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**Connecticut State Medical Society Testimony**
**Proposed Merger of CVS/Aetna**

**Submitted October 3, 2018**

On behalf of the physicians and physicians in training of the Connecticut State Medical Society ("CSMS"), thank you for the opportunity to present testimony concerning the proposed merger between CVS an Aetna (hereinafter the "Proposed Merger").

At the outset, CSMS would like to recognize the ongoing discussions we have had with CVS leadership, including their physician management and CEO and EVP that has allowed for an open process of discussion, debate and presentation of differences of opinion. However, despite this airing of concerns, we continue to believe that this Proposed Merge is anti-competitive and not in the best interest of the public.

CSMS has grave concerns that Aetna's corporate culture of profit driven health insurance and health care will remain in place without some guarantees by CVS that focus on network accessibility and network adequacy, physician determined care delivery and reduction of the limitations on the provision of medical care through prior authorizations and denials that have followed the Aetna business model most recently. While we see CVS as a provider of medical and health care services and a partner in patient care in Connecticut, Aetna has been more of a barrier to care recently and has restricted and limited the provision of medical necessity services under the auspices of misguided prior authorizations and medical payment policies.

CSMS' further concerns are set forth below.

## THE PROPOSED MERGER IS ANTI-COMPETITIVE IN NATURE

In accordance with Connecticut General Statutes, one of the primary roles of the Connecticut Insurance Department ("CID") is to examine the anti-competitive impacts of this Proposed Merger. Connecticut General Statutes §38a-131, provides, in relevant part, that "an acquisition

involving two or more involved insurers competing in the same market shall be prima facie evidence of a violation of the competitive standards described in this subsection..."

A lot has been made in the media and the press about the so-called "vertical" nature of this merger, but the reality is that there are substantial horizontal concerns within the Proposed Merger. Aetna and CVS both compete in the Medicare Part D Prescription Drug Plan ("PDP"). Substantial analysis has been done by the American Medical Association ("AMA"), as well as several anti-trust experts who have scrutinized every detail of this Proposed Merger. We turn your attention to the pre-filed testimony submitted by the AMA in connection with the Proposed Merger and the numerous expert filings appended to such testimony. CSMS fully supports the testimony and the expert filings submitted by the AMA.

As you will note in the AMA's testimony, specifically reference is made to expert analysis done by University of California, Berkeley, health economics professor Richard Scheffler, PhD. According to the analysis done by Professor Scheffler, under the horizontal merger guidelines, in all but four of the 34 PDP regional markets, this Proposed Merger would either be "presumed to be likely to enhance market power" or would "potentially raise significant competitive concerns and often warrant scrutiny."

Specifically, in Connecticut, just under 300,000 individuals were enrolled in a PDP in 2018. As of the date of Professor Scheffler's report, CVS held a market share of 21.7% and Aetna a market share of 8.9%. If the Proposed Merger were permitted, the new CVS/Aetna entity would hold a combined market share of approximately 30.6% of the PDP market and would be number one in market share. Post-merger, the PDP market would be substantially controlled by only two insurers: the new CVS/Aetna entity and UnitedHealthGroup.

One way to measure competition in a market is to use what is known as the "four firm concentration ratios" or NAIC CR4 test which was adopted by the 2015 National Association of Insurance Commissioners ("NAIC") in its "model insurance Holding Company System Regulatory Act."

The NAIC CR4 test looks to the four-firm concentration ratio by summing the market shares of the four largest insures in a given market. In Professor Scheffler's report, he notes that as of

2018, the four largest insurers in the Connecticut PDP market comprised 77% of the market share. Under the NAIC CR4 test, a highly concentrated market is one in which the sum of the market shares of the four largest insurers is 75% of the market. In Connecticut, a prima facie violation of this competitive standard is easily satisfied as the four largest PDP insurers comprise 77% of the market. It must be noted that Aetna is not currently in the top four insurers in the PDP market (it is currently in position five), and therefore any such merger of Aetna and CVS would substantially increase the 77% market share of the 4 largest PDP insurers.

Looking to Connecticut law, Connecticut General Statutes §38a-131 (d)(1)(B), provides that there is evidence of a violation of competitive standards if "there is a significant trend toward increased concentration in the market." A significant trend is said to have occurred "when the aggregate market share for any grouping of the largest insurance companies in the market, from the two largest to the eighth largest, has increased by seven percent or more of the market over a [defined] period...." Looking at the analysis done by Dr. Scheffler, it is clear that the market shares of the four largest PDP insurers increased by 20 percent over a period of 8 years (64 percent in 2010 to 77 percent in 2018). This satisfies the conditions set forth in the statute.

The NAIC CR4 test has already established that Connecticut's PDP market is highly concentrated, PRIOR to any merger between CVS an Aetna. When looking at an already highly concentrated PDP market, combined with the evidence of a violation of competitive standards set forth in Connecticut General Statues §131(d)(1)(B), CID must conclude that there is in fact evidence of a violation of competitive standards in the Proposed Merger with regard to the PDP market and such Proposed Merger is anti-competitive in the PDP market.

In the Pharmacy Benefit Manager (PBM) market, the Proposed Merger also presents horizontal merger concerns. Aetna has a PBM and while it outsources parts of its PBM needs to CVS currently, it retains PBM services that constitute a significant share of the PBM marketplace. As such, looking at this as a merger of PBM market participants, the merger again runs afoul of the horizontal merger guidelines.

The Potential Merger would eliminate Aetna as a competitor in the PBM market. The increased market power that would result in the PBM market would empower the remaining PBMs to raise their prices, structure their offerings in a way that limit choice and engage in unfair contractual

practices. As competition is reduced, there are no incentives to conduct business in a manner that benefits the health and welfare of patients, but rather only benefits the "bottom line" of the PBM.

CSMS has significant concerns about the anti-competitive impacts of this Proposed Merger in both in the PDP and the PBM markets. When environments are anti-competitive, it is the consumer that is hurt. In the area of healthcare, we cannot afford for the healthcare of our patients to be compromised. The stakes are too large. Patients who lack choices will pay not only financially, but also with their health.

CSMS urges CID to follow the leads of the California Department of Insurance in finding significant anti-competitive concerns and impact with this merger (see Attachment A). CSMS also urges CID to carefully consider the concerns outline in a letter to Commissioner Wade dated September 17, 2018 from the New York State Department of Financial Services (see Attachment B).

## THE PROPOSED MERGER WILL NEGATIVELY IMPACT THE PATIENTS OF CONNECTICUT

At the heart of any conversation on controlling healthcare costs, is the cost of pharmaceuticals. It is no secret that the costs of pharmaceuticals are rising at alarming rates and that patients can no longer bear the costs of certain medications. It is concerning to CSMS that in conversation with CVS NO firm commitment has been made to the patients of Connecticut to make any effort to lower pharmaceutical costs. CVS touts the cost-saving measure associated with this Proposed Merger, but no such commitments have been made to funnel any such cost-savings to the patients of Connecticut in the form of lower drug costs.

Equally as concerning to the physicians of CSMS is the rise of the CVS "minute clinic." It testimony before the California Department of Insurance, CVS noted that upwards of 80% of primary medical care can be done through their minute clinic offices, which are not staffed by physicians. Primary and preventative medicine are fundamental to patient health and wellbeing. Physicians have extensive training to not only treat illnesses as they arise, but to also recognize and prevent more significant medical conditions before they become potentially life threatening.

Quite simply put, the staff at the minute clinics does not have adequate training to serve as primary care providers when it comes to treatment of significant illnesses as well as preventative medicine.

In addition, the minute clinic model disrupts the continuity of care for patients. Primary care physicians know which specialists they have referred patient to and are aware of the treatment provide to their patients by any such specialist. The Minute Clinics do not adequately communicate patient treatment to both primary care physicians and specialist. CSMS physicians have reported receiving no information from Minute Clinics their patients have sought treatment at or have reported that such treatment reports can arrive months after treatment is rendered. This model of care clearly is not beneficial to the health and wellbeing of Connecticut's patients and, in fact, only serves to increase healthcare costs as certain test and procedures may be duplicated.

CSMS would have hoped that the CID hearing process could have afforded the interested public, the physicians and patients of Connecticut, more access to information and more time to question the parties engaged in this purchase so that concerns could be heard in a public forum and the parties could provide answers to the questions that the public has tied to profits, market consolidation, and care delivery. It is unfortunate that the CID decided it was in the best interest of the public to limit the process, restrict who and how questions could be presented and what information was made publicly available for the process of public review. We only can hope and must question the due diligence process of the CID in this matter.

Again, while we appreciate and continue to believe that CVS will engage in open discussion with CSMS and the physicians and patients of Connecticut, our concerns about the proposed new company's structure, size, and market control, leads CSMS at this time to oppose the merger and ask that CID reject the request of CVS taking over Aetna. CSMS would hope, however, if approved, that there would be commitments in writing made by CVS as to the need for some structural and practical changes at Aetna to improve and increase transparency of medical treatment guidelines, medical payment policies and focus more on the provision of medical care in partnership with physicians and other health care professionals, as well as patients, rather than in an ongoing adversarial role.

# Attachment A

STATE OF CALIFORNIA
**DEPARTMENT OF INSURANCE**

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Dave Jones, *Insurance Commissioner*

August 1, 2018

The Honorable Jeff Sessions
Attorney General of the United States
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950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001

Mr. Makan Delrahim
Assistant Attorney General
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**RE: Proposed merger of CVS Health Corporation and Aetna, Inc.**

Dear Attorney General Sessions and Assistant Attorney General Delrahim:

I am writing regarding the proposed acquisition of Aetna Inc. (Aetna) by CVS Health Pharmacy, Inc., a direct, wholly-owned subsidiary of CVS Health Corporation (CVS). The California Department of Insurance has evaluated the effect of this proposed merger on competition in the California health insurance market and on California consumers. This letter provides the results of that evaluation and includes evidence obtained during a hearing I held on this matter.

As California's Insurance Commissioner, I am responsible for regulating the largest insurance market in the United States where insurers collect $310 Billion annually in premiums from Californians and California businesses. California is now the fourth largest insurance market in the world. Increasing competition in California's insurance markets delivers important benefits to Californians. Mergers which decrease competition are not in the interest of Californians. Health insurers and managed care plans collect more than $122.9 billion in premium annually from Californians.[1] As Insurance Commissioner, I closely monitor changes and proposed changes in the insurance market, such as proposed health insurer mergers or acquisitions that might directly affect California and its businesses and residents. I also monitor and review regional, national, and international changes in the insurance markets which have collateral

[1] Josh Cothran, *The Private Insurance Market in California, 2013* (Cal. Health Care Found. Feb. 2015), http://www.chcf.org/publications/2015/02/data-viz-health-plans. The California Department of Insurance regulates indemnity, Exclusive Provider Organization (EPO), and Preferred Provider Organization (PPO) coverage in California. The California Department of Managed Health Care regulates managed care organizations (health care service plans, aka HMOs).

impacts on the California insurance market. The California Department of Insurance is routinely called upon for its expertise on national insurance market and regulatory issues.

In 2016, I reviewed three proposed health insurance mergers, two of which I concluded were anti-competitive. The first merger, that of Centene and Health Net, involved a company focused on government contracts (Centene) acquiring a struggling company active in the commercial market (Health Net). I approved that acquisition after imposing stringent requirements on the combined entity to remain in the commercial market as a strengthened, viable competitor. The second proposed merger, that of Anthem and Cigna, I concluded was anti-competitive under the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) Anti-Trust Guidelines. After an extensive legal and evidentiary hearing I formally requested that the DOJ bring an action to block the Anthem-Cigna merger.[2] The DOJ filed an action and obtained a federal district court order blocking that merger. I also concluded, after an extensive legal and evidentiary hearing, that the third proposed merger, that of Aetna and Humana, was anti-competitive and would reduce consumer choice, reduce the quality of healthcare in California, and was likely to result in increased prices. I formally requested that the DOJ sue to block the Aetna-Humana merger.[3] The DOJ sued to block this merger and obtained a federal district court order blocking the merger, which was consistent with the findings I had made regarding the anti-competitive impacts of this merger.

The three mergers of health insurers in 2016 involved horizontal mergers -- they were mergers involving competitors in the same industry. In contrast the proposed CVS-Aetna merger is predominantly a vertical merger, involving entities that do not largely directly compete with each other: a health insurer and a pharmacy benefit manager (PBM) / retail pharmacy chain which operate at different points in the health insurance and pharmaceutical supply chain or service. Vertical mergers (also called "non-horizontal" mergers) can raise competition concerns however, because if a seller owns their supplier, they may erect barriers that also make it difficult for other sellers to use that supplier. This is especially problematic if that supplier has dominant market power, which is the case here with CVS. Although this merger is predominantly a vertical one, this merger also has horizontal impacts.

The proposed CVS-Aetna merger raises a number of competitive concerns for California health insurance and healthcare consumers. CVS has a dominant footprint as a retail pharmacy chain. It also dominates the market for PBM services through its subsidiary, CVS-Caremark. As a PBM, CVS-Caremark acts as an intermediary in the drug distribution chain by negotiating prices with drug companies, and receiving rebates from them, while also establishing networks and formularies for insurers. Consolidating the retail and PBM services of CVS with a major health insurer may have an adverse effect on the ability of other health insurers to access these

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[2] See Letter of Insurance Commissioner Dave Jones to Attorney General Loretta Lynch dated June 16, 2016 containing detailed findings of fact and law regarding anti-competitive impact of Anthem-Cigna merger, http://cdicms.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/LetterCSDOJAnthem-Cigna06-16-16.pdf

[3] See Letter of Insurance Commissioner Dave Jones to Attorney General Loretta Lynch dated June 23, 2016 containing detailed findings of fact and law regarding anti-competitive impact of Aetna-Humana merger. http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Aetna-Humana-Letter-to-US-DOJ-Final-835am-signed.pdf

suppliers, hindering their ability to compete in, or enter, the California insurance market. Such anti-competitive impacts could hurt California consumers.

My Department does not have direct approval authority over this proposed acquisition because the transaction does not involve a California domestic or commercially domiciled insurance company. However, the transaction does involve an Aetna subsidiary, Aetna Life Insurance Company, which is licensed by the California Department of Insurance to sell health insurance in California, and provides coverage to more than a million Californians.

This merger poses immediate competitive concerns in California and nationwide, based on an evaluation of regional markets using the factors recited in the DOJ *Non-Horizontal Merger Guidelines*, revised April 18, 1997.[4] Similarly, the merger poses competitive concerns in the Medicare Part D market when reviewed using the factors recited in the U.S. DOJ and Federal Trade Commission's (FTC's) *Horizontal Merger Guidelines*.[5] Additionally, another significant concern is that the proposed merger of Aetna and CVS removes Aetna as a potential competitor from an already concentrated PBM market. In an era where the largest insurers increase barriers to entry by consolidating market power, the loss of a PBM entrant with the resources and expertise needed to expand into a heavily consolidated market would be a substantial loss for Californians as well as nationally.

