consumers,* MODERN HEALTHCARE (Mar. 21, 2017) *available at* http://www.modernhealthcare.com/article/20170321/NEWS/170329990.

[6] Emma Court, *Is Amazon getting into the pharmacy business? This is what you need to know*, MARKETWATCH (Nov. 28, 2017) *available at* https://www.marketwatch.com/story/is-amazon-getting-into-the-pharmacy-business-this-is-what-you-need-to-know-2017-10-09.

much technology, it is most obviously a complement to services offered by humans, rather than a substitute:

> "People have gotten carried away with Amazon," said Ana Gupte, a health care analyst at Leerink Partners. "CVS and Aetna is an Optum wannabe. UnitedHealth is the winning business model, and Optum is showing the way."[7]

**Similarly, Walgreens is looking to complete its acquisition of AmerisourceBergen**,[8] a drug wholesaler, in order to form a supply chain that could give it an advantage in providing low-cost pharmaceuticals to existing (and future) customers. Walgreen's approach, although similar to Walmart's effort to provide generic drug discounts, is nevertheless distinct as it entails the full, vertical integration of wholesaler and pharmacy services, whereas Walmart's approach relies upon arms-length contracting. Perhaps more importantly, however, the two arrangements highlight the diversity of mechanisms by which firms are reforming the current model by experimenting with increased integration of typically distinct services in the pharmacy supply chain.

Other efforts focus on integrating insurance and treatment functions or on bringing together other, disparate pieces of the healthcare industry in interesting ways.

**Walmart, for example, recently announced a deal with Quest Diagnostics** to experiment with offering diagnostic testing services and potentially other basic healthcare services inside of some Walmart stores.[9] While such an arrangement may simply be a means of making doctor-prescribed

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[7] Chad Terhune, *Health Companies Race To Catch UnitedHealth As Amazon Laces Up*, KAISER HEALTH NEWS (Nov. 3, 2017), https://khn.org/news/health-companies-race-to-catch-unitedhealth-as-amazon-laces-up/.

[8] Michael Siconolfi, Dana Mattioli, and Joseph Walker, *Walgreens Has Made Takeover Approach to AmerisourceBergen*, WALL STREET JOURNAL (Feb. 12, 2018), https://www.wsj.com/articles/walgreens-has-made-takeover-approach-to-amerisourcebergen-1518480542.

[9] Alex Kacik, *Quest Diagnostics, Walmart partner to offer lab testing services in stores*, MODERN HEALTHCARE (Jun. 26, 2017), http://www.modernhealthcare.com/article/20170626/NEWS/170629919.

diagnostic tests more convenient, it may also suggest an effort to expand the availability of direct-to-consumer (patient-initiated) testing (currently offered by Quest in Missouri and Colorado) in states that allow it. A partnership with Walmart to market and oversee such services could potentially dramatically expand their use.

Capping off (for now) a buying frenzy in recent years that included the purchase of PBM, CatamaranRx, **UnitedHealth's Optum unit announced it will purchase DaVita Medical Group** — a move that would significantly expand UnitedHealth's ability to offer medical services, including urgent care, outpatient surgeries and health clinic services. give it a significant group of doctor's clinics throughout the country.[10]

And perhaps most interestingly, **Swiss pharmaceutical company, Roche, announced this month that "it would buy the rest of U.S. cancer data company Flatiron Health** for $1.9 billion to speed development of cancer medicines and support its efforts to price them based on how well they work."[11] Not only is the deal intended to improve Roche's drug development process by integrating patient data, it is also aimed at accommodating efforts to shift the pricing of drugs, like the pricing of medical services generally, toward an outcome-based model.

Traditionally, efforts to provide coordinated care in the healthcare stack have had their locus in doctor's offices, hospitals, or other similar facilities.[12] The CVS Health/Aetna merger promises an opportunity to provide a different, more consumer-oriented focal point for consumers: the nearly ten thousand CVS retail and MinuteClinic locations.

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[10] Sy Mukherjee, *UnitedHealth Is Buying a Major Doctor Group on the Heels of the CVS-Aetna Deal*, FORTUNE (Dec. 6, 2017), http://fortune.com/2017/12/06/unitedhealth-davita-cvs-aetna/.

[11] *Roche to buy Flatiron Health for $1.9 billion to expand cancer care portfolio*, REUTERS (Feb. 15, 2018), https://www.reuters.com/article/us-flatiron-health-m-a-roche-hldg/roche-to-buy-flatiron-health-for-1-9-billion-to-expand-cancer-care-portfolio-idUSKCN1FZ2R0.

