

STATEMENT

of the

American Medical Association and the Utah Medical Association

to the

Utah Insurance Commissioner

Re: CVS Health Corporation’s Proposed Acquisition of Control of Aetna Health of Utah Inc.

August 17, 2018

The American Medical Association (AMA) and the Utah Medical Association (UMA) appreciate the opportunity to provide comments regarding CVS Health Corporation’s (CVS) proposed acquisition of control of Aetna Health of Utah Inc. (Aetna). The AMA and UMA believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers’ exercise of market power pose a substantial risk of harm to consumers. Competition, in contrast, will lower premiums, forcing insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs.

The CVS acquisition of Aetna is a merger of competitors in a Utah Stand-Alone Medicare Part D prescription drug plan (PDP) market that is already highly concentrated. The merger would create a combined company with the second largest PDP market share in the state.

The AMA and UMA have analyzed the likely competitive effects of this proposed acquisition. We have considered University of California, Berkeley health economics Professor Richard Scheffler, PhD’s report (attached), based on publicly available information, on whether there is substantial evidence that the effect of this proposed acquisition may be substantially to lessen competition in any line of insurance in this Utah.¹ In our analysis, aided by Professor Scheffler, we applied the competitive standard required by U.C.A. 1953 § 301A-16-104.5(4)(a) & (b) (Utah Competitive Standard), and considered relevant statutory factors.² We have also considered studies on the effects of health insurance mergers on competition in health insurance and the publicly available testimony of Aetna and CVS executives and of academic experts offered roughly two months ago (on June 19, 2018) in a hearing before the California Department of Insurance on this proposed merger.³

As explained below, AMA and UMA conclude that CVS’ proposed acquisition of Aetna fails the Utah Competitive Standard. Thus, the acquisition “may be substantially to lessen competition” and the Commissioner of the Utah Insurance Department should enter an order denying the acquisition.⁴

¹ U.C.A. 1953 § 301A-16-104.5(4)(a).

² See the attached August 15, 2018, expert report entitled “Testimony Regarding CVS Health Corporation’s Proposed Acquisition of Aetna Inc. in Utah,” by Dr. Richard M. Scheffler (Scheffler Report). Dr. Scheffler is a Distinguished Professor Emeritus of Health Economics and Public Policy at the School of Public Health and the Goldman School of Public Policy at the University of California, Berkeley.

He also holds the Chair in Healthcare Markets and Consumer Welfare endowed by the Office of the Attorney General for the State of California and am the founding director of The Nicholas C. Petris Center on Health Care Markets and Consumer Welfare.

³ See <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm>.

⁴ See U.C.A. 1953 § 301A-16-104.5(a).

THE MERGER IS ANTICOMPETITIVE IN THE MARKET FOR MEDICARE PART D STAND-ALONE PRESCRIPTION DRUG PLANS

The Relevant Product Market Is the Medicare Part D Stand-Alone Prescription Drug Plan Market

Medicare beneficiaries can enroll in a Part D private insurance plan that provides prescription drug coverage. For most Medicare beneficiaries not offered a plan by a previous employer, there are two ways to obtain Part D coverage. They can remain in Original Medicare⁵ and enroll in a Stand-Alone PDP (PDP) that only covers prescription drugs and pays monthly premiums for the drug coverage, or they can enroll in a Medicare Advantage (MA) plan that offers Medicare prescription drug coverage (MA-PD). In MA plans, Medicare pays most or all of the premiums to a private insurer. Most MA plans are managed care plans; in return for reduced choice of providers and utilization review, the Medicare beneficiary obtains more complete coverage, typically including pharmacy coverage.⁶

Aetna and CVS have argued that PDP is not a relevant product market but is instead part of a larger market that includes MA-PD because, they argue, consumers will readily turn to MA in the event of a small PDP price increase.⁷ This is highly unlikely: as consumers are not likely to switch between MA-PD plans and Original Medicare with PDP in response to small price increases. Although the focus was on health (i.e., medical) insurance markets, *United States v Aetna*, 240 F. Supp.3d 1 (D.D.C 2017), is illustrative and highly suggestive. The *Aetna* court observed that under Supreme Court precedent,⁸ markets “must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn.”⁹ The *Aetna* court found little consumer switching between MA and Original Medicare in response to price increases.¹⁰ Instead, senior consumers have distinct and substantial preferences shaped by their comfort with managed care plans and desire to receive all of their benefits from one source, i.e., MA, weighed against their ability to shop and choose among providers, as is provided by Original Medicare. Consistent with this determination in *United States v. Aetna*, the evidence to date from Medicare Part D suggests that most beneficiaries, once enrolled, tend to stick with the plans they have chosen, even when they are faced *with relatively large* premium increases.¹¹