The proposed CVS-Aetna merger would combine the country's third largest health insurer by market value with one of the country's largest PBM / pharmacy chains at a time when the national market for PBM services is already highly concentrated. In addition to removing Aetna as an important potential competitor from the PBM marketplace, the enhanced market power of a merged CVS and Aetna will have an anticompetitive effect on both California's PBM and health insurance markets, as well as an anticompetitive impact on the retail pharmacy market. The combined entity will also be able to increase barriers to other entities seeking entry into the PBM market, increase costs, decrease the quality of care provided to its members, and reduce competition in the retail pharmacy market. Accordingly, in light of the anti-competitive impacts of the proposed merger, and the fact that the alleged benefits could be achieved through other arrangements, such as contracting, I conclude that the proposed merger of CVS and Aetna is anti-competitive and recommend that the United States Department of Justice challenge this transaction.

## I. BACKGROUND: THE CVS-AETNA MERGER HEARING

I held a public hearing regarding the proposed merger on June 19, 2018. The hearing transcript, reports of expert witnesses, and comments submitted by the companies and members of the

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[4] U.S. Dep't of Justice *Non-Horizontal Merger Guidelines*,(originally issued as part of "U.S. Department of Justice Merger Guidelines, June 14, 1984") [hereinafter *Non-Horizontal Merger Guidelines*], *available at* https://www.justice.gov/sites/default/files/atr/legacy/2006/05/18/2614.pdf.

[5] U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* (Aug. 19, 2010) [hereinafter *Horizontal Merger Guidelines*], *available at* https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

public are available on the website of the California Department of Insurance.[6] Thomas M. Moriarty, Executive Vice President, Chief Policy and External Affairs Officer, and General Counsel, testified for CVS, and Kristen Miranda, California Market President and West Region Head, testified for Aetna. Expert witnesses offered analyses of the competitive impact of the proposed mergers. Representatives of consumers, medical providers, and community organizations also testified. I also received written public comment. Further, my Department and I reviewed multiple studies and published articles regarding the impact of health insurance mergers, and the CVS and Aetna merger in particular.

## II. THERE IS SUBSTANTIAL EVIDENCE THAT THE MERGER WOULD IMPAIR COMPETITION BY INCREASING MARKET CONCENTRATION AND ENHANCING CVS/AETNA'S MARKET SHARE AND MARKET POWER IN THE PBM MARKET, THEREBY ERECTING BARRIERS TO NEW ENTRANTS.

The PBM market, like the rest of the health insurance market in California and nationally, already suffers from a high degree of market concentration and limited competition. Approximately 70% of all prescriptions are filled by one of three PBM firms: Express Scripts, Caremark (owned by CVS), and OptumRx (owned by UnitedHealth).[7] It is difficult for new entities to enter and compete in the PBM market. This difficulty is amplified in a large market like California. The concentrated nature of the PBM market, the lack of a strong regulatory scheme, and the opaqueness of PBM contracts, puts consumers and direct purchasers of PBM services at a severe disadvantage.

### *A. The CVS-Aetna merger will eliminate Aetna as a potential entrant into the already highly condensed and competitive PBM market.*

By acquiring Aetna, CVS prevents Aetna from entering the PBM market as a separate competitor. Aetna has stated publicly that it had considered entering the PBM marketplace prior to agreeing to be purchased by CVS.[8] Aetna, as one of the nation's largest health insurers, could develop its own in-house PBM. In fact, Aetna currently undertakes numerous important PBM services in-house, including rebate contracting with drug manufacturers for most of its commercial clients, as well as formulary development.[9]

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[6] California Department of Insurance (CDI) Hearing transcript and materials are available at: http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm.

[7] Amanda Starc, Associate Professor of Strategy, Kellogg School of Management, Northwestern University, *Comments on Selected Issues RE the Proposed Mergers of Aetna and CVS*, May 15, 2018 (rev. July 3, 2018) ("Starc Report"), at 9; *citing* Fein, Adam, *The 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, (2017) Pembroke Consulting, Inc. and Drug Channels Institute.

[8] Thomas Sabatino, *Testimony*, House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, February 27, 2018 at 40:01 of recorded testimony available here: https://judiciary.house.gov/hearing/competition-pharmaceutical-supply-chain-proposed-merger-cvs-health-aetna/.

[9] CVS Aetna Supplemental Submission to CDI July 16, 2018, http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/CVS-Aetna-Supplemental-Submission-to-CDI-July-16-2018.pdf.

Aetna's financial statements to the SEC state that it performs the following PBM services for Aetna's pharmacy customers, including: product development, commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs.[10] This demonstrates an existing proficiency and level of experience providing significant PBM services. If Aetna were to enter the PBM market and offer PBM services to others, it would provide meaningful additional competition in the PBM market.[11]

The *Non-Horizontal Merger Guidelines* point out that "the non-horizontal merger of a firm already in the market... with a potential entrant... to the market may adversely affect competition in the market."[12] Removal of a potential competitor from the market may have the effect of "harm to 'perceived potential competition.'"[13] The removal of Aetna as a potential PBM entrant eliminates a potential large competitor that would have reduced concentration in the market. When there is more competition in the market, prices tend to decrease and consumers can benefit from not only lower prescription drug prices, but, potentially, lower premiums as well if health insurers pass on drug cost savings to insureds. Additionally, in order for a PBM to be successful, it needs covered lives to negotiate volume discounts with drug manufacturers. Removal of Aetna, the third largest health insurer in the nation with more than 23 million covered lives, from the PBM market restricts the opportunities for new as well as existing PBM competitors in the market. Further, as Aetna provides its own key PBM functions in-house, given its market share in the insurance market it is also already a significant participant in the PBM market as a self-supplier; thus, the proposed merger with CVS has horizontal merger implications in the PBM market, as well.

### *B. Evidence Demonstrates that the Merger Would Put Other Health Insurers at a Competitive Disadvantage*

CVS currently provides PBM services to 94 million plan beneficiaries nationally, of which 22 million are Aetna subscribers.[14] Additionally, many of the largest PBM competitors are also owned by health insurers, such as OptumRx which has merged with UnitedHealthcare, and Cigna, which has initiated a merger with Express Scripts.

The PBM market's lack of competition and the merger of CVS-Aetna is likely to put other insurers that do not own a PBM at a disadvantage. Post-merger, as a PBM, CVS will have less incentive to keep down the cost of prescription drugs and other health care costs for other health insurers competing with Aetna. PBMs garner profits through rebates with pharmaceutical manufactures. The PBM retains a portion of these rebates and passes a portion of the remaining rebate back to the health insurer, which allows the insurer to potentially lower premium rates.

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[10] Sood Report at 9; Aetna 10-k Report (Dec. 31, 2017), at 7, available at http://www.aetna.com/investors-aetna/assets/documents/2017/4q17-form-10k.pdf (SEC 10-k Report).
[11] Starc Report, *supra* at 12.
[12] *Non-Horizontal Merger Guidelines, supra* at 1.
https://www.justice.gov/sites/default/files/atr/legacy/2006/05/18/2614.pdf.
[13] Id.
[14] Sood Report at 10.

Post-merger, when acting in its capacity as a PBM, CVS would have less of an incentive to pass these rebates to contracted health insurers that may be in competition with Aetna. Consumers insured with those competitors could face higher premiums as a result.

The risk that CVS would have less of an incentive to pass on rebates or provide services to competing health insurers increases the risk of "vertical foreclosure." Vertical foreclosure occurs when a newly integrated distributor stops selling products to a downstream firm's rivals, or increases the rival's costs, such as if CVS refuses to contract with health insurers or increases the cost of prescription drugs to other health insurers.[15] Vertical foreclosure increases antitrust concerns because a rival health insurer could be excluded from the market or forced to pay higher costs. Such risks are increased in a concentrated market like the current PBM market where an insurer has only two other large PBM firms to choose from, one of which is already owned by another health insurer (OptumRX – UnitedHealth).

Professor Neeraj Sood[16] analyzed whether CVS-Aetna would have a financial incentive to place competing health insurers that contract with the combined entity's PBM at a disadvantage, and risk losing those PBM customers, in order to gain insurance customers. Professor Sood found that if CVS-Aetna, post-merger, lost a PBM customer it would equate to approximately $23 in lost profits. However, a gain by CVS-Aetna of a health insurance consumer would result in approximately $323 in profits. This results in a single insurance consumer being as valuable as fourteen PBM consumers, thus providing a strong incentive for CVS-Aetna to disadvantage competing health insurers in its PBM practices.[17]

The PBM market is largely unregulated, resulting in an opaque pricing and rebate structure that gives both the pharmaceutical manufacturer and the PBM incentives to allow higher prices and higher rebates, therefore increasing the risk of vertical foreclosure. Although CVS states that it currently passes along more than 90 percent of its overall rebates to clients, they provided no evidence of anything that would prohibit them from changing this practice post-merger.[18]

### *C. The CVS-Aetna merger will result in a need for two-level entry into the PBM and health insurance market.*

The CVS-Aetna merger will make it much more difficult to enter the PBM market unless the PBM is able to simultaneously enter, or is already in, the health insurance market. The *Non-Horizontal Guidelines* note that this "need for simultaneous entry to the secondary market gives rise to substantial incremental difficulty as compared to entry into the primary market alone."[19] The cost for such entrance, including the process of building a provider network and securing sufficient covered lives, is extremely high and likely to create a bar to those smaller entities that previously may have been able to enter the PBM market only. Expert witnesses at the June 19,

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[15] Starc Report at 10.
[16] Neeraj Sood, Ph.D., Professor of Public Policy, Sol Price School of Public Policy, University of Southern California.
[17] Sood Report at 11-12.
[18] CVS-Aetna July 3, 2018 letter at 2.
[19] *Non-Horizontal Merger Guidelines, supra* at 27.

2018 hearing stated that new entrants to the PBM market would be required to have the capabilities to be a payer and PBM in order to compete in the PBM market after the CVS-Aetna merger.[20] This additional burden on entry into the PBM market will only further stifle competition. [21]

Additionally, in Aetna's SEC 10-K Report, it states that "other suppliers also provide certain [PBM] services" to Aetna.[22] If, post-merger, Aetna transfers this business to CVS it will only further diminish the ability of new entrants to enter the PBM market if the opportunity to bid and contract to provide these services is removed from the market.

*D. The CVS-Aetna merger will harm independent retail pharmacies.*

Much like the PBM market, the pharmacy markets nationally are "uncompetitive or highly concentrated."[23] In their supplemental letter, CVS Health argued that their pharmacy share "in California is 21.3% and nationally is 16.2%."[24] While significant itself, this nationwide and California market share obscures the market dominance of CVS in specific regions. In filings with the Securities and Exchange Commission, CVS Health states "[w]e currently operate in 98 of the top 100 United State drugstore markets and hold the number one or number two market share in 93 of those markets."[25] In 14 of the country's largest metro-areas, CVS and Walgreens, together, control 50 to 75 percent of the drugstore market.[26] Research suggests that drug prices consumers pay at pharmacies in a single local market may vary widely for the same product, but that drug prices found at independent pharmacies and online discount websites were lower on average than prices at chain drug stores, such as CVS.[27] Consumers, then, are arguably better served when there is not only a competitive market, but when that market includes independent pharmacies and online discount websites to fill prescriptions in addition to large retail pharmacies. The CVS-Aetna merger will only serve to increase CVS's dominance in the pharmacy market and will likely increase overall prescription drug prices for consumers.[28]

In addition, CVS-Aetna could disadvantage other retail pharmacies by creating cost-sharing structures that incentivize insureds to seek services from CVS over their competitors. During our hearing, representatives from Aetna stated that they "certainly don't have any plans to modify cost sharing for CVS versus non-CVS retail pharmacies"[29] to accomplish this. However,

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[20] Starc Report, *supra* at 11; Sood report, *supra* at 16.
[21] Report of Professor Thomas L. Greaney, University of California Hastings College of Law, June 19, 2018 at 6, http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Greaney-Statement-to-CA-Department-of-Insurance-6-19-18.pdf
[22] SEC 10-k Report, *supra* at 7.
[23] Sood Report, *supra* at 13.
[24] CVS Aetna Supplemental Submission to CDI July 3, 2018, at 3 http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/CVS-Aetna-Supplemental-Submission-to-CDI-July-3-2018.PDF.
[25] SEC 10-k Report, *supra* at 6.
[26] Sood Report, *supra* at 13
[27] Sood Report, *supra* at 6.
[28] Sood Report, *supra* at 14.
[29] Testimony of Kristen Miranda, California Market President & West Region Head, Aetna, CDI Transcript, *supra*, at 63:15-20.

this vague response is far less than a binding affirmative commitment not to engage in anticompetitive behavior which could drive small, independent pharmacies out of business or result in CVS purchasing them, thus further concentrating the retail pharmacy market. Similarly, in addition to cost-sharing, the combined entity could engage in other anticompetitive conduct, such as giving preferential display to CVS pharmacies in price-comparison websites, or by Aetna providing preference to CVS pharmacies in network designs.[30]

*E. The Market Dominance of CVS in Specialty Pharmacy, in Combination with Aetna, Would Provide Market Power That Promotes Anti-Competitive Practices That Negatively Affect Patient Care*

CVS Specialty, a subsidiary of CVS Health, is the largest specialty pharmacy in the nation.[31] Three of the largest specialty pharmacies, owned by CVS Health, Walgreens Boots Alliance, and Express Scripts, account for 60% of all specialty prescription revenues.[32] CVS has a 25% specialty prescription market share by revenues.[33] Specialty pharmacies are a source of medications for patients with complex, serious conditions, such as cancer, cystic fibrosis, and HIV/AIDS; certain of these drugs (such as chemotherapy drugs) may, however, also be available from a treating physician.[34] Specialty pharmacies are a significant source of revenue growth.[35] Because of the highly attractive potential for increased revenues, the combined CVS-Aetna entity will have strong incentives to steer insured persons, through such mechanisms as using preferential cost-sharing arrangements, towards CVS Specialty for specialty drugs, and financially penalize consumers for obtaining the specialty drug from their treating physician. This financial penalty fragments care by removing the oversight of the treating physician, which impairs monitoring of the course of treatment. This is of particular significance for chemotherapy treatments.[36]

## III. THE MERGER WILL HAVE HORIZONTAL ANTICOMPETITIVE IMPACTS ON THE MEDICARE PART D MARKET.

*A. Analysis of HHI Demonstrates that the Merger Would Significantly Increase Concentration in the Medicare Part D Market.*

Although the merger has been described as a vertical merger and the preceding analysis focuses on the potential anti-competitive impacts of the vertical merger, the CVS-Aetna merger also presents horizontal merger implications. Both CVS and Aetna participate in the Medicare Part D (Part D) prescription drug plan market. In 2018, 25 million people nationally and 2.3 million in

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[30] Sood report, *supra* at 13-14
[31] CVS Health 2017 Annual Report, at 10: http://investors.cvshealth.com/~/media/Files/C/CVS-IR-v3/reports/cvs-ar-2017.pdf.
[32] Starc report, *supra* at 10.
[33] "The Top 15 Specialty Pharmacies of 2017: PBMs and Payers Still Dominate" Drug Channels, March 13, 2018, https://www.drugchannels.net/2018/03/the-top-15-specialty-pharmacies-of-2017.html.
[34] Starc Repot, *supra* at 13.
[35] Testimony of Barbara McAneny, M.D., CDI Transcript, *supra*, at 180:15-16.
[36] Id. at 181:22-25.