[12] *Is the CVS-Aetna Merger a Game Changer for Health Care?*, KNOWLEDGE@WHARTON (Dec. 08, 2018), http://knowledge.wharton.upenn.edu/article/potential-impact-cvsaetna-merger/.

The concept is simple, but compelling. The long shadow of transaction costs dominates individual decision making in all situations, and no less so when it comes to healthcare. On the margins, it is simply easier, all things considered, for individuals to ignore potential, developing health issues when the cost in time spent going to doctors' offices and receiving tests is outweighed by the likelihood that any particular illness will occur.

The CVS Health/Aetna merger promises to alter this calculus by providing individuals access to low-cost, convenient methods of interacting with healthcare professionals in an environment they are already likely to frequent.

Importantly, treating CVS retail sites as a healthcare "hub" does not mean the side-stepping of doctor-provided care. But, as noted, it may not be optimal for doctors to be at the center of many healthcare-related decisions given the relative amount of time people spend elsewhere, and the practical dominance of preventive care (in terms of time, consumer attention, etc.) versus therapeutic services.

Nevertheless, a significant source of the efficiencies created by this transaction is that outcome-based care is naturally better managed by insurers than doctors; at the margin, doctors and patients have misaligned incentives. Insurers, on the other hand, are the natural locus for outcome-based case administration because they stand reasonably well in the shoes of consumers given that their benefit is inversely correlated with treatment cost, and positively correlated with treatment quality and preventive care that ameliorates the need for treatment in the first place.

## "The Firm as a Problem Solving Institution"

### Merger vs Contract

The transition from fee-for-service to value-based care is not an easy one. Entrenched interests and relationships, substantial investment requirements, and both risk and uncertainty, as well as significant regulatory hurdles, impede the transition. Finding new ways to integrate services, take advantage of technological opportunities, and allocate risks and obligations is naturally a key concern for players in this industry.

The efficiencies that are believed to result from integrated, value-based care are difficult to realize through a contractual process. Provision of full-spectrum services (such as through the integration of clinical, pharmacy, and other services, PBM services, distribution, and health insurance), entails substantial forward-looking investment, with uncertain returns and, more to the point, an uncertain distribution of returns across the various components. Such uncertainty, coupled with the substantial investment it entails, necessarily creates unknown risk that is difficult for parties on both sides of a transaction to adequately assess and allocate. Organizing these functions within a single firm can overcome the inordinate transaction costs that would otherwise impede such arrangements.

Similarly, coordinating speculative, ongoing efforts to create innovative new business methods with returns stretched out over an indefinite time horizon is difficult, if not impossible, to specify in advance, and integration (relative to contracting) can mitigate the costs of the inevitable need for adaptation on the fly in response to new information and unexpected exigencies.[13]

Liability is another tremendous risk that is (partially) ameliorated by integration. Particularly in the healthcare field, the need to collect, store, analyze, and share information across firms — including, of course, sensitive patient information — creates both a increased risk of data breach and exacerbates the problem of obtaining the requisite consent to share private data. Integration at least reduces those problems and makes the sharing of the liability risk and security costs easier.

As part of this innovative new corporate structure, the combined CVS Health/Aetna entity can also remove the double marginalization that occurs in the drug manufacturing and distribution chain by removing a third-party PBM from the insured-pharmacy-insurer relationship.

Additionally, combining the two firms removes the incentive for a PBM to act contrary to the interests of its client (the health plan) where its own

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[13] Both of these (and other) problems, as well as the idea of "the firm as a problem solving institution," are explored in Harold Demsetz, *The Theory of the Firm Revisited*, 4 J. L. ECON. & ORG. 141 (1988).

interests may diverge.[14] In particular, where PBMs receive greater revenue from rebating higher margin drugs, they may have an incentive to move negotiations in the direction of more expensive drugs. It has thus been claimed, in fact, that PBMs increase drug prices overall. It is by no means clear that this claim is accurate,[15] but, regardless, any such potential theoretically disappears once CVS Caremark also stands in the position of an insurer.

## Adding Value to the Healthcare Ecosystem

Pharmacists have long been an important source of advice,[16] both for their ability to recommend preventive treatments and also to recommend doctor visits when apparently necessary.[17] CVS currently has an incentive to sell in-store goods (*e.g.* cough medicines). Aetna currently has an incentive to

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[14] Linette Lopez, *The Feds Just Asked A Huge Healthcare Company Who Their Real Clients Are And The Answer Is Totally Unsatisfying*, BUSINESS INSIDER (Dec. 7, 2017) *available at* http://www.businessinsider.com/sec-looks-into-express-scripts-rebates-from-pharmaceutical-firms-2017-12 ("Over the last year or so Washington has been wondering if enough of those rebates are actually being passed along to you. It's also wondering if those rebates incentivize PBMs to choose expensive drugs that have higher rebates.")