The Relevant Geographic Markets

The State of Utah

By Utah statute, “in the absence of sufficient information to the contrary... the relevant geographical market is assumed to be this state.”¹²

⁵ By statute, Congress has provided that seniors can obtain Medicare benefits either “through the original Medicare fee-for-service program,” or “through enrollment in a [Medicare Advantage] plan.” 42 U.S.C. § 1395w-21(a)(1).

⁶ Starc, Amanda, “Comments on Selected Issues re: The Proposed Mergers of Aetna and CVS”, (Starc Report) at 6. This report can be accessed on the California Department of Insurance Website at http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/StarcReport-revised_070318.pdf.

⁷ The California Department of Insurance rejected this CVS/Aetna contention and characterized it as “unpersuasive and not supported by the weight of evidence.” See California Department of Insurance correspondence of August 1, 2018, to the Hon. Jeff Sessions at 9. This correspondence can be accessed on the California Department of Insurance Website at <http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr085LtrJonestoUSAGSessionsreCVS-AetnaMerger.pdf>.

⁸ *Times Picayne Publishing Company v. United States*, 345 U.S. 594, 612 (1953).

⁹ *United States v Aetna*, 240 F. Supp.3d 1, 20 (D.D.C 2017).

¹⁰ *Id.* at 42.

¹¹ Kaiser Family Foundation, “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?” (October 10, 2013), available at: https://urldefense.proofpoint.com/v2/url?u=https-3A_www.kff.org_medicare_issue-2Dbrief-to-2Dswitch-2Dor-2Dnot-2Dto-2Dswitch-2Dare-2Dmedicare-2Dbeneficiaries-2Dswitching-2Ddrug-2Dplans-2Dto-2Dsave-2Dmoney_&d=DwIFAg&c=iqeSLYkBTkTEV8nJYtdW_A&r=YXZfhuF5LazfglWur9aEAPmfrPHSGcBoFhGKGQuxCJY&m=mOKiygMKlsziuEiutaB3n4vnDLgvm4sxSeJJYAItUhY&s=CINaEiUZNCFYU5QGaEf6lKViBTaFi8nQ2y5bEJIMsEc&e.

¹² U.C.A. 1953 § 301A-16-104.5(1)(d)(i).

The Idaho-Utah PDP Region

However Part D plan sponsors compete on premiums to attract enrollees.¹³ This bidding process determines the maximum premium amount Medicare will pay on behalf of low income subsidy (LIS) enrollees. The amount is calculated separately for 34 Part D geographic regions. Twenty-five of the 34 nationwide Part D geographic regions are single state. The remaining nine regions are comprised of multiple states. Utah is in one such multiple state region that includes Idaho.

The importance of the 34 Part D regions in the determination of the maximum premium amount Medicare will pay on behalf of LIS enrollees, plus the fact that plan sponsors must offer a plan in at least one entire region (and cannot pick and choose which geographies within a region they offer plans) constitute “sufficient” reasons to conclude that the Utah/Idaho region is the most appropriate geographical market in which to determine the likely competitive effect of the merger.

The Relationship between Market Concentration and Consumer Injury in PDP Markets

Northwestern University professor Amanda Starc, PhD, whose research focuses on health economics and health insurance, points to a number of studies showing insurer pricing power in the PDP context.¹⁴ Insurer market power in PDP enables an insurer to charge premiums above competitive levels and/or to degrade insurance quality.¹⁵ More generally, the weight of the research on insurance markets indicates that more competing firms or less concentrated local markets lead to lower premiums.¹⁶

As will be shown below, this merger will vastly increase the concentration in both the Utah state and the Utah/Idaho regional PDP markets. These markets are already lacking in competition and are poorly performing. Nationally, monthly PDP consumer premiums have increased by 58% since the start of the Part D program in 2006. During the same period, the consumer price index increased by only 24%.¹⁷ According to Professor Starc, this merger is likely to lead to further consumer harm.¹⁸

This Merger May Substantially Lessen Competition under the Utah Competitive Standard

Application of the Competitive Standard to the State of Utah PDP Market

Utah law employs a “four-firm concentration ratio” test (CR 4) to determine the degree of anticompetitive danger present in a particular market. Under CR 4, a highly concentrated market is one in which the sum of the market shares of the four largest insurers is 75% or more of the market.¹⁹ In 2018, the Utah PDP market is, in fact, highly concentrated since the CR 4 in the Utah PDP market is 75%.²⁰ (And if the State of Utah approved CVS’s acquisition of Aetna, the market concentration would rise to 81%).²¹ Consequently, because CVS’s current share of the Utah PDP market is 13% and Aetna’s share is 6%, the acquisition constitutes prima facie evidence that violates the Competitive Standard.²²

¹³ Scheffler Report at 2.

