STATEMENT

of the

American Medical Association

to the

Department of Managed Health Care

Re: The Acquisition of Aetna, Inc. by CVS Health Corporation

May 16, 2018

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the proposed merger of CVS Health Corporation (CVS), the largest retail pharmacy chain and specialty pharmacy in the United States and one of the two largest pharmacy benefit managers (PBM), and Aetna, Inc. (Aetna) the third largest U.S. health care insurer. We commend the Department of Managed Health Care (DMHC) for scrutinizing this massive proposed merger and the potential negative impact it poses to Californian health care consumers.

AMA is concerned that the proposed merger has the potential to worsen competition (or reduce hopes for amelioration) in four poorly performing product markets in California and across the country: PBM services; health insurance; retail pharmacy; and specialty pharmacy.

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 may 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 under the antitrust laws to enjoin the entire transaction to protect consumers.[6] Likewise, the DMHC should condemn health care mergers that harm competition in any single market given the agency's mission of protecting health care consumers.

Health Insurance Markets, including those in California, are Highly Concentrated

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

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[1] US Department of Justice and Federal Trade Commission, MERGER GUIDELINES (1984) [1984 MERGER GUIDELINES]).
[2] *Brown Shoe v. United States*, 370 U.S. 294, 323 (1962) (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)

AMA's 2017 Update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, a comprehensive study of competition in health insurance markets, finds that nearly 70 percent of the combined HMO + PPO + POS + EXCH (commercial) markets are highly concentrated. Moreover, Aetna's market share is either the first or second largest in 57 of the 389 Metropolitan Statistical Areas (MSA) studied. In a separate analysis of Medicare Advantage (MA) insurer markets, the AMA found that 85 percent of MA markets are highly concentrated. Aetna had the first or second largest MA market share in 60 of the 382 MSAs studied. In a total of 94 MSAs, Aetna had the first or second largest share in the commercial market, MA market, or in both of those markets.

The competition picture in commercial health insurance is even worse in California.[8] Seventy-five percent of MSA-level commercial health insurance markets in the state are highly concentrated.[9] Moreover eighty-two percent of MSA-level MA markets in California are highly concentrated.

Thus health insurance markets need new entry. But as explained below, a vertical merger between a large insurer and a national PBM with scale and buying power will only further raise entry barriers into these highly concentrated California health insurance markets—an anticompetitive result that should be of great concern to Californians.

The PBM Market is Highly Concentrated and CVS as One of the Two Largest PBMs Can Exercise Market Power

California payers (insurers and employers) are faced with a national market for PBM services that is highly concentrated, and CVS has a large share that places it as one of the two largest PBMs. A February 2018 report from the President's Council of Economic Advisers (CEA Report) observes that "three PBM's account for 85% of the market, which allows them to exercise undue market power."[10] The ability of large PBMs to offer exclusive distribution contracts and to negotiate the deepest volume discounts and rebates from drug firms is a major factor in entrenching their market power and raising barriers to entry.[11]

Moreover, the present non-competitive structure of the PBM market, allows CVS to engage in opaque pricing. Thus, the CEA Report concludes that "[p]ricing in the pharmaceutical drug market suffers from high market concentration in the pharmaceutical distribution system and a lack of transparency."[12]

Similarly U.S. Food and Drug Administration (FDA) Commissioner Scott Gottlieb, MD, in a March 17, 2018 speech noted how PBM's exercise their market power in concert with health insurers also exercising their market power and lacking any incentive to reduce consumer costs:

> Too often, we see situations where consolidated firms—the PBMs, the distributors, and the drug stores—team up with payors. They use their individual market power to effectively split some of the monopoly rents with large manufacturers and other intermediaries rather than passing on the saving garnered from competition to patients and employers.[13]

[8] *Competition in Health Insurance: A Comprehensive Study of US Markets* (2017 update).
[9] Id.
[10] Council of Economic Advisers, Reforming Bio Pharmaceutical Pricing at Home and Abroad (February, 2018) at 10. *See also*, Sood, N., Shih,T., Van Nuys, K., and Goldman, D. 2017. "The Flow of Money through the Pharmaceutical Distribution System." Leonard Schaeffer Center for Health Policy and Economics, University of Southern California.
[11] American Antitrust Institute correspondence to the Hon. Makan Delrahim, Assistant Attorney General (March 26,2018) at 5.
[12] CEA Report at 10
[13] Speech by Scott Gottlieb, M.D., Commissioner of the U.S. Food and Drug Administration before the America's Health Insurance Plans National Health Policy Conference, "Capturing the Benefits of Competition for Patients", Washington, DC. (March 7, 2018)