California are covered under a Part D prescription drug plan.[37] Nationally, Aetna has a 9% market share among Part D plans while CVS Health has a 24% market share, with even greater overlap in some geographic markets. Economic evidence suggests that increasing the market concentration and reducing competition for Part D plans will likely result in higher premiums.[38] In some states, the combined Part D market share of CVS and Aetna is even greater-- in Connecticut, CVS has a 30.1 percent share of Part D enrollees and Aetna's share is 7.6 percent in that state.

Professor Richard M. Scheffler of the U.C. Berkeley School of Public Health analyzed the 34 Part D regions for overlap in the standalone prescription drug plans (PDP) that provide coverage to Medicare recipients (distinguished from Medicare Advantage Prescription Drug Plans (MAPDP)). Dr. Scheffler used the Herfindahl-Hirschman Index (HHI) to measure the PDP market concentration, in accordance with the *Horizontal Merger Guidelines*. To determine the HHI, Dr. Scheffler calculated market concentration using two different assumptions 1) premerger HHI, with CVS and Aetna operating as separate firms; and 2) post-merger HHI, where CVS and Aetna operate as a single firm. Additionally, market concentration measures from 2009 to 2017 were calculated to show the trend in the PDP market.

Professor Scheffler concluded that the CVS/Aetna post-merger HHIs and HHI increases would result in determinations of "presumed likely to enhance market power" or "potentially raise significant competitive concerns and often warrant scrutiny" in a large number of counties for each of these markets, as defined in the *Horizontal Merger Guidelines*, as follows:

1. Market Concentration Trends and Post-Merger HHI:

    a. The national PDP market would become moderately concentrated (HHI of between 1,500 and 2,500) with an HHI increase over 400, and thus the merger would "potentially raise significant competitive concerns and often warrant scrutiny."

    b. The California PDP market would become moderately concentrated (HHI of between 1,500 and 2,500) with an HHI increase 434 points, and thus the merger would "potentially raise significant competitive concerns and often warrant scrutiny."

These HHI and HHI increase levels, together with relatively high entry barriers, increase the oligopolistic nature of these markets and raise a reasonable probability of coordinated anticompetitive conduct by market participants.

CVS and Aetna representatives, both at our June 19th hearing and in a supplemental submission, assert that there is ample competition in the Part D market, because the PDP market also competes with MAPDP. I find this assertion unpersuasive and not supported by the weight of evidence. Instead, I agree with the court in *United States v. Aetna Inc.*, 240 F.Supp.3d 1, 20, 42

[37] AMA report, *supra* at 2.
[38] Starc report, *supra* at 3.

(D.D.C. 2017), that there is very little consumer movement between MAPDP and PDP plans in response to price increases. Other studies have also shown that most Medicare enrollees tend to stick with their original plan of choice, even when they are faced with relatively large premium increases.[39] It is true that there are ten competitors in the PDP market in California, but this merger would result in just three competitors controlling 83% of the market,[40] a significant concentration of the market with likely anti-competitive impacts.

## IV. CVS AND AETNA HAVE PROVIDED NO RELIABLE EVIDENCE DISPROVING THE LIKELY HARMS FROM THE MERGER, OR INDICATING THAT THE ASSERTED EFFICIENCIES OR CONSUMER BENEFITS WOULD COUNTERACT THE HARM TO COMPETITION

### *A. The Companies Have Neither Provided Reliable Evidence of Claimed Efficiencies, Nor Reliable Evidence that Efficiency Savings Will Be Passed on to Consumers.*

The *Horizontal Merger Guidelines* note that "[e]fficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means" or if the efficiencies could be achieved unilaterally or by collaborative means short of a merger.[41] When the parties fail to present persuasive evidence about a merger's benefits, such as actual efficiencies, one can infer that evidence is lacking.

In testimony at our hearing, CVS asserted that the proposed acquisition would result in $750 million dollars of savings from reduced marketing, as well as general and administrative expenses. At the hearing, I asked representatives of both CVS and Aetna for greater detail on how these savings would be generated and what percentage of these savings would be passed on to consumers. They were unable to provide an estimate.[42]

> Commissioner Jones: Let me ask specifically, will the entirety of the $750 million be allocated to reductions in premium or decreases in the rate of increase of premium for the merged entity?
>
> Mr. Moriarty *[Executive Vice President, Chief Policy and External Affairs Officer, General Counsel, CVS Health]*: I can't say, Commissioner, what percentage will. There will certainly be some. There obviously are investments that need to be made in systems and other programs to drive these longer term, and you'll see a component of that reinvested into the business as well to improve the services and develop better programs as we go forward.

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[39] *To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?* October 10, 2013, Kaiser Family Foundation, available at: https://www.kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/.

[40] Based on April 2018 CMS plan enrollment data.

[41] *Horizontal Merger Guidelines, supra,* at 30.

[42] CDI Hearing Transcript, 13:12-4, 16-19, 50:13-51:1, 51:14-51:19

> ...
>
> Commissioner Jones: Can Aetna give me any estimate of the portion of the $750 million a year that can be allocated to premium reductions or decreases in the increase in premium?
>
> Mr. Wingle *[Vice President for Operations, Product, and Technology, Aetna.]*: I don't have that information available at this time.

Similarly, in the two supplemental responses provided by the companies after the hearing, the companies were unable to quantify the estimated premium reduction anticipated as a result of the alleged efficiencies resulting from the merger.[43] This alleged benefit should be considered speculative in any weighing of benefits against anticompetitive impacts.

Professor Sood noted that "[p]ost-merger CVS would have a stronger incentive to control prescription drug costs... and overall health care costs for Aetna."[44] This is in comparison to the current assumption that, as a PBM, CVS does not have as strong an incentive to negotiate greater savings on behalf of health insurers. Post-merger "CVS would have reduced incentives to engage in practices that increase rebates at the cost of increasing spending on prescription drugs for Aetna."[45] However, as Professor Sood points out, the estimated savings and increased efficiencies touted by CVS-Aetna only occur if Aetna is not already providing its own core PBM services including strategic decisions on formulary design and price negotiations with pharmaceutical companies.[46] Currently, it appears that Aetna already performs its own core PBM services including product development, formulary management, pharmacy rebate contracting and administration, sales and account management, and precertification programs. As Aetna already performs its core PBM functions, the potential efficiencies from merging with the PBM arm of CVS would be minimal."[47]

Additionally, Professor Lawton Burns[48] and others noted that healthcare related mergers, including non-horizontal mergers, result in price increases, not price decreases.[49] An increase in market power does not necessarily result in savings being passed on to consumers.

### *B. Neither CVS nor Aetna Have Provided Reliable Evidence that Quality Will Improve*

At our hearing, CVS and Aetna's representatives only spoke in generalities about quality improvement. As noted above, academic experts on health insurer mergers find that in an

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[43] CVS-Aetna Supplemental Submissions to CDI on July 3, 2018, at 2-3, July 16, 2018, *supra.*
[44] Sood Report, *supra* at 8.
[45] Sood Report, *supra* at 8.
[46] Sood Report, *supra* at 9.
[47] Sood Report *supra* at 9.
[48] Lawton Burns, Ph.D., MBA, James Joo-Jin Kim Professor, Department of Health Care Management, The Wharton School, University of Pennsylvania.
[49] Burns Report, *supra* at 7.

oligopsony, quality usually decreases when there are so few competitors that they lack an incentive to compete to attract or retain customers by improving quality.

### C. *The CVS-Aetna merger will not benefit consumers*

PBMs act as intermediaries between drug manufacturers, employers, and health insurers. PBMs earn profits by selling prescription drugs at a markup to self-insured employers and health insurers. Arguably, the CVS-Aetna merger could drive down prescription drug costs because CVS would have an incentive to negotiate lower drug prices on behalf of Aetna, which could assist Aetna in lowering premiums. However, problematically, CVS and Aetna representatives would not commit to lowering premiums. Instead, they cite only to the "synergies" created by the merger which will result in cost savings to Aetna insureds, invoking the UnitedHealth – OptumRx merger as an example. CVS and Aetna state that UnitedHealth – OptumRx merger created "overall savings of $11-16 per member per month" and CVS expects that their merger would "yield hundreds of millions of dollars in medical cost savings, which could be passed on to consumers in the form of lower health premiums."[50] However, despite these savings, CVS-Aetna continues to refuse to commit to pass these savings on to consumers in the form of reduced premiums.

The "synergies" cited by CVS as benefiting consumers include: improving chronic care management, shifting care to lower-cost and more convenient sites, earlier and more effective medical interventions, and increased medication adherence. CVS relies on these methods as potential cost savings to consumers, by reducing the cost of site of care (by, for example, offering MinuteClinic visits rather than a doctor or urgent care visit) as well as number of occurrences (lower copays if visits are reduced). While such cost reductions may occur, it is more likely to affect a smaller number of high-frequency users. A reduction in premiums (that Aetna and CVS will not commit to) would help Aetna consumers across the spectrum. Further, as detailed in the testimony and report of Professor Burns, the purported benefits of the proposed merger's focus on clinics based in retail pharmacies do not outweigh the risks of fragmentation of care, reduction in care coordination by primary care providers, and avoidance of underserved populations, including persons with complex, chronic conditions.[51] The asserted benefits and efficiencies, if any, of a combination of clinic-pharmacy-and-insurer arise from a level of integration that can be obtained through contracting, without triggering the competitive concerns arising from this merger.

### D. *Divestitures Will Not Fully Restore Competition or Adequately Protect Californians.*

As to the horizontal aspects of this merger, divestiture of some portion of either or both companies or undertakings as to rates, quality, or investments will not remedy or sufficiently mitigate the anticompetitive impacts and results of this merger.[52] Further, once a merger is completed and consumers and competitors begin to experience the negative impact of the

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[50] CVS-Aetna Supplemental Submission to CDI, July 3, 2018, *supra* at 3 (emphasis added).
[51] Burns Report, *supra* at 8-22.
[52] *Horizontal Merger Guidelines*, *supra*, section 10.

merger, it will be too late to effectively mitigate these adverse outcomes. The law requires that any remedies fully restore competition. The necessary divestitures in the markets would be close to impossible to accomplish given the number and scale of the impacted areas. Additionally, divestiture to a company with an already significant market share would not remedy the competitive situation, and divestiture to a new entrant would likely fail in short order. A retrospective analysis of mergers indicates that even smaller divestitures fail to achieve the desired pro-competitive goals.[53]

## V. REGULATORY EXPERIENCE WITH AETNA URGES CAUTION

In testimony during the hearing, CVS and Aetna represented that the combined entity would implement safeguards that will prevent anticompetitive conduct after the merger. However, my Department's regulatory experience with Aetna Life Insurance Company is instructive, in that compliance with legal requirements cannot be assumed to occur in the absence of oversight. For example, the Department's most recent publicly available market conduct examination of Aetna Life Insurance Company indicated a persisting trend of likely violations[54] relating to Aetna's claims handling procedures and practices. This exam found numerous alleged violations, including improper representation of pertinent facts and policy provisions to claimants, incorrect denials, unsatisfactory settlements, failure to inform the insured of the right to independent medical review, and failure to conduct fair investigation of claims. The exam also found violations related to claims handling, including but not limited to failure to conduct a thorough investigation, and failure to provide clear reasons for denial of claims.[55]

Similarly, in recent years, Aetna Life Insurance Company's proposed prescription drug formularies, compared with those of other insurers, have been among the most restrictive in terms of coverage, with Aetna Life Insurance Company placing drugs vital to treating chronic conditions on high-cost tiers and subjecting insureds to excessive utilization management, and raising significant concerns regarding discriminatory formulary and plan designs that would discourage the enrollment of consumers with certain health conditions. My Department found that over half of the covered drugs for the treatment of opioid dependence, and opioid reversal agents, were placed on inappropriately high cost tiers in Aetna Life Insurance Company's proposed formularies. Similar inappropriate placement, as well as inappropriate prior authorization and specialty pharmacy restrictions, were seen for drugs used in HIV treatment. Resolution of these instances of inappropriate placement required regulatory intervention by my Department.

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[53] John Kwoka, Merger Control, and Remedies: A Retrospective Analysis of U.S. Policy (MIT Press 2015).

[54] Department examiners determined these violations based on a review of documentation provided in the course of performing market conduct examinations. The violations, however, are technically "alleged violations" because they have not undergone a formal administrative or judicial process.

[55] Further caution in the review of this merger is merited as this month another state insurance regulator issued an order of penalty against the CVS Caremark PBM operation, with a fine of over $1.5 million, for repeated violations related to claim denials. http://insurance.ky.gov/Documents/CVS%20Caremark%20Order%20-%20Press%20Release.pdf

Many of the concerns regarding anticompetitive conduct, such as information exchange, price differentials, and consumer steering, would be difficult to unwind after such a merger goes forward. Therefore, my Department's regulatory experience with one of the entities should be considered to be cautionary: promises of legal compliance are not necessarily self-executing.

## VI. CONCLUSION

The proposed merger of CVS and Aetna will significantly reduce competition in the PBM and Medicare Part D markets, affecting millions of health care consumers throughout the country. Applying the analysis typically used by the United States Department of Justice and the Federal Trade Commission, the merger will substantially enhance market concentration and power in these markets. A merger of this size and type, according to experts on health insurer and health care mergers, will likely lead to increased prices and decreased quality.

Further, partial divestiture or other remedies traditionally used by the Department of Justice will not adequately protect consumers or address the adverse consequences of a merger of CVS and Aetna. Traditional methods to avoid market concentration will not address potential impacts on service quality, the power to charge excessive rates, or the creation of barriers to block a potential market participant with the resources to enter into new markets.

Finally, the CVS-Aetna merger will eliminate Aetna as an important potential competitor in the PBM market. In the present health insurance and health care markets, it is impossible to create *de novo* a PBM competitor with the strength, experience, and provider relationships that Aetna has established. Loss of Aetna as a potential competitor in the PBM market is an irreplaceable loss of competition because of the extraordinary concentration of the PBM market and high barriers to entry. If there are any other entities considering entry into the PBM market, they will now have to enter the market in conjunction with a health insurer. Single entry PBMs will no longer be feasible to compete with these behemoths.