¹⁴ Starc Report at 7-8.

¹⁵ Id.

¹⁶ Starc Report at 7.

¹⁷ Scheffler Report at 2.

¹⁸ Starc Report at 3-5 and 15-16.

¹⁹ U.C.A. 1953 § 301A-16-104.5(b)(ii).

²⁰ Scheffler Report at 2.

²¹ Scheffler Report, pages 2-3.

²² Scheffler Report at 3.

Additionally, CVS's acquisition of Aetna raises competitive concerns under U.C.A. 1953 § 31A-16-104.5(4)(c) in the State of Utah. This section is concerned with the trend toward increased concentration in markets, and states a significant trend toward increased concentration exists when

the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by 7% or more of the market over a period time extending from any base year 5 to 10 years before the acquisition up to the time of the acquisition.

The Scheffler report establishes a significant trend toward increased concentration according to this section – the market share of the largest four firms increased by 13 percentage points (or 21%) from 2009 to 2018.²³

One final consideration highlighting the anticompetitive nature of the acquisition is the absence of market volatility with respect to health insurer rank in Utah. According to U.C.A. 1953 § 31A-16-104.5(4)(f), a party may establish the absence of requisite anticompetitive effect on based on several factors, one being the “volatility of ranking of market leaders.” Dr. Scheffler found that “Volatility of ranking of market leaders” has not occurred in the Utah PDP market.²⁴

Application of the Competitive Standard to the Idaho-Utah PDP market

If the Utah-Idaho PDP market, rather than the state of Utah is the relevant geographic market, the case for condemnation under the Utah competitive standard is even stronger. The CR 4 in the Utah-Idaho PDP market is 77%.²⁵ (If the State of Utah approved the acquisition, the four-firm concentration ratio would increase to 84%). In this highly concentrated PDP market, CVS holds a 15.9% share and Aetna's share is 6.8%. Consequently, CVS's proposed acquisition constitutes prima facie evidence that violates the Competitive Standard in the Utah-Idaho PDP market. Because CVS's current share of the Utah PDP market is 13% and Aetna's share is 6%, the acquisition constitutes prima facie evidence that violates the Competitive Standard.²⁶

Additionally, the acquisition raises competitive concerns under U.C.A. 1953 § 31A-16-104.5(4)(c) with respect to a trend toward increased concentration in the Utah-Idaho PDP market. Dr. Scheffler's report shows a significant trend toward increased concentration according to section (4)(c), since the – the market share of the largest four firms increased by 15 percentage points (or 24%) from 2009 to 2018.

Finally, similar to the experience of the Utah state market, “volatility of ranking of market leaders” has not occurred in the Utah-Idaho PDP market.²⁷

CLAIMED EFFICIENCIES ARE NOT SUFFICIENT TO REBUT THE PRIMA FACIE EVIDENCE THAT THE ACQUISITION VIOLATES THE COMPETITIVE STANDARD

Under Utah law, an order may not be issued against the acquisition for violating the Competitive Standard if

(i) the acquisition will yield substantial economies of scale or economies in resource use that cannot be feasibly achieved in any other way, and the public benefits that would arise from the economies exceed the public benefits that would arise from not lessening competition; or

²³ Scheffler Report at 3.

²⁴ Scheffler Report at 3-4.

²⁵ Scheffler Report at 4.

²⁶ Scheffler Report at 3.

²⁷ Scheffler Report at 5.

(ii) the acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits that would arise from not lessening competition.²⁸

The claimed efficiencies for this acquisition fall far short of satisfying (i) or (ii) above, as described below.