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

Retail Pharmacy

CVS has the status of being one of the nation's two dominant pharmacy chains in a highly concentrated retail pharmacy market.[14] CVS's share of drug sales in the United States is roughly 25%.[15] Together with Walgreens Company (Walgreens), the two chains control 50% of national drug sales.[16]

Moreover, in a number of large MSAs, CVS's shares appear to be large enough to be consistent with CVS possessing market power either unilaterally or through coordinated interaction. A 2015 Business Insider article entitled, "CVS and Walgreens Are Completely Dominating the US Drugstore Industry," reports that even before CVS acquired 1660 Target Corporation (Target) pharmacies, CVS and Walgreens together controlled between 50 and 75% of the retail pharmacy markets in Los Angeles, San Francisco, and Riverside/San Bernardino.[17]

Moreover, CVS's high local market shares understate the likelihood of market power. CVS pharmacy chains may be considered "must have" pharmacies. 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 U.S. drugstore markets and held the number one or number two market share in 93 of these markets.[18]

Specialty Pharmacy

CVS has growing dominance in specialty pharmaceuticals. Specialty drugs are typically utilized by oncologists to treat cancer. However rheumatologists, ophthalmologists, gastroenterologists, neurologists and others are also using specialty drugs that are high-cost and have special development, handling, administrative and medical monitoring requirements. Specialty pharmacy is driving the pharmacy industry's revenue growth. [19] According to Pembrook Consulting, "the growth of specialty drugs is reshaping the pharmacy and pharmacy benefit management industries."[20]

CVS's status as one of the two largest PBMs has allowed it to steer patients and third-party payers to utilize CVS as their specialty pharmacy. In 2016, CVS reportedly had a 28% specialty pharmacy market share, measured by specialty pharmaceutical revenues.[21] That share dwarfed the next largest dispenser

[14] 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.
[15] See, 2016s top retail pharmacy chains, according to drugstore news (July 20, 2017),http://www.drugchannels.net/2017/07/2016s-top-retail-pharmacy-chains.html
[16] Id
[17] "CVS and Walgreens Are Completely Dominating the US Drugstore Industry", Business Insider (July 29, 2015), http://www.businessinsider.com/cvs-and-walgreens-us-drugstore-market-share-2015-7
[18] See CVS Health Corp., Annual Report (Form 10K) for fiscal year ended December 31, 2016 (February 9, 2017) at 9 (citing CVS health Corp., Annual Report (Form 10K) at 6 (February 10, 2015))
[19] Outlook for Specialty Pharmacy Prescription Revenues, Drug Channels (subsidiary of Pembroke consulting), April 11, 2017, *http://www.drugchannels.net/2017/04/our-exclusive-2021-outlook-for.html*
[20] Id
[21] 2016 Pembrook consulting analysis cited in paragraph 32 of the complaint in *Sentry Data Systems Inc. v. CVS health et al,* case 018--CV-60257, docketed 02/05/2018

specialty pharmaceuticals, which was Walgreens, with a 10% market share.[22] CVS's dominance of specialty pharmacy is growing, as described in the "CVS Health 2017 Annual Report:"

> We remain the largest specialty pharmacy by a considerable margin, resulting in greater scale and stronger purchasing economics . . . Looking at 2018, we expect to continue outpacing the marketplace by adding another $4 billion in specialty revenue.

CVS Acknowledges that CVS Pharmacy and CVS Specialty Pharmacy Appear to Possess 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:

> To 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.[23]

Merger Ramifications in the PBM Market

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

As recommended by the CEA Report, "policies to decrease concentration in the PBM market…can increase competition and further reduce the price of drugs paid by consumers."[24] Allowing a CVS-Aetna merger would be at war with policies to decrease concentration in PBM markets.

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 Inc.'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.com, Inc. (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).[25]

[22] *Id.*
[23] CVS Health 2017 Annual Report at 20
[24] CEA report at 10
[25] At a February 26, 2018 U.S. House Judiciary hearing on the proposed merger, Aetna's General Counsel acknowledged that Aetna has considered entering the PBM marketplace but rejected this alternative in favor of merging with CVS.

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.[26]

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 ultimately to acquire the sort of bargaining power required to compete with CVS or Express Scripts Holding Company (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.

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 ongoing lawsuit alleging PBM overcharging. One expert has concluded that most of the increase in drug pricing can be attributed to rebates pocketed by PBMs.[27] Without new entry and competition, PBMs can continue to keep secret the size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients.[28] Because a CVS acquisition of Aetna would reduce the likelihood of needed PBM market entry, the likelihood of new efficiencies and improved PBM market performance would be diminished.

