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Statement of

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Before the
United States House Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

on

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

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Introduction

Chairman Marino, Ranking Member Cicilline, and members of the Subcommittee, I am pleased to appear before you today to share with you a few observations on the potential impact of the proposed transaction on consumers and my experience in thinking about these issues as a health care antitrust economist.

I am Lawrence Wu, President of NERA Economic Consulting, a global firm of experts dedicated to applying economic, financial, and quantitative principles to complex business and legal challenges. NERA is a part of Oliver Wyman Group, which is a business unit of Marsh & McLennan Companies. While I am proud to be affiliated with NERA, I am appearing today solely on my own behalf, and the views and opinions I express are entirely my own and should not be attributed to NERA, Oliver Wyman Group, or Marsh & McLennan Companies.

My area of expertise is the economics of antitrust and competition and, more specifically, competition in health care markets. After getting my PhD in economics from the University of Chicago's Graduate School of Business, I joined the Federal Trade Commission as a staff economist in 1992. At the FTC, I reviewed numerous mergers and acquisitions in the health care field. I joined NERA Economic Consulting in 1996, and over the past 22 years, my colleagues and I have had the opportunity to analyze the competitive effects of scores of mergers and acquisitions, including those involving hospitals, health insurers, providers of pharmacy benefit management services (PBMs), medical device manufacturers, and providers of clinical health care services.

This afternoon, I would like to give you my perspective on the proposed transaction as an experienced health care antitrust economist. I have not been retained by the merging parties, the Antitrust Division of the Department of Justice, or any other party to evaluate the proposed transaction. I also have not seen and am not in the position to know what the merging parties are planning to do, nor do I know what issues are being considered by the Antitrust Division of the Department of Justice.

Keeping Our Focus on Consumer Welfare

As a health care antitrust economist, my focus is on consumer welfare, which means I pay attention to the factors that will determine whether a proposed transaction is likely to result in lower prices for health insurers and ultimately consumers, an improvement in the quality of health care that patients receive, increased access to care, and/or more innovation. Transactions that lead to such benefits would be categorized as procompetitive. Transactions that substantially lessen competition with the result being higher prices, lower quality, reduced access to care, or less innovation would be viewed as anticompetitive.

I have three main observations that I would like to share with you regarding the potential competitive impact of CVS Health's proposed acquisition of Aetna.

Vertical Mergers May Help to Align Incentives

First, compared to mergers that combine companies that are head-to-head competitors in the same market, the proposed transaction likely raises fewer competitive issues. This is because while the merging parties compete for Medicare Part D enrollment, the two companies are otherwise largely in different lines of business. CVS Health is in the retail pharmacy, PBM, and clinical care business, while Aetna is in the health insurance business. In the context of the pharmaceutical supply chain, CVS Health and Aetna operate at different points: as an insurer, Aetna is a buyer of prescription drugs; as a pharmacy, CVS Health sells prescription drugs to patients, including those insured by Aetna; in its capacity as a PBM, CVS Caremark has an agreement with Aetna to provide PBM services to Aetna PBM members; and with its MinuteClinics, CVS Health is a provider of health care services that may be covered by Aetna. This is the sense in which the proposed merger has been described as a "vertical merger" (which would be a transaction that combines companies at different points along the supply chain) as opposed to a horizontal merger (which would be a transaction that combines companies that compete in the same market). I am aware of only one area of direct competitive overlap between the merging parties, and that is in Medicare Part D prescription drug benefits coverage.

Vertical mergers can sometimes raise competitive concerns, but they also have the potential to align incentives so that the combined company can increase output, improve coordination among providers so that they can deliver a higher quality of care, and reduce or eliminate markups above cost that occur along the supply chain, which will help to lower prices. As noted by D. Bruce Hoffman, Acting Director of the Bureau of Competition at the Federal Trade Commission, efficiencies are "more intrinsic to a vertical transaction due to the cost-reducing effects of most vertical mergers, at least in the abstract. Due to the elimination of double-marginalization and the resulting downward pressure on prices, vertical mergers come with a more built-in likelihood of improving competition than horizontal mergers."[1] The fact that the proposed transaction is vertical in nature is important because that increases the potential for the transaction to improve consumer welfare.

Getting Patients the Care They Need in More Cost Effective Settings Remains a Challenge

Second, it isn't easy to get patients high quality, cost effective care. As reported in a New York Times article in 2013, half of all U.S. hospital admissions came through the emergency department, which is generally one of the most expensive places for patients to get diagnostic care and treatment for minor problems like infections or flu.[2] This is a major problem that the country's health insurers and health care systems have

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[1] Remarks of D. Bruce Hoffman, "Vertical Merger Enforcement at the FTC," January 10, 2018, at https://www.ftc.gov/system/files/documents/public_statements/1304213/hoffman_vertical_merger_speech_final.pdf.

[2] Reed Abelson, "E.R.'s Account for Half of Hospital Admissions, Study Says," The New York Times, May 20, 2013 at http://www.nytimes.com/2013/05/21/business/half-of-hospital-admissions-from-emergency-rooms.html.

been trying to address—what do they need to do to ensure that patients receive high quality care in the most cost-effective setting? Technological innovation has helped. Indeed, we have seen the growth and proliferation of ambulatory surgery centers, outpatient care clinics, and urgent care centers, which do not have the high fixed costs of an acute care hospital emergency room.