Aetna Already Performs Core PBM Functions and Presently Integrates Pharmacy and Medical Data to Lower Costs

In a June 19 hearing before the California Department of Insurance, CVS/Aetna claimed that “a key driver of consumer benefits from the merger would be the ability to combine CVS’s pharmacy data and expertise with Aetna’s medical data and expertise.”²⁹ However, Neeraj Sood, PhD, Professor of Health Policy and Vice Dean for Research at the Sol Price School of Public Policy, University of Southern California, pointed out both in an expert report and during testimony at the June 19 hearing that, based on Aetna’s U.S. Securities and Exchange Commission (SEC) filings, Aetna *already performs its own core PBM functions and thus already integrates pharmacy and medical data to lower healthcare costs.*³⁰

Most telling has been CVS/Aetna’s nonresponse to professor Sood’s findings that the alleged principal efficiency justification for this merger is nonexistent. Instead, in a reply letter filed subsequent to the June 19 hearing, CVS/Aetna reference an OptumRx white paper—a non-peer-reviewed marketing piece—touting the benefits of integrating medical and pharmacy benefits that CVS says lead to substantial premium reductions.³¹ However, the white paper actually claims only cost savings and makes no mention of substantial premium reductions. Even assuming a potential efficiency of integrating PBM and health insurance functions, if the experience with past horizontal insurance mergers is prelude in this vertical integration, the benefits are not likely to be passed along to Utah consumers by the merging health insurance company; and in any event, the benefits are neither merger specific nor of a sufficient magnitude to justify the anticompetitive effects of this acquisition.

Potential Efficiency in PBM/Health Insurance Market Does Not Justify This Acquisition

Assuming *arguendo* that at some recent time Aetna abandoned its in-house PBM, AMA and UMA will consider here whether the acquisition would be justified on the claimed basis that it would combine CVS pharmacy data and expertise with Aetna’s medical data and expertise as argued by CVS/Aetna.

Some economists, including Craig Garthwaite, PhD, in earlier congressional testimony favoring this merger, are citing economic research (Starc and Town 2015) that suggests a benefit of insurer-PBM integration in the MA and Part D markets.³² Starc and Town’s research suggests that MA-PD plans, which cover both drug and medical expenditures, tend to be designed to offset medical expenditures, as compared to stand-alone PDP plans which only cover drugs. They find MA-PD insurers charge consumers low co-pays for preventive medications—which effectively means sending consumers the right price signals. The findings are consistent

²⁸ U.C.A. 1953 § 31A-16-104.5(4)(g).

²⁹ This testimony may be accessed at the California Department of Insurance Website at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm>

³⁰ See “Potential effects of the proposed CVS acquisition of Aetna on competition and consumer welfare,” (Sood report), which may be accessed at the California Department of Insurance Website at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm>.

³¹ CVS-Aetna supplemental submission at 3. This submission may be accessed on the California Department of Insurance Website at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm>.

³² See Garthwaite, testimony before the House Judiciary Committee at a hearing entitled “Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna”, February 27, 2018, available at <https://judiciary.house.gov/wp-content/uploads/2018/02/Garthwaite-REVISED-Testimony> and citing Starc A. and Town B. *Internalizing Behavioral Externalities: Benefit Integration in Health Insurance*, 2017, NBER Working Paper No. 21783.

with the idea that firms that only cover drugs and are at no risk for higher medical costs would have little incentive to consider the influence of their benefit design decisions on enrollee medical care utilization, whereas firms that cover both would have an incentive to lower medical costs.

To better understand the Starc and Town research cited in the congressional testimony and the extent to which the so-called “alignment of medical and pharmacy benefits” efficiency might favor this acquisition, the AMA has consulted Professor Starc, the lead co-author of the cited economic research. In her expert report on the CVS/Aetna proposed merger, she concludes that a merged CVS/Aetna entity has the potential to foreclose future entry or raise the cost of current rivals in the PBM industry, the specialty pharmacy market, and critically the Part D market. She further concludes that the potential for foreclosure is likely to have negative impacts on consumer welfare.³³ Ultimately, it is her opinion that “the potential harm to consumer welfare from the proposed merger is likely to outweigh the potential gains.”³⁴

Professor Starc reached her opinion condemning this acquisition while at the same time concluding that the alignment of medical and pharmacy benefits is an efficiency that can only be *fully* achieved through *integration* within a firm. But, according to Professor Starc, the integration efficiency could be fully achieved “by developing an in-house PBM,” an approach pursued by other players.³⁵ Indeed, as described by Professor Sood, “Aetna’s own financial statements to the SEC indicate that it already performs its core PBM functions.”³⁶ Alternatively, a potentially large portion of the potential gain could instead be achieved via contract between the insurer and the PBM. An insurer could put the PBM at risk for at least part of medical spending.³⁷