[15] In fact, both the GAO and the FTC (among others) have found otherwise. *See* GAO, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies* (Jan. 2003) at 28, *available at* http://www.gao.gov/assets/240/236828.pdf ("PBMs have helped the FEHBP plans we reviewed reduce what they would likely otherwise pay in prescription drug expenditures while generally maintaining wide access to most retail pharmacies and drugs."); *Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc.* (Apr. 2, 2012) at 2, *available at* https://www.ftc.gov/sites/default/files/documents/closing_letters/proposed-acquisition-medco-health-solutions-inc.express-scripts-inc./120402expressmedcostatement.pdf ("[C]ompetition for accounts is intense, has driven down prices, and has resulted in declining PBM profit margins….").

[16] *See* Kieran Dalton and Stephen Byrne, *Role of the pharmacist in reducing healthcare costs: current insights*,6 INTEGRATED PHARMACY RESEARCH AND PRACTICE 37 (2016) *available at* https://www.dovepress.com/role-of-the-pharmacist-in-reducing-healthcare-costs-current-insights-peer-reviewed-fulltext-article-IPRP.

[17] Testimony of Thomas M. Moriarty. Executive Vice President, Chief Policy and External Affairs Officer, and General Counsel CVS Health, before the Subcommittee. on Regulatory Reform, Commercial and Antitrust Law, U.S. House of Representatives 4 (Fed. 27, 2018), *available at* https://judiciary.house.gov/wp-content/uploads/2018/02/Moriarty-Testimony.pdf.

keep its members healthy so they don't over-consume expensive drugs and services. A merged entity could align these incentives and offer CVS retail stores as a location for access to both preventive as well as therapeutic products and services in the proper ratio for patient health.

Einer Elhauge conducted a review of the literature relevant to healthcare fragmentation and its effects on preventive and therapeutic treatments. According to his survey, a critical concern for the healthcare system is how to efficiently integrate the different levels of the healthcare value chain in a way that reduces fragmentation and encourages preventive care utilization.[18] In addition to focusing on bringing drug costs down, an integrated data flow would reduce fragmentation and enable the combined entity to evaluate holistic health outcomes in a way that tracks client health before there is a need for therapeutic intervention.

Aetna's community care manager program is an example of a service that could be strengthened through integration with community pharmacies.[19] This program aims to connect subscribers with low-cost, early-intervention health advisers who can evaluate clients' needs and be sure they are receiving the necessary social services, nutrition advice, and medical care before problems worsen.

Similarly, and analogous to the benefits of this program, Aetna, recently partnered with Meals on Wheels to provide support for both the meal delivery service as well as "check in" services that provide Aetna with a means to monitor the ongoing health of its senior population. The program takes advantage of a creative opportunity for Aetna to increase its access to observational information about a particularly at-risk population of enrollees who might otherwise rarely be observed, even by doctors.[20]

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[18] Einer Elhauge, *Why We Should Care About Health Care Fragmentation And How To Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE 4 (Einer Elhauge, ed., Oxford University Press 2010).

[19] Aetna, Achieving better health with Aetna Community Care, *available at* https://aetnacommunitycare.aetna.com/#anchor.

[20] *Meals on Wheels America and Aetna Form Innovative Collaboration to Improve Senior Care*, BUSINESSWIRE (Sep. 27, 2017), https://www.businesswire.com/news/home/20170927005687/en.

The merger with CVS Health offers an analogous opportunity to increase observational information about a vastly wider (and more mobile) population that, nevertheless, is doubtless under-observed by people with sufficient training to translate that data into useful preventive care.

## The Economics of Vertical Mergers

It is important to note that the proposed merger between CVS Health and Aetna is a vertical merger and, as such, does not implicate the straightforward threat to the competitive process that can arise from the potential lessening of competition between two head-to-head rivals. Vertical mergers can sometimes pose *other* threats, of course. But it is well established in the economic literature, and in the case law, that vertical mergers and so-called "vertical restraints" more broadly are generally procompetitive.[21]

> Over the past several decades, there has been resounding and bipartisan agreement — amongst mainstream antitrust economists, practitioners, enforcement agencies, and even politicians — that while mergers between vertically aligned companies … can in rare circumstances harm competition, they usually make consumers better off.[22]

Our endeavor here today, and for the DOJ Antitrust Division, then, is to carefully examine whether the specific facts of this merger are likely to create the rare conditions sufficient to override that presumption. And, as we engage in this analysis, it is extremely important that we retain fidelity to rigorous analytical process.