With its MinuteClinics, CVS Health is trying to get high quality diagnostic care to patients in a more cost effective way. If the proposed transaction can increase the use of these clinics or facilitate the expansion of such care, particularly in areas where access to outpatient care clinics and urgent care centers is limited, then the proposed transaction has the potential to benefit patients in an important way. For example, as noted by Leemore Dafny, a professor at Harvard Business School and a member of the faculty at the Kennedy School of Government, the combined firm has, among other things, the opportunity to reduce total spending for care by redirecting patients to lower-cost sites (which may include CVS Health's MinuteClinics) for certain services and by finding ways to reduce emergency department visits and admissions.[3]

Mergers and Acquisitions Have Played an Important Role in Helping Health Care Providers and Insurers Address the Problems They Face in Ensuring that Patients Receive High Quality, Cost Effective Health Care

Third, over the past 25 years, health care providers and insurers have explored a variety of business models and structures to meet changes in consumer demand and to improve the way health care is delivered and paid for. Consider the following examples:

- There was a time when health insurers thought HMOs were the way to ensure that their subscribers would receive better care at lower costs. However, as consumers began demanding more choice over their health care provider, many insurers began offering insurance plans with broader provider networks.

- There was a time when a hospital could specialize (e.g., heart hospitals) or focus on a narrow geography. Over time, we have seen how mergers and acquisitions have allowed many of these hospitals to achieve economies of scale and scope by making them part of a broader health system with a full range of providers.

- There was a time when hospitals acquired primary care physician groups because that was the way to ensure more referrals. Some efforts were successful, and others were not, and soon after, the wave of such acquisitions subsided. Today, hospitals are looking again at how they can find ways to work more effectively with their primary care and specialty physician groups to better coordinate patient care.

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[3] Leemore S. Dafny, "Does CVS-Aetna Spell the End of Business as Usual?" The New England Journal of Medicine, Vol. 378, No. 7, February 15, 2018, pp. 593-595, at http://www.nejm.org/doi/full/10.1056/NEJMp1717137.

- Today, many health systems are not just providers of health care—they also are getting into insurance and forming their own health plans. Indeed, since 2010, dozens of provider systems established their own health plans.[4] The idea is that if the health system can deliver high quality health care at a lower cost, the system would then be able to offer insurance at a lower price than other health plans. Some of these provider-sponsored health plans have succeeded, but many have not. Provider-sponsored health plans are going through a market test, and as noted in a 2017 Robert Wood Johnson Foundation study by Allan Baumgarten, "[f]or these new health plans to succeed, they must deliver on a value proposition of providing high-quality care at a lower cost." [5]

This experimentation—which has involved mergers and acquisitions—is innovation in action. To address the nation's health care problems, hospitals, physician groups, insurers, PBMs, and clinical service providers are constantly looking for ways to achieve greater economies of scale, provide patients with the health care or medicines they need in a more cost effective or convenient way, and take advantage of improvements in technology. More than that, they also have been trying to find ways to better align incentives, coordinate care, and manage their resources. I have had the opportunity to see how providers have tried to reorganize the way they deliver care, and I have seen how mergers and acquisitions have been an important part of the overall solution.

In the context of the overall evolution of the health care marketplace, I see the proposed transaction as another example of innovation in action. Clearly, there are many ways for insurers to obtain PBM services. Many insurers contract with PBMs for such services, and one example is the long-term strategic agreement that CVS Caremark and Aetna currently have. But there are other ways. Indeed, United Healthcare has chosen to obtain the PBM services that it needs through its fully-owned PBM, OptumRx, which is the vertically integrated structure towards which Aetna and CVS Health want to move. Which business model will prove to be more efficient in delivering high quality, cost effective PBM services to insurers and their subscribers? Only time will tell.

Like previous efforts to find a better way to deliver and pay for high quality, cost effective health care, the proposed transaction has the potential to do some good, but it will have to pass the market test. Certainly, the talented attorneys and economists at the antitrust agencies will ensure that any potential for competitive harm that they foresee—which generally would be low for a vertical transaction in any case—is minimized.

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[4] Allen Baumgarten, "Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans," Robert Wood Johnson Foundation, June 2017, at https://www.rwjf.org/en/library/research/2017/06/analysis-of-integrated-delivery-systems-and-new-provider-sponsor.html.

[5] *Ibid*.

Conclusions

Over the years, I have had the opportunity to see firsthand the problems that hospitals, physicians, health insurers, PBMs, providers of clinical health care services, and medical device makers have been trying to solve. And I have observed how innovation and experimentation have played a key role in improving our country's health care system. I know, for example, that many people still get their health care in expensive settings when they could be better served in an urgent care setting, and I can see how an expansion of low-cost diagnostic centers may help control health care costs and improve access to care. This transaction has the potential to achieve these goals. If the Antitrust Division finds that the proposed transaction has a low risk of competitive harm, then let the experiment happen and see what innovation flows from the transaction. If the benefits are achieved as claimed, then it will have been a success. If not, then we will have run the market test, but without a high likelihood that competition was adversely affected.

Thank you for convening this hearing. I look forward to answering any questions that you might have.