Finally, the magnitude of any alignment of medical and pharmacy benefits is, according to Professor Starc, further limited to the set of contracts joint to Aetna and CVS’s PBM plans in which the merged entity is at risk for both medical and pharmacy benefits. In the Part D market, this will be limited by the (lack of) consumer switching from stand-alone plans to MA plans. In the commercial market, this will be limited to fully insured contracts, primarily in the small-group market.³⁸ Importantly, the potential efficiencies do not apply to self-insured contracts, which compose a significant fraction of Aetna’s business and thus substantially diminish the potential for efficiencies.

Unlikely Pass-Through of Cost Savings

Professor Starc further concludes that any cost efficiency created by the acquisition would not likely translate into lower premiums or more attractive benefit packages for consumers.³⁹ Even Dr. Garthwaite concedes that consumers will only benefit from the Starc and Town identified efficiency, or any other that might result from the acquisition, if there is a competitive market in health insurance.⁴⁰ 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 health care costs. This has been shown in the history of horizontal health insurer mergers. For example, as Harvard professor Leemore Dafny, PhD notes:

³³ Starc Report at 15.

³⁴ Starc Report at 16.

³⁵ Starc Report at 13-14.

³⁶ Sood Report at 9.

³⁷ Starc Report at 13.

³⁸ Starc Report at 14.

³⁹ Starc Report at 14.

⁴⁰ Craig Garthwaite and Fiona M. Scott-Morton, “Perverse market incentives encourage high prescription drug prices.” Pro-Market Blog, November 1, 2017.

If past is prologue, 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.⁴¹

Therefore, the adverse ramifications in the health insurance market of a combined CVS/Aetna, discussed earlier, are likely to swamp any merger-associated cost efficiency.

Summary of the Efficiency Defense in the Relevant Health Insurance, PBM Markets and Pharmacy Markets Where Competitive Harm Caused by the Merger is Likely

Perhaps Professor Sood most succinctly summarizes the verdict on this acquisition in the health insurance, PBM and pharmacy markets:

Within each of the specific markets—insurance, pharmacy and PBM—in which the merger is likely to have anticompetitive effects, there are no potential benefits of sufficient magnitude and certainty that would outweigh the anticompetitive effects of the merger.⁴²

Claimed Health Care Provider Efficiencies Would Not Occur in Markets in which the Effects of the Merger May Be Substantially to Lessen Competition and Thus Cannot Justify the Merger

During the June 19 hearing before the California Department of Insurance, CVS and Aetna, however, urged the California Department of Insurance to consider their efficiency claims in providing medical services. Post-merger the merged entity would route patients needing basic urgent care to walk-in clinics. This, the merging parties say, would keep patients out of expensive hospital emergency departments. 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 CEO Larry Merlo. “We’re bringing healthcare to where people live and work.”⁴³

The CVS/Aetna claimed health care hub-provider efficiencies are irrelevant to whether this merger may substantially lessen competition. As a matter of law, likely efficiencies must occur *in the specific markets in which the merger is likely to have its anticompetitive effects*. The U.S. Supreme Court made this point clear in *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), in which the U.S. Supreme Court ruled against a proposed bank merger because it would likely have “the effect of substantially lessening competition in the relevant market.”⁴⁴ In that case, after concluding the effect of the proposed merger would be substantially to lessen competition, merger proponents argued that the bank merger was justified because it would give the merged bank countervailing market power, which would enable it to compete with large out-of-state banks for very large loans.⁴⁵ The Court rejected this “out-of-market efficiencies” justification, stating that:

If anticompetitive effects in one market could be justified by procompetitive consequences in another, the logical upshot would be that every firm in an industry could, without

⁴¹ 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.

⁴² Sood Report at 17.

⁴³ “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>.

⁴⁴ *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 323-324 (1963).