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[21] *See, e.g.*, Francine Lafontaine & Margaret Slade, *Exclusive Contracts and Vertical Restraints: Empirical Evidence and Public Policy*, HANDBOOK OF ANTITRUST ECONOMICS 391, 409 (Paolo Buccirossi ed., 2008); James C. Cooper, Luke M. Froeb, Daniel O'Brien & Michael G. Vita, *Vertical Antitrust Policy as a Problem of Inference*, 23 INT'L J. INDUS. ORG. 639 (2005); Daniel O'Brien, *The Antitrust Treatment of Vertical Restraint: Beyond the Possibility Theorems*, in REPORT: THE PROS AND CONS OF VERTICAL RESTRAINTS 40 (2008).

[22] Joshua D. Wright, *Democrats Must End Fiery Rhetoric Against AT&T-Time Warner Merger*, THE HILL (Jun. 26, 2017), http://thehill.com/blogs/pundits-blog/lawmaker-news/339348-democrats-must-end-fiery-rhetoric-against-mergers.

The subjects of our population's health and the US healthcare system naturally engender strong emotional reactions and, often, tend toward scapegoating. In the current antitrust climate, especially, that scapegoating often means an ill-advised return to the "big is bad" antitrust of the 1960s and 70s. But especially where "big" arises from vertical combinations suggesting innovative new business models, consumer interests are at risk when a reflexive opposition to corporate combinations creeps in. The overriding goal of antitrust is to protect consumer welfare, and that can only be accomplished through a steady, careful analysis of the facts and innovative potential specific to this merger:

> The data [on vertical mergers] suggest [that] an evidence-based antitrust enforcement approach aimed at protecting consumers will not presume that [vertical mergers] are harmful without careful, rigorous, and objective analysis. Antitrust analysis is — or at least should be — a fact-specific exercise. Weighing concrete economic evidence is critical when assessing mergers, particularly when assessing vertical mergers where procompetitive virtues are almost always present.[23]

As in virtually every other industry where they have been studied in detail, vertical mergers between firms in healthcare and health insurance markets tend to yield procompetitive benefits that help reduce internal firm costs and generally align consumer welfare with the incentives that drive firm conduct.[24] And, as in this case, such mergers often facilitate the alignment

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[23] *Id.*

[24] See, for example, the 2013 merger of Highmark and West Penn Allegheny which was approved by the DOJ, U.S. Dept. of Justice, *Statement of the Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement with West Penn Allegheny Health System* (Apr. 10, 2012), *available at* https://www.justice.gov/opa/pr/statement-department-justice-s-antitrust-division-its-decision-close-its-investigation. After review by the Pennsylvania Insurance Department three years later, the merger was reported to be a success for the state, Compass Lexecon , *Assessment of Healthcare Competition Following Highmark Inc.'s Affiliation with West Penn Allegheny Health System, Inc. and other Healthcare Providers* (2017), *available at* http://www.insurance.pa.gov/companies/industryactivity/corporatetransactionsofpublicinterest/highmarkwestpennalleghenyhealthsystem/documents/compass%20lexecon%20public%20assessment%20of%20healthcare%20competition%20in%20wpa%20july%202017.pdf.

between complementary firms of investment incentives and risk sharing that enable them to adopt novel business models and to experiment with innovative products and services that would otherwise be virtually impossible to realize.

Ironically, it is in precisely these circumstances — where a merger is aimed at creating innovative business arrangements, rather than, say, merely the realization of administrative efficiencies — that the risk of erroneous condemnation is greatest.

Even more so than in other areas of law, errors are inevitable when undertaking antitrust analysis, largely because the identical conduct or arrangements that can lead to procompetitive effects under one set of competitive conditions can lead to anticompetitive effects under another. And, unfortunately, distinguishing the two and predicting the likely effects is necessarily based on an imperfect understanding of the relevant markets and where they are headed.[25]

This is all the more true where the procompetitive benefits of a proposed merger or conduct are relatively novel or where those benefits are based on inchoate, innovative organizational aims. Particularly when considered in light of the general presumption in favor of vertical arrangements, humility and great caution must be exercised to avoid stifling new business practices that could have broadly positive impacts on consumer welfare.