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

[26] See, e.g. "A Force behind the Aetna Bid: Amazon," the *Wall Street Journal*, (October 27, 2017).
[27] "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.
[28] CEA report at 10

effect competitive conditions in the health insurance marketplace must be carefully scrutinized.[29] CVS's 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 and Express Scripts that are large enough to drive the biggest discounts in drug prices. However, if CVS merges with Aetna all of the large PBMs, with the uncertain exception of Express Scripts, would either have been acquired by the Big Five insurers or have otherwise become an in-house service of these insurers.[30] With the recent announcement of Cigna's agreement to acquire Express Scripts, CVS may soon become the only large source PBM services that is independent of insurers and to which smaller health insurers or new market entrants can turn. Thus, this merger will exacerbate the PBM market power that has caused the poorly performing PBM market.

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, ultimately to the detriment of competition and consumers. For example, CVS could have less of an incentive to give these insurers aggressive bids that would strengthen them as Aetna's rivals. Also, 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 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 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's 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.

[29] 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).

[30] United Healthcare now operates Optum RX2; Humana has Humana Pharmacy Solutions; Anthem is developing its own PBM service with the help of CVS; and CIGNA operates CIGNA Pharmacy Management, in addition to proposing to acquire Express Scripts.

Merger Ramifications in the Markets for Retail and Specialty Pharmacy

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, 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.[31]

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. 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's acquisitions department sent letters to the independent pharmacists inquiring about buying their stores.

DMHC should investigate whether CVS has engaged in predatory behavior, as reported in the American Prospect article. If accurately reported, DMHC should weigh this prior conduct and the dominant market positions that CVS now possesses in PBM and retail pharmacy markets. DMHC 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.

Specialty Pharmacy

The enhancement of CVS's market power in PBM services that would be caused by the merger has worrisome ramifications in the specialty pharmacy market that CVS dominates.

CVS may require Aetna patients to receive drugs through its own specialty pharmacies rather than from the pharmacies operating in treatment settings such as physician practices, hospitals and health systems where patient compliance with dosing amounts and intervals can be monitored, side effects evaluated and, if necessary, critical drug dosages adjusted. This likely harmful merger effect is described in an on-line article appearing in the Lancet:

[31] 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=

> A substantial share of CVS health pharmacy revenues are derived from specialty pharmacies, which distribute expensive drugs, including chemotherapy agents. The company might press patients to obtain drugs there that would be better provided through a physician's office. 'These are very expensive drugs and they can hurt you if they aren't managed closely', explained Ray Dean Page (incoming chair of the clinical practice committee of the American Society of Clinical Oncology.)[32]

A CVS practice of forcing patients to obtain specialty drugs from its specialty pharmacy rather than in clinical treatment settings where they can receive clinical services needed to stay alive is now among the allegations of a class action filed in the United States District Court for the Northern District of California. The suit alleges, in part, that many enrollees in health plans where CVS controls and administers the pharmacy benefits are told they are required to obtain their HIV/AIDS medications from CVS's California specialty pharmacy, a wholly-owned subsidiary of CVS. Patients allegedly are "told that they must either pay more out of pocket or pay full price with no insurance benefits whatsoever-thousands of dollars or more each month-to purchase their medications at an in network community pharmacy where they can receive counseling from a pharmacist and other services they may need to stay alive."[33] While these facts are yet unproven allegations in litigation, similar allegations of CVS's tying its specialty pharmacy services to its PBM services appear in a second lawsuit, this one pending in the Southern District of Florida.[34] There the plaintiff alleges that CVS forces "patients and third-party payers to utilize CVS as their specialty pharmacy."[35]

The Merger May Substantially Lessen Competition Because It Would Allow a Merged CVS/Aetna to Control the PBM Services of Anthem

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 both nationally and in California, while owning Aetna, the third largest health insurer both nationally and in the Santa Barbara-Santa Maria MSA, and the fifth largest California-wide, could be highly problematic.[36] It could facilitate in already highly concentrated health insurance and PBM markets, 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 Appears Anticompetitive in Markets for Part D Medicare, Including in California

Both Aetna and CVS have sizable footprints in the Medicare Part D prescription drug plan market. A firm that conducts antitrust analyses, Event Driven, has studied the Centers for Medicare & Medicaid Services' (CMS) January 2018 Part D enrollment data and has concluded that Aetna and CVS together control almost one-third of standalone Medicare Part D lives in the United States.[37] According to the study, there is significant overlap in the markets served by Aetna and CVS. Of the 34 CMS prescription drug regions,