For these reasons, I conclude that the proposed merger of CVS and Aetna will have anti-competitive effects and not be in the interest of consumers or health insurance and healthcare markets in California and nationally. The CVS and Aetna merger will harm Californians and our health insurance market, and is likely to increase drug prices for consumers rather than reduce them. The CVS and Aetna merger will harm consumers in markets across the United States. Accordingly, I request that the United States Department of Justice sue to block the CVS-Aetna merger.

Sincerely,

Dave Jones

DAVE JONES
California Insurance Commissioner

# Attachment B

NEW YORK STATE
DEPARTMENT of
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

September 17, 2018

Hon. Katharine L. Wade
Commissioner
Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford, CT 06103

**Re: Issues for Consideration in Connecticut DOI's Review of the Proposed Acquisition of Aetna Inc. by CVS Health Corporation**

Dear Commissioner Wade:

I write to provide comments on behalf of the New York Department of Financial Services (NYDFS) regarding the proposed acquisition of control of Aetna Inc. (Aetna) and its subsidiaries by CVS Health Corporation (CVS)[1] in connection with the public hearing before the Connecticut Insurance Department scheduled for October 4, 2018. NYDFS has been reviewing this transaction, and we have identified several key issues that may be harmful to both New York and Connecticut consumers and markets, which we ask to be considered as the Connecticut Insurance Department evaluates this proposed acquisition.

NYDFS has regulatory approval authority regarding the proposed acquisition by CVS of Aetna Health Insurance Company of New York (Aetna-NY). In addition, Aetna has two managed care organizations subject to New York State's jurisdiction, and three Connecticut domestic insurers licensed to transact insurance business in New York, including Aetna Life Insurance Company (Aetna Life). NYDFS's interest in this proposed transaction is further substantial given the volume of Aetna's business in New York. In 2017, Aetna Life's direct business written in New York, approximately $3 billion, exceeded the direct premium writings of any other state or territory. Furthermore, Aetna Life's 2017 direct accident and health insurance premium writings in New York was 10.7% of its total direct accident and health insurance premium writings, making New York a significant market for Aetna.[2] The impact of CVS operating as a pharmacy benefit manager as well as a commercial enterprise is also a significant consideration in evaluating this proposed acquisition. In short, the decision on this acquisition of control will have a substantial effect on New York consumers and markets.

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[1] The Connecticut domestic insurance subsidiaries of Aetna Inc include Aetna Life Insurance Company, Aetna Insurance Company of Connecticut, Aetna Health and Life Insurance Company, Aetna Health Inc (a Connecticut corporation), and Aetna Better Health Inc. (a Connecticut corporation)

[2] New York is the state where Aetna Life wrote the most Accident & Health (A&H) business in 2017, with approximately 10.7% of its total A&H direct business of $28.0 billion, compared to all other 49 U.S. states, four U.S. territories, Canada, and other alien territories. Furthermore, Aetna Life's A&H direct premiums written in New York represents approximately 33% of the A&H market share in New York.

Therefore, I respectfully request that NYDFS's concerns, discussed below, be considered and addressed during the upcoming hearing and in your regulatory review of the transaction.

**1. Effects on Competition in Various Markets**

- ***Unfair Competitive Advantage For Aetna.*** Pharmacy Benefit Managers (PBMs), such as CVS Caremark, have a tremendous impact on health insurance coverage and premiums, since pharmaceuticals are the leading cost of health care today. PBMs negotiate prices with drug companies, receive rebates from them, and act as suppliers to insurers, while also establishing networks and formularies for insurers. PBMs lack full transparency and regulation, despite their tremendous impact on health insurance products and prices. Particularly in this context, the proposed acquisition of a health insurer by a PBM raises significant market competition concerns, because CVS Caremark would have the power – and the financial incentive – to offer Aetna larger rebates or other significant discounts to draw policyholders away from other insurers, thereby increasing market share that is already significant, and causing anti-competitive effects in the rest of the market. An independent study conducted has already found that CVS makes up to fourteen times more per insurance policyholder compared to per PBM enrollee; therefore, CVS has financial incentives to offer Aetna this advantage if this transaction were to proceed.[3] As a result, small and regionally-based carriers, without an affiliated PBM, will be further disadvantaged, thereby harming markets and consumers. This creates significant competitive concerns for the health insurance market nationally.

- ***Concentration in PBM Market.*** The current PBM market is very concentrated, i.e., the top three PBMs control 70% of the business in this highly opaque industry. CVS Caremark is one of the three pharmaceutical drug suppliers with dominant market power, and this proposed transaction, if approved, would further cement their position by removing Aetna as a potential competitor in the PBM market. As the third largest health insurer in the U.S., Aetna is one of the few insurers with the resources and expertise necessary to enter and compete in a heavily consolidated market. By acquiring Aetna, CVS seeks to remove that significant competition, to the detriment of the rest of the market and consumers. This lack of competition, coupled with the absence of full transparency and regulation over PBMs, and the consolidation of existing PBMs with insurers, would make it increasingly difficult for new entrants to the market, and losing Aetna as a potential competitor creates a loss for all consumers in Connecticut and New York, as well as the rest of the country.

- ***Increase in Medicare Prescription Drug Plan ("Part D") Concentration.*** Both CVS and Aetna participate in the Medicare Part D market. NYDFS has concerns about the resulting concentration effect in New York's Part D market were the proposed CVS-Aetna transaction to be approved.[4] Economic studies have shown that increased market concentration and reduced competition for Part D plans will likely result in higher premiums. Research also indicates that Medicare enrollees tend to stick with their original plan of choice, even when there are relatively large premium increases. Armed

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[3] Neeraj Sood, Ph.D., Professor of Public Policy, Sol Price School of Public Policy, University of Southern California.

[4] CVS and Aetna have a 24% and 9% market share, respectively, of Part D enrollees in the U.S. In Connecticut, CVS and Aetna have a 30.1% and 7.6% market share, respectively, of Part D enrollees. Therefore, the resulting concentration effect would be significant in both New York and Connecticut.

with this consumer behavior knowledge and its large market share, post-merger CVS-Aetna would not have much incentive to lower insurance premiums or drug prices, or to pass on its PBM rebates to consumers. Even if divestitures were required, it may only slightly decrease Part D concentration, but it does not address the potential premium or drug price increases. This is very concerning.

2. **Harm to Consumers by Increased Premiums and Drug Prices, and Data Privacy Issues.**

- ***No Commitment to Lower Premiums or Pass Savings to Consumers.*** CVS claims that this transaction would result in operational "synergies" and that the combined company would have an economic incentive to lower prices for Medicare Part D or its insurance premiums overall. However, CVS has not provided definitive support for the claimed synergies, nor offered any specific commitments that the acquisition in fact will benefit policyholders in the short term or long term. For example, CVS has claimed efficiency gains from its proposal to place "minute-clinics" in CVS pharmacies, where consumers can stop in without an appointment to see a nurse or physician assistant. However, sufficient details on the financial and operational aspects of this claim have not been provided. Moreover, we are concerned that such "minute-clinics" might provide unfair competition to other medical providers and hospitals, which when combined with CVS's proposed ownership of a major health insurer creates significant concerns for consumer choice and cost, as well as employment in the health care system overall.

- ***Drug Price Increases.*** As noted, pharmaceutical costs are the single largest driver of premium increases today. Research indicates that prices that consumers pay for drugs may vary widely for the same product, depending upon where the consumer makes the purchase. Drug prices at independent pharmacies and online websites are generally lower than large national drug store chains, such as CVS. However, through this proposed transaction, Aetna may create cost-sharing structures, network designs, or other incentives for insureds to utilize CVS services over their competitors. This would not only increase CVS's market share in the retail pharmacy industry, but the reduction in competition would result in higher drug prices passed on to consumers. The anti-competitive nature of this transaction likely would lead to consumers paying more for the same drugs sold through other channels of distribution, thereby increasing their health care costs, particularly those covered by Aetna.

- ***Data Privacy Concerns.*** CVS Caremark currently has access to drug claim data, patients' electronic medical records, and other member information from insurers that utilize its PBM services and compete with Aetna. NYDFS is very concerned about CVS' ability to protect consumers' data and ensure that data is not shared within the post-acquisition entities in order to increase market share and profits. We are concerned that consumer data will be used to further CVS enterprise initiatives, and that the accumulated data from across the enterprise (or portions of it) may be sold to third parties. In addition to anti-competitive concerns, the accumulation of this amount of consumer health data raises significant cybersecurity concerns. Were this transaction to proceed, CVS must commit to establishing strong safeguards to protect and prevent the sharing of consumers' data, both within the organization and outside of it, to the full satisfaction of regulators and on an ongoing basis.

3. **Effect of Substantial Financial Debt.** We are concerned with the considerable amount of debt – over $40 billion – that CVS is taking on to finance this transaction. S&P has stated that "CVS's financial risk profile will weaken considerably as a result of the significant increase in debt, given the scale of the acquisition as well as execution risks that could affect operating performance."[5] The uncertainty in CVS's ratings and financial risk profile is likely to increase the cost of existing and future debt, further exacerbating the repayment pressure on CVS, impacting Aetna policyholders and providers alike. NYDFS is concerned that this increased debt will create pressure on Aetna to raise premiums or take other actions that negatively impact consumers. The considerable pressure to repay debt would cause the resulting company to repay its substantial obligation before investing in other pro-market and pro-consumer measures, including infrastructure improvements that would be beneficial to consumers and/or provide relief to premiums for consumers.

**Conclusion**

The proposed acquisition of Aetna by CVS will affect millions of consumers in Connecticut and New York, as well as the rest of the country. The proposed transaction, if approved, would create an incredibly large market share in the health care market for the combined company, in an already concentrated marketplace, and is likely to increase prices for members and reduce options for consumers, without any discernible increase in quality. CVS already is a major player in the unregulated and opaque PBM market, which in itself creates real concerns as to the cost of prescription drugs and the reduction in competition. Moreover, CVS is a large commercial enterprise beyond health care, raising questions as to its commitment to health care service and quality. The size of the increased debt from this proposed transaction only amplifies these concerns, as the amount of debt may place undue pressure on consumers of Aetna's health insurance products. For these and other reasons, NYDFS has significant concerns about this proposed transaction and respectfully requests that you consider these concerns as you proceed with your upcoming hearing and transaction review.

Thank you for considering NYDFS's views.

Very truly yours,

Maria T. Vullo
Superintendent
Department of Financial Services

[5] Clara Linnane, *CVS's BBB-Plus Rating Placed On Creditwatch Negative By S&P After Aetna Deal*, MarketWatch (December 4, 2017, 11:32 am), https://www marketwatch.com/story/cvss-bbb-plus-rating-placed-on-creditwatch-negative-by-sp-after-aetna-deal-2017-12-04.

UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

**Connecticut Health Insurance Department**

**Written Statement on Proposed Acquisition of Aetna by CVS**

**October 2, 2018**

## Introduction

Universal Health Care Foundation of Connecticut offers these comments to highlight our concerns about the proposed acquisition of Aetna by CVS.

The Foundation of Connecticut is dedicated to achieving universal access to quality and affordable health care and to promoting health in Connecticut. We envision a health care system that is accountable and responsive to the people it serves.

We disagree with the fundamental argument put forth by CVS and Aetna that this merger will "deliver substantial public benefits such as improved health outcomes and lower health care spending," (Form A, page 3).

And we are concerned that the regulatory process underway in Connecticut is not sufficiently dedicated to answering this important question, "Will consumers benefit?"

After reviewing the evidence, our answer is that we have strong doubts that consumers will gain from the proposed acquisition. For that reason, we are proposing several conditions, should the merger be approved. We are including in our comments excerpts from statements made by experts at an investigatory hearing held in June in California. We are also including excerpts from comments written by public officials from New York and California who both raise serious concerns about the merger.

## Proposed Approval Conditions

If the acquisition of Aetna by CVS is approved despite the many concerns that exist about its potential to harm consumers, the Connecticut Insurance Department should at least consider imposing conditions on its approval. We suggest these three conditions, below:

- Connecticut passed a prescription drug transparency bill, PA 18-41, An Act Concerning Prescription Drug Costs, which begins to hold PBMs, insurers and drug companies accountable for high and rising prescription drug prices, by requiring each industry to provide information to state government. The merger takes Aetna and puts it under the control of CVS, a PBM. We would like to see assurances that this new combined entity will report as both a PBM and as an insurer.
- Aetna had announced previously that they were going to pass prescription drug rebates on to consumers at the pharmacy counter when customers are in their deductible period. The Insurance Department should require that they stick to this policy after the merger.

- CVS should be required to work with the Office of Health Strategy to expand and open Minute Clinics in underserved areas of the state where there is a demonstrated shortage of primary care. Minute Clinics should also be required to accept Medicaid patients, if this is not true already.

**Expert Witness Testimony from California's Department of Insurance Investigatory Hearing**

In California, a much more extensive hearing was held on June 19, 2018 that included testimony from expert witnesses familiar with the downsides of health care mergers. (See http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Aetna-CVS-Merger-Information.cfm) No such opportunity to hear from experts is happening in Connecticut. Instead, written comments can be submitted and speakers may make public comments, limited to 3 minutes each, on the day of the hearing.

Several of the comments from these experts are included below, along with links to their testimony, to ensure that they are included in the public record.

1. **Lawton R. Burns, Ph.D., MBA The James Joo-Jin Kim Professor Department of Health Care Management, The Wharton School University of Pennsylvania "Proposed Merger of Aetna, Inc. into CVS Health Corporation," June 19, 2018**

   http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Burns-Testimony-of-Lawton-R-Burns-in-Aetna-CVS-Merger-June-2018.pdf

   - "The proposed merger is based on the corporate strategy of vertical integration. There is no prima facie evidence for consumer welfare benefits flowing from this strategy. Indeed, in the healthcare industry, this strategy usually leads to higher prices, higher costs, and higher utilization. Sometimes it also results in greater market power."
   - "The specific benefits of the merger espoused by company executives are unlikely to be achieved. The numerous benefits cited lack any documentation and are contradicted by the research evidence.
   - Many of these benefits rely on retail pharmacies and in-store health clinics to 'transform' healthcare and serve as a healthcare hub for consumers. For a multitude of reasons, such outcomes are unlikely. In fact, pharmacy-based retail clinics are unlikely to improve quality, improve health outcomes, or reduce cost of care.
   - I conclude that there are no apparent benefits from the proposed merger that compensate for welfare losses stemming from antitrust concerns."

