



STATEMENT

of the

American Medical Association

to the

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

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

February 27, 2018

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

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

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

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

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

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

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

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

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

¹ US Department of Justice and Federal Trade Commission, MERGER GUIDELINES (1984) [1984 MERGER GUIDELINES].

² *Brown Shoe v. United States*, at 323 (describing foreclosure of competitors as "the primary vice of vertical merger").

³ 1984 MERGER GUIDELINES.

⁴ See, Michael H Riordan & Stephen Salup, *Evaluating Vertical Mergers: a Post Chicago Approach*, 63 Antitrust L.J. 513 (1995); Press Release, Federal Trade Commission, "FTC Seeks to Block Cytyc Corp.'s Acquisition of Digene Corp." (June 24 2002) (avail at <https://www.ftc.gov/news-events/press-releases/2002/06/ftc-seeks-block-cytyc-corps-acquisition-digene-corp>) (By purchasing Digene, Cytyc would have been in a position to harm competitors by restricting access to Digene's HPV test, and also to thwart the entry of potential new competitors by denying them access to Digene's HPV test).

⁵ Remarks of D. Bruce Hoffman, Acting Director, Bureau of Competition, Federal Trade Commission before the Credit Suisse Washington Perspectives Conference (January 10, 2018).

⁶ See *Brown Shoe v. United States*, 370 US at 337 (Section 7 violated "if the anticompetitive effects of the merger are probable in any significant market"); Philip E Arreeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 972a (4th ed. 2014).

⁷ See *United States v Aetna*, 240 F Supp.3d (D.D.C 2017); *United States v. Anthem*, 835 F 3d 345 (D.C. Cir. 2017).

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

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

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

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

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

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

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

⁸ "Pro Market Blog of the Stigler Center at the University of Chicago Booth School of Business, Craig 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.

⁹ Id.

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

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

Merger Ramifications in the PBM Market

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

Removal of Aetna as a Likely PBM Market Entrant

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

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

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

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

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

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

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

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

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

Merger Ramifications in the Market for Retail Pharmacy

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

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

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

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

¹³ See footnote 8.

¹⁴ “Robert Goldberg, “Drug Costs Driven by Rebates,” Center for Medicine in the Public Interest, <http://bionj.org/wp-content/uploads/2015/11/drug-costs-driven-by-rebates.pdf>.

¹⁵ See <http://prospect.org/article/abusing-drugs>.

¹⁶ David Dayen, “Abusing Drugs: How CVS Uses Its Market Power to Destroy Competing Independent Pharmacies,” *American Prospect* (Jan 23, 2018) at https://urldefense.proofpoint.com/v2/url?u=http-3A_prospect.org_article_abusing-2Ddrugs&d=DwIFAg&c=iqeSLYkBTkTEV8nJYtdW_A&r=YXZfhuF5LazfglWur9aEAPmfrPHSGcBoFhGKGQuXCJY&m=F4J9rI1hwFVMepr1zb2N4aRTip5sKlsAHo7J4GPO4zU&s=y9khpj6sXs3L6fNCKrAjuMTWgN80081bnBGd6PvwZrw&e=

Merger Ramifications in the Health Insurance Market

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alleged Efficiency Justifications for the Merger

Alleged Efficiency in PBM/Health Insurance Markets

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

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

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

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

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

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

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

Alleged Efficiency in Retail Pharmacy/Basic Urgent Care

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

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

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

¹⁸ See footnote 8 supra.

¹⁹ See Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?”, Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

²⁰ “CVS to Buy Aetna for 67.5 Billion, Remaking Health Sector,” *Bloomberg Markets* (December 3, 2017), available at <https://www.bloomberg.com/news/articles/2017-12-03/cvs-is-said-to-buy-aetna-for-67-5-billion-remaking-industry>.

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

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

Conclusion

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

²¹ See, Ashwood, Gainer et al. “Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending,” *Health Affairs* (Millwood) 2016; 35:449-455.

²² “CVS’s Megadeal to Change US Healthcare Faces Stiff Challenges,” *Bloomberg News*, December 22, 2017). See also, “A Force behind the Aetna Bid: Amazon,” the *Wall Street Journal*,(October 27, 2017).

²³ “Aetna-CVS Deal a Defensive Play As Amazon Threat Looms” *Bloomberg First Word* Dec 15, 2017.

²⁴ See, note 19.