[32] Ted Alcorn,"Major Healthcare Companies Merge in the USA", (March 22, 2018), http://dx.doi.org/10.1016/S1470-2045(18)30247-X
[33] Complaint in *John Doe One et al v. CVS Health Corporation,* case 2:18-CV-01280-RS WL-J PR, filed February 16, 2018
[34] *Sentry Data Systems v. CVS Health et al,* Case 0:18-cv-60257, filed February 5, 2018
[35] Id.
[36] The market share rankings have been determined by the AMA Health Policy group that produces *Competition in Health Insurance: a Comprehensive Study of US Markets* (2017). *See also, United States v Aetna, supra and United States v. Anthem, supra.*
[37] The Event Driven study is available at https://event-driven.com/aetcvs-part-d-overlap-potential-divestiture-analysis/

a combined CVS/Aetna would control at least a 30% share in half of them (17). Regions found to have the most significant overlap include California.[38]

Alleged Efficiency Justifications for the Merger

Alleged Efficiency in PBM/Health Insurance Markets

Some economists, including economist Craig Garthwaite, are citing economic research (Starc and Town 2015) that suggests a benefit of insurer-PBM integration in the Medicare Advantage and Medicare Part D markets.[39] Their research suggests that Medicare Advantage Prescription Drug (MA-PD) plans which cover both drug and medical expenditures tend to be designed to offset medical expenditures, as compared to stand-alone Medicare Part D plans which only cover drugs. The research suggests that MA-PD insurers design benefits to substitute drugs for more expensive medical care costs. They find that MA-PD plans have more generous drug coverage than drug-only plans. The spending effects are driven by drugs that have been identified as reducing medical expenditures and treating chronic conditions. The findings are consistent 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.

Although the Starc and Town (2015) research is some evidence for the substitution effects (higher drug utilization to offset more expensive medical care), prominent Wharton scholars, health economist Mark Pauly and medical sociologist Lawton R. Burns, observe that "economists are not all in agreement on how large or common such offsets can be."[40]

Moreover, whatever the benefit, it would potentially be limited to the set of contracts joint to Aetna and CVS: plans in which the merged entity is at risk for both medical and pharmacy benefits. In the Medicare 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.

Most importantly, any cost efficiencies obtained as a result of the merger could increase insurer profits or reduce premiums. As Dr.Garthwaite himself concedes, consumers will only benefit from the Starc and Town identified efficiency, or any other that might result from the merger, if there is a competitive market in health insurance.[41] 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. [42] This has been shown in the history of horizontal health insurer mergers: "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

[38] As another 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.

[39] See Garthwaite, testimony before House Judiciary Committee on " 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.

[40] Lawton R. Burns and Mark Pauly "CVS, Aetna Boast of 'Synergies,' but That's Just Corporate Speak", The Hill, 12/07/17, http://thehill.com/opinion/healthcare/363630-cvs-aetna-boast-of-synergies-but-thats-just-corporate-speak

[41] Pro Market Blog of the Stigler Center at the University of Chicago Booth School of Business, Craig Garthwaite 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

[42] As explained earlier, competition in health insurance would be made even less likely post a CVS / Aetna merger.

insurance premiums."[43] 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.

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. It could redesign that contract to put CVS at risk for at least part of medical spending. Therefore, 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

CVS-Aetna 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 MinuteClinics 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."[44]

This claim that the merger would create strong efficiencies with respect to primary care services is wildly speculative. David Blumenthal, MD, President of the Commonwealth Fund 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.

Similarly, Wharton Professors Pauly and Burns throw cold water on the health care delivery efficiency claim. They conclude that reminiscent of the integrated delivery network formations of the 1990s that claimed efficiencies, "the CVS-Aetna deal may be an exercise in market power and competitive positioning."[45]

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[43] 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.

[44] "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.

[45] See, note 40

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.[46] A Bloomberg news article entitled, "CVS's Megadeal to Change U.S. Healthcare Faces Stiff Challenges," cautions: "There are serious challenges to CVS's proposal. Revamping the stores could cost several billion dollars."[47] 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."[48] 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.'"[49] MorningStar points out that "CVS has significantly overpaid for Aetna", roughly double its standalone fair value. DMHC 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 applauds the DMHC for reviewing this massive proposed CVS-Aetna merger and for considering the potential consumer injury it would inflict upon Californians. We urge the DMHC to ensure that a rigorous review of this merger is conducted.

[46] See, Ashwood, Gainer et al. "Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending," *Health Affairs* (Millwood) 2016; 35:449-455.
[47] "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).
[48] "Aetna-CVS Deal a Defensive Play As Amazon Threat Looms" Bloomberg First Word Dec 15, 2017.
[49] See, note 19.