2. **Thomas L. Greaney, Professor of Law, University of California Hastings College of Law, "Statement before the Investigatory Hearing on Merger of Aetna Inc. into CVS Health Corporation," June 19, 2018**

   http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Greaney-Statement-to-CA-Department-of-Insurance-6-19-18.pdf

   "My bottom line is this:
   - Market concentration is a leading cause of high costs in health care;
   - Antitrust enforcers have neglected the risks associated with vertical combinations;
   - The CVS/Aetna merger is likely to lessen competition in the standalone prescription drug plan market;

- The CVS /Aetna combination, along with Express Scripts/Cigna merger will likely enhance incentives to stifle competition by foreclosing competition or raising rivals' costs."

3. **Neeraj Sood, PhD, Professor of Health Policy at the University of Southern California, "Potential effects of the proposed CVS acquisition of Aetna on competition and consumer welfare," June 14, 2018**

   http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Sood-AMA-finalv3.pdf

   "In summary, several segments of the pharmaceutical supply chain are highly concentrated and several players engage in practices that hurt consumers. The acquisition of Aetna by CVS will increase incentives for CVS to be a better PBM for Aetna but it will simultaneously create incentives for CVS to be a worse PBM for health plans competing with Aetna. These incentives will likely reduce competition in health insurance markets. In my opinion, the potential costs of reduced competition in insurance markets outweigh potential benefits of CVS being a better PBM for Aetna. The acquisition of Aetna by CVS will also likely reduce competition in the pharmacy and PBM markets, increasing drug spending and out of pocket costs for consumers. The potential costs of reduced competition in pharmacy and PBM markets due to the merger outweigh potential benefits, if any, of integration of medical and pharmacy data due to the merger."

4. **Amanda Starc, Associate Professor of Strategy Kellogg School of Management Northwestern University, Comments on Selected Issues Re: The proposed mergers of Aetna and CVS, May 15, 2018**

   http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/StarcReport-revised_070318.pdf

   "Given the degree of concentration and horizontal consolidation in the insurance industry, it is reasonable to believe that any cost-savings will increase insurer profits, rather than reducing consumer costs. Empirically, there are reasons to be skeptical that the savings will be realized and ultimately captured by the consumer. Therefore, the potential for harm to consumers from this merger is likely to outweigh any gains."

**Written Comments from Public Officials**

Two public officials from other states, California's Insurance Commissioner Dave Jones and New York's Superintendent of the Department of Financial Services Maria Vullo, have also weighed in, expressing multiple concerns about the acquisition.

5. **Decision Letter of California Insurance Commissioner Dave Jones, August 1, 2018**
   http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr085LtrJonestoUSAGSessionsreCVS-AetnaMerger.pdf

   "I conclude that the proposed merger of CVS and Aetna will have anticompetitive effects and not be in the interest of consumers or health insurance and healthcare markets in California and nationally. The CVS and Aetna merger will harm Californians and our health insurance market, and is likely to increase drug prices for consumers rather than reduce them. The CVS and Aetna merger will harm consumers in markets across the United States.

Accordingly, I request that the United States Department of Justice sue to block the CVS-Aetna merger."

6. **Letter from Maria T. Vullo, Superintendent, New York State Department of Financial Services to Insurance Commissioner Katharine Wade, "Issues for Consideration in Connecticut DOI's Review of the Proposed Acquisition of Aetna, Inc. by CVS Health Corporation," September 17, 2018**

   "The proposed acquisition of Aetna by CVS will affect millions of consumers in Connecticut and New York, as well as the rest of the country. The proposed transaction, if approved, would create an incredibly large market share in the health care market for the combined company, in an already concentrated marketplace, and is likely to increase prices for members and reduce options for consumers, without any discernible increase in quality. VS already is a major player in the unregulated and opaque PBM market, which in itself creates real concerns as to the cost of prescription drugs and the reduction in competition. Moreover, CVS is a large commercial enterprise beyond health care, raising questions as to its commitment to health care service and quality. The size of the increased debt from this proposed transaction only amplifies these concerns, as the amount of debt may place undue pressure on consumers of Aetna's health insurance products."

## Conclusion

In summary, CVS and Aetna describe this merger as "pro-competitive." The reality is that it is anti-competitive. It increases barriers to entry in the multiple markets of specialty pharmacy, retail pharmacy, PBMs and health insurance. As the statements from experts and public officials cited in our comments show, the merger will lead to higher prices, not lower prices, and reduced choices. The data sharing and synergies promised by the applicant to improve quality of care and health are not likely to materialize. Adding a few more Minute Clinics in Connecticut, without specifying where primary care access is needed most, is not going to have a major impact on access to care. Finally, there are no assurances that any savings, should they be achieved, will actually be passed on to consumers.

At Universal Health Care Foundation of Connecticut, we believe it is important to elevate the concerns of real people – and ask for *real* solutions to the challenges of rising health care costs and limits on access to quality care. The acquisition of Aetna by CVS is *not* a solution. Instead, it represents the consolidation of monopoly power at the expense of consumers.

**STATEMENT**

**of the**

**American Medical Association**

**to the**

**Insurance Commissioner of the State of Connecticut**

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

**October 2, 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 insurer. We commend the Insurance Commissioner of the State of Connecticut (Commissioner) for scrutinizing this massive proposed merger and the potential negative impact it poses to Connecticut health care consumers. It is the AMA's position that unless blocked, this merger would likely injure consumers by raising prices, lowering quality, reducing choice and stifling innovation in Connecticut health insurance markets. As such, we urge the Commissioner to block the proposed CVS-Aetna merger.

## THE MERGER VIOLATES CONNECTICUT'S STATUTORY LAW PROTECTING HEALTH INSURANCE MARKETS FROM ANTICOMPETITIVE MERGERS

According to Connecticut General Statute § 38a-131:

> (i) An acquisition involving two or more involved insurers competing in the same market shall be prima facie evidence of a violation of the competitive standards described in this subdivision if (I) there is a significant trend toward increased concentration in the market, (II) one of the involved insurers is included in a grouping of large insurance companies that shows the increase in market share specified in subparagraph (B)(ii) of this subdivision, and (III) another involved insurer's market share is two per cent or more.
>
> (B)(ii) For purposes of this subparagraph, there is a significant trend toward increased concentration in the market when the aggregate market share for any grouping of the largest insurance companies in the market, from the two largest to the eight largest, has increased by seven per cent or more of the market over a period extending from any base year not less than five years and not more than ten years prior to the proposed acquisition.

As explained in the attached report of Richard Scheffler, PhD, 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, CVS' proposed acquisition of Aetna fails the Connecticut Competitive Standard in Connecticut's Medicare Part D Stand-alone Prescription Drug Plan Market.[1] Thus, the acquisition may substantially lessen competition and the Commissioner should enter an order denying the acquisition.

## ADDITIONAL REASONS WHY THE MERGER IS ANTICOMPETITIVE IN CONNECTICUT HEALTH INSURANCE MARKETS

### *Health Insurance Markets in Connecticut are Highly Concentrated*

It is now well-established that markets for health insurance, including those in Connecticut, are highly concentrated with high barriers to entry, and that they are often dominated by one or two insurers.[2] The AMA's 2017 Update to *Competition in Health Insurance: A Comprehensive Study of U.S. 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 (MSAs) 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

[1] See Dr. Sheffler's attached Report.

[2] 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).

first or second largest MA market share in 60 of the 381 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 State of Connecticut's commercial health insurance market is consistent with this picture.[3] Half of MSA-level commercial health insurance markets in Connecticut are highly concentrated (New Haven-Milford, Norwich-New London-Westerly).[4] The proposed CVS-Aetna merger potentially raises significant competitive concerns in Connecticut's remaining three MSA-level health insurance markets (Bridgeport-Stamford-Norwalk, Danbury, and Hartford-West Hartford-East Hartford). Connecticut's health insurance markets need new entry. As explained below, however, a vertical merger between a large insurer and a national PBM with scale and buying power will only further raise entry barriers into these Connecticut health insurance markets – an anticompetitive result that should be of great concern to the Commissioner and Connecticut residents.

*Merger Ramifications in Connecticut's Health Insurance Market*

According to health economist and University of Southern California professor Neeraj Sood, PhD,[5] the merger "will further strengthen the already dominant position of Aetna and will exacerbate the lack of competition in health insurance markets. This will come from CVS-Aetna's ownership and control of two segments of the pharmaceutical supply chain-PBMs and retail pharmacies."[6]

A Merged CVS-Aetna is Likely to Foreclose Aetna Rivals by Supplying Needed PBM and/or Pharmaceutical Services on Disadvantageous Terms that Favor Aetna

PBM services are an important input into the production and selling of health insurance, an area of the economy that requires more, not less, competition.[7] Aetna rivals and would-be sellers of health insurance need to be able to purchase essential PBM services.

In the event the CVS-Aetna merger were approved by the Commissioner, Aetna rivals that decide to rely on drug rebates from CVS would likely to be hurt by the merger, ultimately to the detriment of competition and Connecticut consumers. PBMs are agents of health insurance plans.[8] They help health plans negotiate with pharmacies and pharmaceutical firms. According to Professor Sood, a national expert on pharmaceutical and health insurance markets, if CVS were to merge with Aetna, CVS would be a worse agent for health plans competing with Aetna. The PBM arm of CVS-Aetna would have weaker incentives to control prescription drug costs and overall health care costs for health plans competing with Aetna. Indeed, in Professor Sood's opinion "the PBM arm of CVS-Aetna has an incentive to disadvantage health plans competing with the insurance arm of CVS Aetna in passing rebates from pharmaceutical firms. This will likely result in less competition in the insurance market."[9]

Professor Sood observes that the adverse effects of the incentives for CVS-Aetna to disadvantage competing health plans are exacerbated by the fact that the PBM market is highly concentrated. Health

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[3] *Competition in Health Insurance: A Comprehensive Study of US Markets* (2017 update).

[4] Id.

[5] Neeraj Sood, PhD, is Professor of Health Policy and Vice Dean for Research at USC's Sol Price School of Public Policy. He is also a faculty member and past Director of Research of the USC Leonard Schaeffer Center for Health Policy and Economics and a Research Associate at the National Bureau of Economic Research.

[6] See Dr. Sood's attached Report at 8.

[7] 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. 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).

[8] Sood Report at 8.

[9] Sood Report at 10.

plans competing with CVS-Aetna do not have many options to switch PBMs. 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. Given the U.S. Department of Justice's recent approval of the Cigna-Express Scripts merger, if Aetna were to merge with CVS, all large PBMs would either have been acquired by the country's five largest insurers, e.g., Aetna, Anthem, Cigna, Humana, and UnitedHealth Group, or would otherwise have become an in-house service of these insurers.[10]

Aetna rivals or new market entrants 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. Facing little threat from competing PBMs, they would have strong incentives and capacity to coordinate their strategies to disadvantage rival health insurers.[11]

The result of this input foreclosure for health insurers seeking PBM services will be less competition in an already highly concentrated Connecticut health insurance market. In the words of Professor Sood, the merger will further strengthen the already dominant position of Aetna and will exacerbate the lack of competition in health insurance markets.[12] Professor Amanda Starc, PhD, Associate Professor of Strategy at the Kellogg School of Management and a Faculty Research Fellow at the National Bureau of Economic Research, also foresees increased barrier to entry:

> Even if the PBM and health insurance markets were competitive, the merged firm could reduce future competition in the insurance market. If the merged entity is successful, future entry may require capabilities to be a payer, PBM, and provider, which may be difficult and especially costly for potential new entrants to replicate.[13]

CVS-Aetna respond to these input foreclosure concerns by contending that Aetna would comprise a small fraction of their combined revenue and the merged firm would never follow the risky strategy of not aggressively bidding for a large fraction of the market.[14] However, the strategy is hardly risky given the high PBM market concentration and the strong incentives for the major vertically integrated health insurers to coordinate their strategies to disadvantage rival health insurers. Moreover, opaque pricing and the rebate structure give both the pharmaceutical manufacturer and the PBM incentives to allow higher list prices and higher rebates.[15] How an Aetna competitor would ever detect whether it was being given a bid less desirable deal than that given Aetna is unclear. Finally, the size of the incentives for CVS-Aetna to disadvantage health plans competing with the insurance arm of CVS-Aetna is substantial. Professor Sood concludes "that one insurance customer is as valuable as 14 PBM customers; providing strong incentives for CVS Aetna to disadvantage competing health plans to gain insurance customers even if it risks losing some PBM customers."[16]

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[10] 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. See also Sood Report at 10.

[11] See testimony presented at a June 19, 2018, hearing concerning the proposed CVS-Aetna merger before the California Department of Insurance by University of California at Hastings Law Professor and prominent antitrust in healthcare scholar, Thomas Greaney, accessible at http://www.insurance.ca.gov/01-consumers/110-health/60-resources/CVS-Aetna-Merger-Information.cfm.

[12] Sood Report at 8

[13] See Dr. Starc's attached Report at 11.

[14] See e.g. Thomas Moriarty Esq., testimony before the US House Judiciary Committee at a hearing entitled "Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna (February 26, 2018).

[15] Starc Report at 11.

[16] Sood Report at 12.

*A Merged CVS-Aetna is Likely to Foreclose Aetna Rivals by Refusing to Supply Retail Pharmacy Services to them or by providing them 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. Professor Sood reasons that CVS-Aetna could leverage its must-have pharmacy network to disadvantage competing plans.[17] Health plans that do not have CVS in their pharmacy network will be less attractive to consumers, especially in markets where CVS has a dominant market share. CVS-Aetna could exploit this fact to charge higher prices to health plans competing with CVS-Aetna. This effect, says Professor Starc, may be especially important in the market for generic drugs, which are generally competitive at the wholesale, but not the retail level and represent a large fraction of total bills.[18] In recent years, prices for some generic molecules (even particularly old ones whose branded equivalents' patents expired decades ago) have increased substantially. According to Professor Sood, if health plans refused to accept the high prices and do not include CVS-Aetna pharmacies in their network, they risk losing customers. If they accept the high prices, then they face higher health care costs, which might result in higher premiums and lower market share for these health plans. This will result in less competition in the insurance market.[19]

The likelihood of the merged firm's pharmacy customers falling victim to the merged company's favoring the Aetna side of its business is enhanced by "the numbers." Professor Sood has found that "one insurance customer is as valuable as roughly nine pharmacy customers; providing strong incentives for CVS-Aetna to disadvantage competing health plans to gain insurance customers even if it risk losing some PBM customers."[20]

*The Merger is Likely to Lead to Anticompetitive Behavior Due to Information Sharing Among Competing Health Insurers*

If CVS were to merge with Aetna, then health plan entrants and Aetna rivals 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 drug experience of Aetna's competitors, which might help it engage in cream-skimming. Aetna could determine the illness profile of its competitors' covered populations. If Aetna determines that those populations consist of desirable insureds, it can design formulary profiles and other health insurance benefit design features to attract them. But if they have high drug expenditures, Aetna could steer them away.