⁴⁵ *Id.* at 370.

violating § 7, embark on a series of mergers that would make it in the end as large as the industry leader.⁴⁶

Courts have followed the *Philadelphia National Bank* Court's rejection of out-of-market efficiencies as a cognizable merger justification. As the court in *Law v. NCAA*, 902 F. Supp. 1394 (D. Kan. 1995) stated:

Procompetitive justifications for price-fixing must apply to the same market in which the restraint is found, not to some other market. See *United States v. Topco Assoc., Inc.*, 405 U.S. 596, 610, 31 L. Ed. 2d 515, 92 S. Ct. 1126 (1972) (competition "cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy"); *United States v. Philadelphia National Bank*, 374 U.S. 321, 370, 10 L. Ed. 2d 915, 83 S. Ct. 1715 (1963) (anticompetitive effects in one market cannot be justified by procompetitive consequences in another); *Sullivan v. National Football League*, 34 F.3d 1091, 1112 (1st Cir. 1994) (it seems "improper to validate a practice that is decidedly in restraint of trade simply because the practice produces some unrelated benefits to competition in another market"), [****32**] cert. denied, 131 L. Ed. 2d 133, 115 S. Ct. 1252 (1995).⁴⁷

Even if CVS and Aetna could demonstrate that health care hubs will be established as claimed and result in efficiencies, such efficiencies would occur in the market for the provision of primary care services. But such primary care efficiencies are out-of-market in relation to those markets in which the effect of the proposed CVS/Aetna acquisition violates the Competitive Standard. Consequently, under existing case law, any primary care efficiencies that the merged CVS/Aetna might create are neither relevant to, nor justification for, the proposed merger.

The Claimed Health Care Provider Efficiencies are also Wildly Speculative

Notwithstanding their antitrust irrelevance, the CVS/Aetna claim that retail clinics hosted in CVS pharmacies can effectively serve the health care hub for patients and consumers were examined by Wharton professor Lawton R. Burns, PhD.⁴⁸ In a detailed, richly annotated report, Professor Burns reaches the following conclusions:

The proposed merger between CVS Health and Aetna is unlikely to yield a long list of benefits advanced by executives from both companies. The documentation on how these benefits are to be achieved is lacking; their evidence base in the scientific literature is questionable; and the implementation challenges are enormous....Any effort to achieve such benefits through the use of retail clinics and analytics is unlikely to succeed. More generally, the strategies of vertical integration and diversification that underlie the merger lack a firm evidence base for any consumer benefits.⁴⁹

⁴⁶ Id.

⁴⁷ *Law v. NCAA*, 902 F. Supp. 1394, 1406 (D. Kan. 1995).

⁴⁸ Professor Burns is the James Joo –Jin Kim professor at the Wharton School of the University of Pennsylvania. He is a professor in the Management and Department of Healthcare Management. He teaches courses on the U.S. healthcare system in the industrial organization of healthcare. These courses cover the entire value chain of healthcare including hospitals, managed care organizations, insurers, pharmacies, retail clinics, pharmacy benefit managers and pharmaceutical and medical products.

⁴⁹ Burns, Lawton R., "Limits on Consumer Benefits from Proposed Merger of Aetna Inc. into CVS Health Corporation" (Burns Report) at 26. See also Burns, Lawton R., Response to Aetna Supplemental Submission, July 9, 2018 (Burns Response). Both of these documents may be accessed on the California Department of Insurance Website at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm>.

David Blumenthal, MD, President of the Commonwealth Fund has similarly found the CVS/Aetna claim that the merger would create strong efficiencies with respect to primary care services to be wildly speculative. He observes in the December 14, 2017, Harvard Business Review:

To become a Geisinger or an 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.

A recent study of 1.3 million Aetna enrollees found that retail clinics result in higher health care spending.⁵⁰ A Bloomberg News article entitled, “CVS’s Megadeal to Change U.S. Healthcare Faces Stiff Challenges,” cautions that, “[t]here are serious challenges to CVS’s proposal. Revamping the stores could cost several billion dollars.”⁵¹ 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.”⁵² 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 MinuteClinics ‘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.’”⁵³ MorningStar points out that “CVS has significantly overpaid for Aetna,” roughly double its standalone fair value.

CONCLUSION

CVS’s acquisition of Aetna violates the Competitive Standard in the Utah PDP market and the Utah-Idaho PDP region. Claimed efficiencies for this acquisition are not sufficient to save the acquisition in the face of this violation. The AMA and UMA, therefore, respectfully request that the Utah Insurance Commissioner oppose the proposed CVS-Aetna acquisition.

⁵⁰ See, Ashwood, Gainer et al. “Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending,” *Health Affairs* (Millwood) 2016; 35:449-455.

⁵¹ “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).

⁵² “Aetna-CVS Deal a Defensive Play As Amazon Threat Looms” *Bloomberg First Word* (Dec 15, 2017).

⁵³ *Supra* note 51.