Importantly, apparent increases in concentration, or simply in size or scope, may, as here, reflect a relative shift from price competition to product design competition (innovation). In order "[t]o assess fully the impact of a merger on market performance, merger authorities and courts must examine how a proposed transaction changes market participants' incentives and abilities to undertake investments in innovation."[26] The failure to do

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[25] "To a large extent, predictions about these efficiencies depend less on models and more on fact specific data than is true on the anticompetitive effects side of the ledger." Daniel A. Crane, *Rethinking Merger Efficiencies*, 110 MICH. L. REV. 347, 355 (2011).

[26] Michael L. Katz and Howard A. Shelanski, *Merger Policy and Innovation: Must Enforcement Change to Account for Technological Change?* in INNOVATION POLICY AND THE ECONOMY (Adam B. Jaffe, Josh Lerner and Scott Stern, eds., 2005) 109, 110.

so leads inexorably to the erroneous condemnation of welfare-enhancing mergers aimed at innovation.

## A Note on the Merger's Likely Effect on PBMs

At root PBMs perform three common functions relevant to the operation of the pharmaceutical supply chain, any or all of which can be performed by other entities.[27] These functions are readily separable and there are many examples of them being performed in a number of combinations by a range of different entities.

First, PBMs aggregate demand (by negotiating on behalf of the collected members of health plans and/or self-insured employers), and wield the resulting bargaining power in negotiations with pharmacies and pharmaceutical manufacturers. But this bargaining power arises at root from the size of the pool of enrollees on whose behalf they negotiate. Relatively large insurers and large employers may not gain much by pooling their members with others, and can obtain the same benefits by negotiating directly. For smaller plans, the ability to negotiate collectively may be of some value, but other entities in the supply chain, including most notably large pharmacy chains and pharmaceutical distributors, can perform the same function.

Moreover, it turns out that the minimum scale required to obtain appreciable benefits in negotiating volume-based rebates with pharmaceutical companies, and reimbursement rates with pharmacies, may be quite low. When the FTC's Bureau of Economics investigated the competitive effects of the Express Scripts/Medco merger, it found no "significant incremental scale economies in the negotiation of rebates or pharmacy reimbursement."[28]

Second, PBMs administer pharmacy benefits on behalf of health plans. Obviously this administrative function can be performed by insurers in-house just as they administer provider benefits.

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[27] *See generally* Jonathan Klick & Joshua D. Wright, *The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures*, 17 AM. L. & ECON. REV. 192, 193 (2015).

[28] Howard Shelanski, *et al.*, *Economics at the FTC: Drug and PBM Mergers and Drip Pricing* (Dec. 2012) at 6, *available at* https://www.ftc.gov/reports/economics-ftc-drug-pbm-mergers-drip-pricing.

Third, PBMs provide formulary services, determining which drugs health plans should cover for which treatments, and with what co-pay. Again, however, this function need not be performed by a separate entity, and both health plans and pharmacies are well-situated to develop and manage their own formularies.

Although the persistence of PBMs as standalone entities suggests there is a benefit to the model, the standalone PBM model is undergoing a fairly relentless and longstanding process of disruption. In 2006 CVS and Caremark Rx merged, bringing the country's largest PBM (and all of its functions) into one of the country's largest retail pharmacy chains — which even in 2006 already offered its own PBM services. Many PBMs have begun integrating mail-order services into their operations, as well.[29] And several insurers (including Aetna after this merger) operate their own PBMs.

It is clear that a wide range of business models and firms can accomplish the basic drug purchasing, pricing and distribution transactions, as well as the ancillary services PBMs provide. The result is that, to a first order of approximation — and particularly with large, experienced, powerful players at each stage, each with different sets of skills, information, bargaining power, and administrative costs — significant inefficiencies or competitive constraints are unlikely to persist for very long under any particular set of arrangements. While the CVS Health/Aetna merger may *alter* the PBM landscape in important ways, therefore, there seems to be little reason to expect that it will *impair* its competitiveness.

## Conclusion

The CVS Health/Aetna merger is part of a growing private-sector movement in the healthcare industry to move beyond some of the structural inefficiencies that have plagued healthcare in the United States since World War II. Not only is it presumptively procompetitive under US antitrust law

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[29] Express Script, for example, maintains a mail-order program, Ed Silverman, *Express Scripts wrangles with small mail-order pharmacy*, STAT (Apr. 13, 2016), as does Costco, the warehouse supermarket chain, Costco, *Costco Mail Order Pharmacy available at* https://www.costcohealthsolutions.com/pages/mail-order.aspx.

as a vertical merger, it is self-evidently a low-risk experiment aimed at better aligning firm and consumer interests.

Without compelling evidence to the contrary, this merger appears to present no significant risks of harm that outweigh the clear benefits that it will provide.

Thank you again for the opportunity to speak with you today.