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 are additional reasons for opposing the merger.

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[17] Sood Report at 11.
[18] Starc Report at 11.
[19] Sood Report at 10 and Starc Report at 11.
[20] Sood Report at 12.

## CONCLUSION

For all the reasons expressed in this statement and reports accompanying this statement, it is the AMA's opinion that this merger would likely substantially lessen competition in Connecticut health insurance markets. The nation has learned the hard way that overlooking consolidation and its anticompetitive effects in health insurance is costly. The AMA, therefore, respectfully requests that the Commissioner block the proposed CVS-Aetna merger.

Exhibits to American Medical Association Statement to
Connecticut Department of Insurance on the
Proposed Merger of CVS-Aetna
October 2, 2018

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Report Regarding CVS Health Corporation's Proposed Acquisition of Aetna Inc. in Connecticut

by

Richard M. Scheffler

September 12, 2018

## Qualifications

I am 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. I hold 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.

I recently testified at the California Department of Insurance's June 19, 2018 hearing on CVS Health Corporation's proposed acquisition of Aetna Inc. Additionally, I testified at the January 22, 2016 hearing on Centene Corporation's proposed acquisition of Health Net, Inc. and the California Department of Insurance's March 29, 2016 hearing on Anthem, Inc.'s proposed acquisition of Cigna Corporation. I also testified at the Federal Trade Commission and Department of Justice Meeting: Examining Healthcare Competition in Washington D.C. (February 25, 2015).

For further background on the Medicare Part D market and a literature review on the impact of market power on Medicare Part D premiums, see the June 19, 2018 testimony I delivered before the California Department of Insurance.[1]

I thank the American Medical Association for supporting my work that went into preparing this report. My report reflects my views and opinions, not necessarily the views of the American Medical Association.

## Connecticut's Medicare Part D Stand-alone Prescription Drug Plan (PDP) Market

In 2018, 43 million of the 60 million people with Medicare have prescription drug coverage under a Medicare Part D plan.[2] Of the 43 million, 25 million (58%) are covered under a stand-alone prescription drug plan (PDP) while the remaining 18 million (42%) are enrolled in Medicare Advantage prescription drug plans (MA-PDs).[2] In this report, I focus exclusively on the PDP market – the part of the Medicare Part D market where CVS Health Corporation and

[1] Scheffler, Richard M. "Testimony Regarding CVS Health Corporation's Proposed Acquisition of Aetna Inc." Expert testimony before the California Department of Insurance. June 19, 2018. Available from: http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Scheffler-CVS-Aetna-Testimony-06-19-18.pdf

[2] Cubanski, Juliette, Anthony Damico, and Tricia Neuman. "Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing." San Francisco, CA: Kaiser Family Foundation. May 17, 2018. Available from: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/

Aetna Inc. have competing business. In Connecticut, just under 300,000 people are enrolled in a PDP in 2018.[3]

Table 1 shows Connecticut PDP market shares by plan sponsor in 2018. In 2018, UnitedHealth Group, Inc. has the largest market share with just under 29% of PDP enrollment in the state. CVS Health Corporation and Aetna Inc. rank 2nd and 5th, respectively, in terms of market share at 21.7% and 8.9%. A CVS Health Corporation acquisition of Aetna Inc. would make the combined company number one in terms of market share at 30.6% market share.

**Table 1.** Connecticut PDP Market Enrollment and Market Shares, 2018

| Plan Sponsor | Enrollment | Market Share (%) |
|---|---|---|
| UnitedHealth Group, Inc. | 84,010 | 28.6 |
| CVS Health Corporation | 63,771 | 21.7 |
| Express Scripts Holding Company | 39,358 | 13.4 |
| Humana Inc. | 39,153 | 13.3 |
| Aetna Inc. | 26,046 | 8.9 |
| WellCare Health Plans, Inc. | 14,960 | 5.1 |
| Anthem Insurance Co. & BCBSMA & BCBSRI & BCBSVT | 10,827 | 3.7 |
| Rite Aid Corporation | 9,766 | 3.3 |
| CIGNA | 4,432 | 1.5 |
| TOTAL | 292,323 | 99.5%* |

Note: *Only plan sponsors with greater than 1% market share are included in the table.

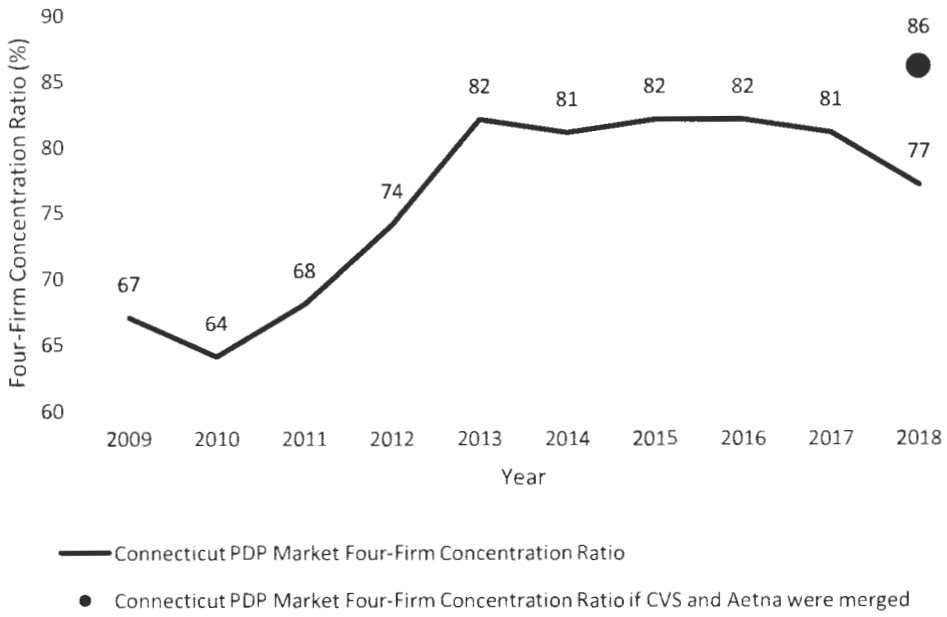
Figure 1 shows the four-firm concentration ratio in the Connecticut PDP market from 2009 to 2018. The four-firm concentration ratio is simply the sum of the market shares of the four firms with the largest market shares. In 2009, the four-firm concentration ratio in the Connecticut PDP market was 67%. By 2018, the four-firm concentration ratio was 77% -- an increase of 10 percentage points.

The combined facts of (1) a Connecticut PDP four-firm concentration ratio of 77% (2) CVS Health Corporation's PDP market share of 21.7%, and (3) Aetna Inc.'s PDP market share of 8.9% are "prima facie evidence of a violation of competitive standards" according to Conn. Gen. Stat. § 38a-131 (d)(1)(A)(i)(I). If CVS and Aetna had been merged in 2018, the Connecticut PDP market four-firm concentration ratio would have been 86%. Additionally, there is also "prima facie evidence of a violation of competitive standards" according to Conn. Gen. Stat. § 38a-131 (d)(1)(B). Conn. Gen. Stat. § 38a-131 (d)(1)(B) states there is evidence of a violation of competitive standards if "there is a significant trend toward increased concentration in the market." A significant trend is considered to have occurred "when the aggregate market share for

[3] Author's analysis of PDP enrollment data from the Centers of Medicare & Medicaid Services (CMS). Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-PDP-Enrollment-by-State-County-Contract.html

any grouping of the largest insurance companies in the market, from the two largest to the eight largest, has increased by seven per cent or more of the market over a period extending from any base year not less than five years and not more than ten years prior to the proposed acquisition." The change in the four-firm concentration ratio from 2010 to 2018 shown in Figure 1 satisfies this condition. The market shares of the four largest firms in the market increased by 20 percent (64 percent in 2010 to 77 percent in 2018) over a period of eight years.

**Figure 1.** Connecticut's Medicare Part D Stand-alone Prescription Drug Plan (PDP) Four-Firm Concentration Ratio, 2009-2018




Note: A four-firm concentration ratio is the sum of the market shares of the four firms with the largest market shares.

### CMS' Connecticut, Massachusetts, Rhode Island, Vermont PDP Region

The Centers for Medicare & Medicaid Services (CMS) divides states into 34 PDP regions.[4] Connecticut, Massachusetts, Rhode Island, and Vermont make up one of the 34 PDP regions. This section reproduces the analysis of the previous section, but under the assumption that the Connecticut/Massachusetts/Rhode Island/Vermont PDP market is the relevant geographic market, rather than the state of Connecticut.

In 2018, the four-firm concentration ratio of the Connecticut/Massachusetts/Rhode Island/Vermont PDP market is 73%. The 2018 market shares of CVS Health Corporation and Aetna Inc. 26.6% and 7.9%, respectively, in the Connecticut/Massachusetts/Rhode Island/Vermont PDP market (see Table 2). A CVS Health Corporation acquisition of Aetna Inc.

[4] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/PDPRegions.pdf

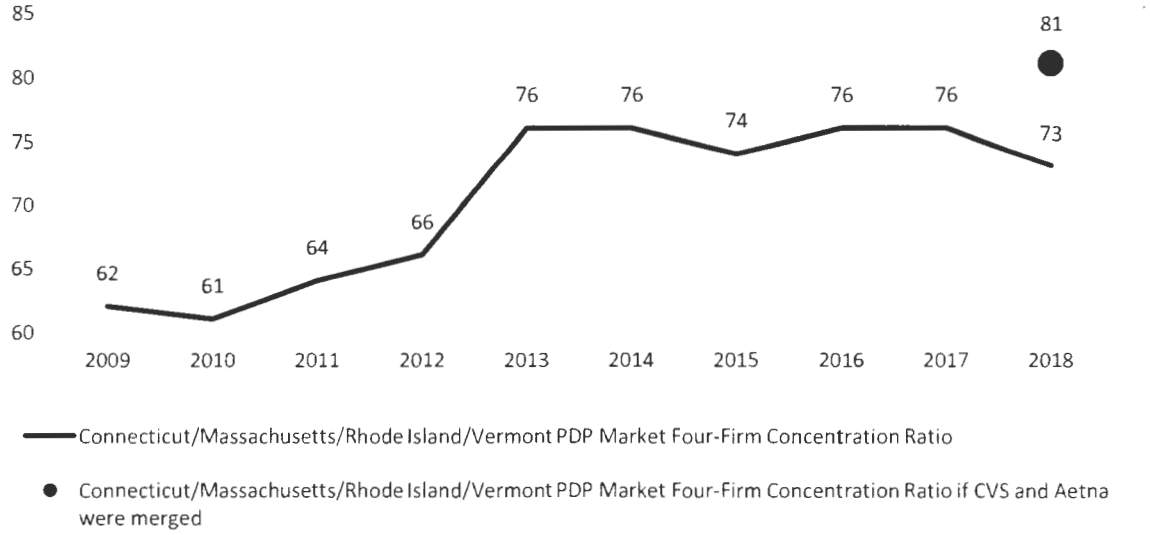
would give the combined company 34.5% market share in the Connecticut/Massachusetts/Rhode Island/Vermont PDP market. A CVS Health Corporation acquisition of Aetna Inc. would increase the four-firm concentration ratio in the Connecticut/Massachusetts/Rhode Island/Vermont PDP market to 81% (see Figure 2).

**Table 2.** Connecticut/Massachusetts/Rhode Island/Vermont PDP Market Enrollment and Market Shares, 2018

| Plan Sponsor | Enrollment | Market Share (%) |
|---|---|---|
| CVS Health Corporation | 310,117 | 26.6 |
| UnitedHealth Group, Inc. | 216,840 | 18.6 |
| Humana Inc. | 164,509 | 14.1 |
| Anthem Insurance Co. & BCBSMA & BCBSRI & BCBSVT | 158,570 | 13.6 |
| Aetna Inc. | 91,712 | 7.9 |
| Express Scripts Holding Company | 90,574 | 7.8 |
| WellCare Health Plans, Inc. | 66,119 | 5.7 |
| Rite Aid Corporation | 43,012 | 3.7 |
| CIGNA | 13,266 | 1.1 |
| TOTAL | 1,154,719 | 99.1%* |

Note: *Only plan sponsors with greater than 1% market share are included in the table.

**Figure 2.** Connecticut/Massachusetts/Rhode Island/Vermont's Medicare Part D Stand-alone Prescription Drug Plan (PDP) Four-Firm Concentration Ratio, 2009-2018




Note: A four-firm concentration ratio is the sum of the market shares of the four firms with the largest market shares.

The combined facts of (1) a Connecticut PDP four-firm concentration ratio of 73% (2) CVS Health Corporation's PDP market share of 26.6%, and (3) Aetna Inc.'s PDP market share of 7.9% are "prima facie evidence of a violation of competitive standards" according to Conn. Gen. Stat. § 38a-131 (d)(1)(A)(i)(II). Additionally, there is also "prima facie evidence of a violation of competitive standards" according to Conn. Gen. Stat. § 38a-131 (d)(1)(B). Conn. Gen. Stat. § 38a-131 (d)(1)(B) states there is evidence of a violation of competitive standards if "there is a significant trend toward increased concentration in the market." A significant trend is considered to have occurred "when the aggregate market share for any grouping of the largest insurance companies in the market, from the two largest to the eight largest, has increased by seven per cent or more of the market over a period extending from any base year not less than five years and not more than ten years prior to the proposed acquisition." The change in the four-firm concentration ratio from 2010 to 2018 shown in Figure 2 satisfies this condition. The market shares of the four largest firms in the market increased by 20 percent (61 percent in 2010 to 73 percent in 2018) over a period of eight years.

Richard Scheffler 09/28/18

# Potential effects of the proposed CVS acquisition of Aetna on competition and consumer welfare

**Neeraj Sood, PhD**

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I thank the American Medical Association for supporting my work in preparing this report. This report reflects my views and opinions, not necessarily the views of the American Medical Association or of my employer, the University of Southern California.

**A. About the author**

I am a Professor of Health Policy and Vice Dean for Research at the Sol Price School of Public Policy, University of Southern California (USC). Sol Price School of Public Policy is ranked 3rd in health policy and management in the nation by the US News and World Report. I am a faculty member and past Director of Research of the USC Leonard D. Schaeffer Center for Health Policy and Economics. I am also a research associate at the National Bureau of Economic Research -- the nation's premier economics research organization.

I have published more than 100 papers and reports on health policy and economics. My past research has focused on health insurance markets, pharmaceutical markets and global health. This research has been published in leading journals in economics, health policy and medicine including publications in the *Quarterly Journal of Economics, Journal of Economic Perspectives, Journal of Health Economics, JAMA* and *Health Affairs.* My work on health care costs and the pharmaceutical supply chain has been cited by the Council of Economic Advisors of President Obama and President Trump. I have been invited to participate in expert consensus committees of the National Academies of Science, Engineering and Medicine. I have received more than $10 million in extramural research funding and have been a scientific advisor and consultant for several organizations in the health care industry. My work has also been featured in media outlets including the *New York Times*, *Washington Post*, *U.S. News and World Report*, and *Scientific American*. I was the finalist for the 16th and 21st Annual NIHCM Health Care Research Award, recognizing outstanding research in health policy. I was also the 2009 recipient of the Eugene Garfield Economic Impact Prize, recognizing outstanding research demonstrating how medical research impacts the economy.

I am an associate editor for leading journals in my field including the *Journal of Health Economics* and *Health Services Research*. I am also a board member of the *American Society of Health Economists*. Prior to joining USC, I was a senior economist at RAND. I obtained my PhD in Public Policy from the Pardee RAND

Graduate School and Masters in Economics from Indiana University and Delhi University.

### B. Scope of this report

This report reflects my opinions and views on the potential effects of the proposed merger of CVS and Aetna on competition in the insurance, pharmacy, and pharmacy benefit management market. Evaluation of the detrimental or beneficial effects of the merger through other potential pathways was beyond the scope of this report. These views are based on my assessment of economic theory, past research, and data on the structure, conduct and performance of firms in relevant industries. Some of the statements in this report are forward-looking statements or predictions and thus inherently involve uncertainties. I use underline font to highlight key points.

### C. Market overview

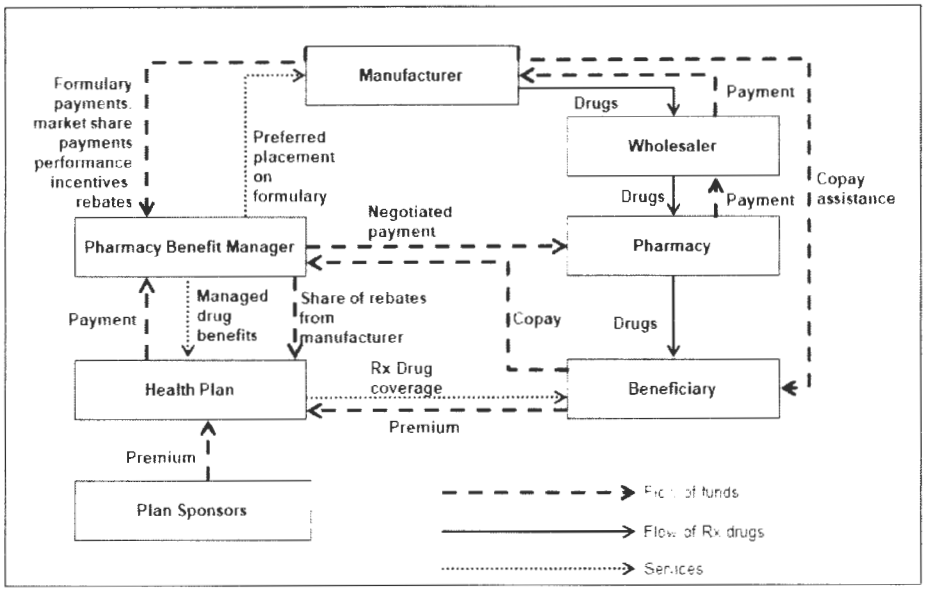
CVS and Aetna are major players in the pharmaceutical supply chain. Therefore, to understand the potential consequences of CVS's acquisition of Aetna we need to first understand the flow of funds and services in the pharmaceutical supply chain. Below, I give a primer on this complex supply chain based on my recent publication on this market.[1] Figure 1 provides a graphical representation of the supply chain.

#### a. The flow of drugs

Consider an insured consumer who purchases a drug from a retail pharmacy. The pharmacy dispenses the drug to the consumer. The pharmacy acquires the drug from a wholesaler and the wholesaler in turn acquires the drug from a manufacturer. So, the drug supply chain is manufacturer to wholesaler to pharmacy to consumer.

[1] http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf, accessed May 18, 2018.

**Figure 1: The flow of drugs, funds and services in the pharmaceutical supply chain**




### b. The flow of funds

The flow of funds is more complex than the flow of drugs. The insured consumer pays a copay or coinsurance to the pharmacy at the point of purchase. The pharmacy passes the copay or coinsurance to the pharmacy benefit manager (PBM). The pharmacy also invoices the PBM for providing the drug to the insured consumer. The PBM pays the pharmacy the negotiated rate for the drug. The PBM in turn invoices the health plan for reimbursing the pharmacy. The health plan pays the PBM. The health plan generates revenue by charging premiums to consumers or their employers. The pharmacy restocks the drug by paying a wholesaler for the drug. The wholesaler in turn pays a manufacturer for the drug. The manufacturer pays a rebate to the PBM. The PBM passes some of the rebate back to the health plan. The manufacturer might also pay the consumer in the form of a copay coupon.

### c. The flow of services

Pharmacies provide retail service or the storefront for consumers to purchase drugs. Wholesalers purchase drugs from manufacturers and sell drugs to pharmacies. Thus, they provide drug distribution and storage services. Manufacturers conduct research and development to discover new drugs. They obtain approval from the Food and Drug Administration to sell the drug to consumers. Once a drug is approved, manufacturers produce and market the drug to doctors, health plans and consumers. Health plans provide insurance to consumers and thus take on the risk of high prescription drug costs and health care costs. PBMs are agents of health plans. They provide two core services to a health plan. First, they negotiate rebates with manufacturers in exchange for preferred formulary placement (lower copays or coinsurance) for the manufacturers' drugs relative to drugs from competing manufacturers. Second, they negotiate contracts with pharmacies and thus decide whether a pharmacy will be in the network and the reimbursement the pharmacy will receive for dispensing drugs to the insured consumer.

### d. Market structure and conduct

I estimate that for every $100 in spending by an insured consumer on a drug sold in a retail pharmacy only $58 reaches the manufacturer and the remaining $42 is kept by intermediaries or "middlemen".[2] Insurers keep $19, PBMs keep $5, pharmacies keep $15 and wholesalers keep $2. The analysis does not directly address the question of whether these returns are "excessive". However, market concentration or lack of competition is an important indicator of companies' ability to earn excess returns, and several segments of the pharmaceutical supply chain are highly concentrated. The top three PBMs account for 70% of the market, the top three pharmacies account for 50% of the market, and the top three wholesalers account for 90% of the market.[3,4,5] Similarly, the large group health insurance market is also

[2] http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf, accessed May 18, 2018.
[3] http://www.drugchannels.net/2017/12/the-cvs-aetna-deal-five-industry-and.html, accessed May 22, 2018.
[4] http://www.drugchannels.net/2018/02/the-top-15-us-pharmacies-of-2017-market.html, accessed May 22, 2018

highly concentrated with the top three insurers accounting for more than 50% of the market in 33 states.[6]

Market power in the pharmaceutical supply chain can hurt consumers by increasing drug spending and out of pocket costs. Prior research documents that market power manifests itself in several practices of intermediaries in the supply chain that potentially harm consumers. For example, my prior work suggests that pharmacies within a local market charge widely varying prices for exactly the same product. The research also suggests that drug prices found at independent pharmacies or at online discount websites were lower on average than prices at chain drug stores.[7] Similarly, insurers often charge consumers more in out of pocket costs than the drug acquisition costs for the insurer. According to a recent study by my colleagues, almost a quarter of pharmacy prescriptions involved a patient copayment that exceeded the average reimbursement by the insurer or PBM to the pharmacy.[8] Furthermore, insurer and PBMs often have "gag clauses" which prohibit the pharmacy from disclosing to consumers that they could save money by paying cash for their prescription drugs rather than using their insurance.[9] Finally, PBMs might not be good agents of health plans and consumers. PBMs often do not disclose the amount of rebates they receive from manufacturers raising questions about the extent to which they pass on rebate dollars to health plans. For example, Anthem, the second largest health plan in the US, recently sued its PBM, Express Scripts, saying it withheld billions in cost savings owed to Anthem. Similarly, PBMs sometimes create incentives to increase drug prices in return for higher rebates. The increase in drug prices might offset the savings from rebates, so that health plans

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[5] https://www.mdm.com/2017-top-pharmaceuticals-distributors, accessed May 22, 2018.

[6] https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/?currentTimeframe=0&print=true&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, accessed May 22, 2018.

[7] Arora, Sanjay, Neeraj Sood, Sophie Terp, and Geoffrey Joyce. "The price may not be right: the value of comparison shopping for prescription drugs." *The American journal of managed care*23, no. 7 (2017): 410-415.

[8] http://healthpolicy.usc.edu/documents/2018.03_Overpaying%20for%20Prescription%20Drugs_White%20Paper_v.1.pdf, accessed May 22, 2018.

[9] https://www.nytimes.com/2018/02/24/us/politics/pharmacy-benefit-managers-gag-clauses.html, accessed May 22, 2018.

end up paying more for drugs despite getting bigger rebates. In addition, the high drug prices hurt consumers in high deductible health plans who pay the list price of the drug rather than the price after rebates and other discounts. [10]

## D. Key findings

In this section, I discuss the potential effects of the acquisition of Aetna by CVS on competition in insurance, pharmacy and PBM markets.

### a. The merging firms

The merger of CVS and Aetna would merge firms with significant market power in their respective markets. Aetna is the third largest insurer in the US with more than 23 million persons receiving insurance through Aetna. Aetna's net revenues in 2016 were $63 billion and its revenues have increased at about 10% per year.[11] CVS is the largest pharmacy company in the US and accounts for 24% of prescription drug revenues in the US. CVS is also one of the largest PBMs in the US and has a market share of about 24%.[12] CVS and Aetna both also sell Medicare Part D prescription drug plans. The combined revenues of CVS-Aetna would be $221 billion making it the fourth largest company in the US.[13] Thus, the merged entity CVS-Aetna would wield considerable market power in the health insurance, pharmacy, and PBM markets.

### b. Potential effects on competition in insurance markets

Health insurance markets in the US are already characterized by a lack of competition. The federal trade commission considers markets to be highly concentrated if the HHI (a measure of market competition) for a market is greater than 2,500. According to recent data from an American Medical Association study,

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[10] https://www.bloomberg.com/news/articles/2016-10-05/patients-lose-out-on-big-pharma-s-secret-rebate-merry-go-round, accessed May 22, 2018.

[11] https://healthpayerintelligence.com/news/top-5-largest-health-insurance-payers-in-the-united-states, accessed May 22, 2018.

[12] http://www.drugchannels.net/2017/12/the-cvs-aetna-deal-five-industry-and.html, accessed May 22, 2018.

[13] http://investors.cvshealth.com/~/media/Files/C/CVS-IR-v3/AET%20transaction/CVS-Aetna%20Investor%20Presentation.pdf, accessed May 22, 2018.

the vast majority of US health insurance markets had an HHI greater than 2,500.[14] For example, 94% of HMO markets are highly concentrated and 86% of PPO markets are highly concentrated. Data from the Kaiser Family Foundation for the individual, small group and large group market paint a similar picture of highly concentrated markets.[15] Aetna is a dominant firm in the health insurance market. According to recent data, Aetna is the number 1 or number 2 insurer in over 70 HMO markets and over 100 PPO markets.[16]

The merged entity CVS-Aetna will be a formidable competitor in the health insurance market. The merger will further strengthen the already dominant position of Aetna and will exacerbate the lack of competition in health insurance markets. The competitive edge would come from CVS-Aetna's ownership and control of two segments of the pharmaceutical supply chain – PBMs and retail pharmacies.

PBMs are agents of health insurance plans. They help health plans negotiate with pharmacies and pharmaceutical firms. If CVS were to merge with Aetna, CVS would be a better agent for Aetna. Post-merger CVS would have a stronger incentive to control prescription drug costs (net of rebates) and overall health care costs for Aetna. CVS would have reduced incentives to engage in practices that increase rebates at the cost of increasing spending on prescription drugs for Aetna. Some of the savings to Aetna will be passed on to Aetna subscribers as lower premiums.

However, the extent of savings from CVS being a better PBM for Aetna depend on what PBM services CVS is providing to Aetna. Savings only arise if CVS is making strategic decisions for Aetna such as decisions on formulary design and price negotiations with pharmaceutical companies. Savings would be minimal or non-

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[14] Competition in health insurance: A comprehensive study of U.S. markets, 2017 Update. American Medical Association.

[15] https://www.kff.org/other/state-indicator/large-group-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, accessed May 22, 2018.

[16] Competition in health insurance: A comprehensive study of U.S. markets, 2017 Update. American Medical Association.

existent if CVS is only providing administrative or claims processing services and Aetna is making its own decisions on formulary design and negotiations with pharmaceutical companies. Aetna's financial statements to the SEC state that "We also perform various pharmacy benefit management services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. Caremark PCS Health, L.L.C. (a wholly-owned subsidiary of CVS Health) performs the administration of selected functions for our retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain pharmacy benefit management services."[17] Therefore, Aetna's own financial statements to the SEC indicate that Aetna already performs its core PBM functions and thus the potential efficiencies from merging with the PBM arm of CVS would be minimal.

Post-merger, CVS would be a worse agent for other health plans. Post-merger, CVS would have weaker incentives to control prescription drug costs and overall health care costs for health plans competing with Aetna. As explained earlier, PBMs earn rebates from pharmaceutical firms. They make profits by keeping some of these rebates and passing the remaining back to health plans. Although passing rebates back to health plans lowers the profit margin of PBMs, they do so because it helps health plans lower costs and thus helps the PBM retain the business from health plans. The PBM arm of CVS-Aetna would have less of an incentive after the merger to pass rebate dollars back to health plans competing with the insurance arm of CVS-Aetna. The rationale is that passing rebate dollars to health plans competing with the insurance arm of CVS-Aetna will lower their costs and thus will hurt the insurance arm of CVS-Aetna. In other words, the PBM arm of CVS-Aetna has an incentive to disadvantage health plans competing with the insurance arm of CVS-

[17] Aetna 10-K report available online at http://investor.aetna.com/phoenix.zhtml?c=110617&p=irol-sec , accessed May 22, 2018.

Aetna in passing rebates from pharmaceutical firms. This will likely result in less competition in the insurance market.

PBMs also negotiate prices with pharmacies on behalf of health plans. In these negotiations the PBM arm of CVS-Aetna has two potential conflicts. First, helping health plans competing with CVS-Aetna lower their pharmacy costs hurts the insurance arm of CVS-Aetna. Second, helping health plans competing with CVS-Aetna lower their CVS pharmacy costs hurts both the insurance arm of CVS-Aetna and the retail arm of CVS-Aetna. Therefore, the PBM arm of CVS-Aetna has an incentive to disadvantage health plans competing with the insurance arm of CVS-Aetna in negotiations with pharmacies. This will result in less competition in the insurance market.

Therefore, the merger simultaneously creates incentives for CVS to be a better agent for Aetna (which potentially helps consumers with insurance from Aetna) and be a worse agent for health plans competing with Aetna (which potentially hurts consumers with insurance from other health plans). CVS currently provides PBM services to 94 million plan beneficiaries of which about 22 million are Aetna subscribers.[18]

The adverse effects of the incentives for CVS-Aetna to disadvantage competing health plans are exacerbated by two facts. First, the PBM market is highly concentrated. So, health plans competing with CVS-Aetna do not have many options to switch PBMs. In addition, several of the largest PBM competitors for CVS-Aetna, such as OptumRx, Humana Pharmacy Solutions, and Prime Therapeutics are also owned by health plans. Second, CVS recently entered into an agreement to provide PBM services to Anthem. Anthem is the second largest health plan in the US and actively competes with Aetna in several insurance markets. For example, in Thousand Oaks, California, Aetna is the second largest insurer and faces stiff competition from Anthem which is the largest insurer. The story is the same in many

[18] https://cvshealth.com/about/facts-and-company-information, accessed May 22, 2018.

other markets ranging from New Haven-Milford, Connecticut to Albany, Georgia to Evansville, Kentucky. The PBM arm of CVS-Aetna has a strong incentive to help the insurance arm of CVS-Aetna be the number one insurer in these markets.

CVS-Aetna will also own one of the largest retail pharmacy networks in the US. CVS Health financial statement filed with the SEC states: "We currently operate in 98 of the top 100 United States drugstore markets and hold the number one or number two market share in 93 of these markets."[19] CVS-Aetna could leverage this pharmacy network to disadvantage competing health plans. Health plans that do not have CVS in their pharmacy network will be less attractive to consumers, especially in markets where CVS has a dominant market share. CVS-Aetna could exploit this fact to charge higher prices to health plans competing with CVS-Aetna. If health plans refuse to accept the high prices and don't include CVS-Aetna pharmacies in their network they risk losing customers. If they accept the high prices then they face higher health care costs which might result in higher premiums and lower market shares for these health plans.

One might question the size of the incentives for CVS-Aetna to disadvantage health plans competing with the insurance arm of CVS-Aetna. After all, if it does not provide competitive PBM and pharmacy services then health plans might drop CVS-Aetna and seek the same services from elsewhere. Consider a consumer who spends $10,000 a year on average (this is roughly equal to US per capita health spending) on health care and $1,000 or roughly 10% of her total spending (this is roughly equal to the fraction of health spending on prescription drugs) is on prescription drugs. Data from SEC on the profitability of PBM and health insurance sectors suggests a net profit margin of PBM services of 2.3% and a net profit margin of health insurers of 3.0%.[20] Therefore, if CVS-Aetna were to lose this consumer as a PBM customer then CVS-Aetna would lose about $23 (2.3% x 1,000) in profits. However, if CVS-

[19] https://www.sec.gov/Archives/edgar/data/64803/000006480316000074/cvs-20151231x10k.htm, accessed May 22, 2018.
[20] http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf, accessed May 22, 2018

Aetna were to gain the same consumer as a health insurance customer then CVS-Aetna would gain about $323 in profits stemming from $300 (3% x 10,000) in profits from providing insurance and $23 in profits from providing PBM services. Therefore, 1 insurance customer is as valuable as 14 PBM customers; providing strong incentives for CVS-Aetna to disadvantage competing health plans to gain insurance customers even if it risks losing some PBM customers.

The numbers are similar when we look at incentives on the pharmacy market. Net profit margins in the pharmacy sector are 4%.[21] Therefore, if CVS-Aetna were to lose an average pharmacy customer they would lose roughly $40 in profits per year. However, if CVS-Aetna were to gain this customer as a health insurance subscriber who also bought his or her prescriptions from CVS-Aetna they would stand to gain $363 in profits. Therefore, 1 insurance customer is as valuable as roughly 9 pharmacy customers; providing strong incentives for CVS-Aetna to disadvantage competing health plans to gain insurance customers even if it risks losing some PBM customers.

Some might argue that lack of competition or greater market concentration in insurance markets might be a good for consumers. It might help health plans negotiate lower prices with hospitals and other health care providers and some of these savings might be passed to consumers as lower health insurance premiums. However, this view is not supported by past empirical research. An amicus brief filed by me and other leading health economists related to the merger of Anthem and Cigna summarizes the past empirical research as follows: "This body of work finds that *consolidation in health insurance markets does not, on average, benefit consumers*. Although, greater insurance market concentration tends to lower provider prices, there is no evidence the cost savings are passed through to

[21] http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf, accessed May 22, 2018

consumers in the form of lower premiums. To the contrary, premiums tend to rise with increased insurer concentration."[22]

In summary, the potential benefits of merging the PBM arm of CVS with Aetna are likely to be minimal. In contrast, the merger creates strong incentives for CVS-Aetna to disadvantage health plans competing with CVS-Aetna. In my opinion, the potential costs of reduced competition due to foreclosure in the insurance market outweigh the potential efficiencies of the merger for CVS-Aetna in the insurance market.

**c. Potential effects on competition in pharmacy markets**

Pharmacy markets in the US are uncompetitive or highly concentrated. According to a 2015 study CVS and Walgreens together control between 50 and 75 percent of the drugstore market in each of the country's 14 largest metro-areas. They also control the majority of the market share in 70 of the top 100 metro-areas in the country.[23] The merger of CVS with Aetna will further strengthen the already dominant position of CVS in the pharmacy market and will exacerbate the lack of competition in pharmacy markets. The health insurance arm or PBM arm of CVS-Aetna could disadvantage pharmacies competing with CVS by excluding them from their pharmacy network or through other business practices. A recent news story in the Columbus Dispatch alleges that CVS already engages in some questionable practices in Ohio.[24] First, the story alleges that the PBM arm of CVS set up a website for consumers to compare drug prices. But the site disadvantaged pharmacies competing with CVS pharmacies by automatically putting CVS pharmacies at the top of the comparison list. Second, the PBM arm of CVS lowered Medicaid payment to independent pharmacies putting them under financial duress. Then the pharmacy arm of CVS sent letters to many of the same pharmacies, asking whether they would be interested in selling their pharmacies to CVS. Third, the

[22] https://www.hbs.edu/faculty/Profile%20Files/Amicus%20Brief%20in%20re%20Anthem-Cigna%20Proposed%20Merger%202017_7df8927a-b54b-4ea2-a49c-55c98d6ef15c.pdf, accessed May 22, 2018.
[23] http://www.businessinsider.com/cvs-and-walgreens-us-drugstore-market-share-2015-7, accessed May 22, 2018.
[24] http://www.dispatch.com/news/20180415/three-cvs-actions-raise-concerns-for-some-pharmacies-consumers, accessed May 22, 2018.

insurance arm of CVS encouraged Medicare beneficiaries to transfer their prescriptions to CVS pharmacies to save money. These communications favored CVS pharmacies over other low-cost pharmacies. Such practices are not isolated to CVS. In September 2017, an independent pharmacy filed a lawsuit against Walgreens and a PBM called Prime Therapeutics.[25,26] The lawsuit alleges that Walgreens and Prime Therapeutics entered into a business agreement in August 2016 which made Walgreens the primary retail pharmacy for Prime Therapeutics. The lawsuit alleges that Prime Therapeutics wrongfully terminated its contract with the plaintiff pharmacy because it wanted to advantage Walgreens.

In addition to the above practices, CVS-Aetna could also advantage CVS-Aetna pharmacies by creating a preferred network and giving preference to CVS-Aetna pharmacies in the network. The incentive to engage in practices that increase the fraction of Aetna subscriber prescriptions filled at CVS pharmacies increases post-merger as currently Aetna does not have an incentive to favor CVS pharmacies even though Aetna's PBM CVS-Caremark has an incentive to engage in practices that favor CVS. Post-merger this check on the incentives for CVS-Caremark to favor CVS will be reduced as Aetna will be part of CVS. Therefore, the merger likely cements CVS pharmacies already dominant position with Aetna and creates additional incentives to further increase the share of Aetna subscriber prescriptions filled by CVS pharmacies. This vertical foreclosure in the pharmacy market will lead to reduced competition in the pharmacy market by leading to exit of existing pharmacies or deterring entry of new pharmacies. Eventually reduced pharmacy competition will lead to higher pharmacy costs for health plans and consumers.

The effects of this vertical foreclosure on competition in the pharmacy market will be most severe in markets where Aetna has a dominant market share. Hovenkamp, a

[25] https://www.duanemorris.com/alerts/small_pharmacy_hits_walgreens_prime_therapeutics_billion_dollar_antitrust_suit_0917.html?utm_source=Mondaq&utm_medium=syndication&utm_campaign=View-Original, accessed May 22, 2018.

[26] https://cookcountyrecord.com/stories/511114389-pharmacy-accuses-insurance-claims-processor-prime-therapeutics-of-squeezing-it-out-of-business, accessed May 22, 2018.

leading antitrust scholar states that "Both tying arrangements and vertical mergers are condemned under the same Clayton Act standard when they "may substantially lessen competition," and the fundamental concerns are the same. However, there are important factual differences. The vertical merger is more permanent than either tying or exclusive dealing contracts, and this serves to eliminate the considerable competition that occurs when vertical contracts must be renewed. Secondly, when tying or exclusive dealing is used to facilitate collusion, downstream firms upon whom these arrangements are imposed can be expected to resist. When the integration occurs by merger, however, the downstream business becomes part of the colluding firm itself. As a result, condemnation on market shares of 25% or perhaps 20% seems appropriate, provided that entry barriers are high and other market factors indicate that collusion or oligopoly is likely."[27] Given that Aetna has greater than 20% market share in several MSA health insurance markets condemnation of the merger on the grounds of foreclosure in the pharmacy market is justified.

The potential anticompetitive effects in pharmacy markets should be compared to potential efficiencies. CVS argues that the merger will lead to lower health care costs through integration of pharmacy and medical data[28]. One view is that providing medical data to pharmacists will allow them to better counsel patients. However, CVS-Aetna will likely not have access to electronic health record data for the vast majority of its subscribers. True integration of pharmacy and medical data to guide medical management of patients either in doctors' offices or pharmacies will prove difficult without access to such data. I believe that just medical claims data is not sufficient to enhance the services provided by pharmacists.

Another view is that juxtaposing pharmacy data with medical data the health plan will be able to identify which types of drugs reduce medical spending. Using this insight, the health plan can design a better drug benefit to lower overall health spending. I

[27] Herbert Hovenkamp, Federal Antitrust Policy §9.4, at p. 346 ( 1994 )

[28] https://judiciary.house.gov/wp-content/uploads/2018/02/Moriarty-REVISED-Testimony.pdf, accessed May 22, 2018.

certainly agree that integration of pharmacy and medical data has the potential to lower health care costs. Prior research clearly shows that more generous coverage of certain drugs or so-called value-based benefit designs lower medical spending.[29] However, it is unclear if Aetna already has access to its pharmacy data from CVS and if so, the extent to which the merger will lead to better integration of data.

In my opinion, the potential anticompetitive effects of the merger on pharmacy markets outweigh potential efficiencies from integration of pharmacy and medical claims data. Even if efficiencies exist, they can be achieved through contractual arrangements for sharing data across organizations.

**d. Potential effects on competition in PBM markets**

PBM markets in the US are uncompetitive or highly concentrated. The top 3 PBMs account for about 70% of the market share. Currently Aetna contracts with CVS for some PBM services, but Aetna has the option to drop CVS and choose another PBM if it is not satisfied with the service. A CVS-Aetna merger would mean that Aetna will not contract with a PBM since it will have its own in house PBM. Given that Aetna is the third largest insurer the merger reduces the size of the PBM market and thus reduces incentives for new PBMs to enter the market. In addition, several of the largest PBMs in the US such as OptumRx, Humana Pharmacy Solutions, and Prime Therapeutics are also owned by health plans. So new stand-alone PBM entry is unlikely given that several health plans already have their own PBMs. It seems likely that the only PBMs vertically integrated with a health plan might be able to effectively compete in this market place.

Some argue that greater market concentration in the PBM market is good for consumers because it helps PBMs negotiate lower prices for drugs. However, there is no empirical evidence that larger PBMs actually reduce drug costs for health plans. On the contrary, recent news stories suggests that several health plans and

[29] https://www.cbo.gov/publication/43741, accessed May 22, 2018.

large employers are unhappy with large PBMs and are seeking alternate models.[30] Prior research on insurance markets suggest that when higher concentration leads to both high monopsony power and higher monopoly power, it can simultaneously lead to lower input prices and higher output prices.

### E. Summary

In summary, several segments of the pharmaceutical supply chain are highly concentrated and several players engage in practices that hurt consumers. The acquisition of Aetna by CVS will increase incentives for CVS to be a better PBM for Aetna but it will simultaneously create incentives for CVS to be a worse PBM for health plans competing with Aetna. These incentives will likely reduce competition in health insurance markets. In my opinion, the potential costs of reduced competition in insurance markets outweigh potential benefits of CVS being a better PBM for Aetna. The acquisition of Aetna by CVS will also likely reduce competition in the pharmacy and PBM markets, increasing drug spending and out of pocket costs for consumers. The potential costs of reduced competition in pharmacy and PBM markets due to the merger outweigh potential benefits, if any, of integration of medical and pharmacy data due to the merger. Thus, 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. Evaluating whether there are other pathways through which the merger might benefit consumers is beyond the scope of this study.

[30] http://prospect.org/article/hidden-monopolies-raise-drug-prices, accessed May 22, 2018.

# COMMENTS ON SELECTED ISSUES RE: THE PROPOSED MERGERS OF AETNA AND CVS[1]

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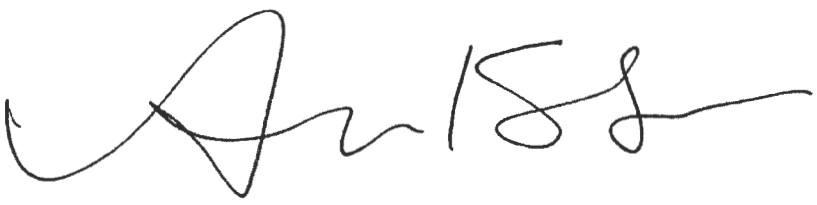
May 15, 2018



[1] I thank the American Medical Association for supporting my work in preparing this document. These comments reflect my views, not necessarily the views of the American Medical Association or of Northwestern University.

## I. Qualifications

I am an Associate Professor of Strategy at the Kellogg School of Management at Northwestern University. I am also a Faculty Research Fellow at the National Bureau of Economic Research (NBER). Much of my research has been focused on health economics and health insurance, particularly on issues involving pharmaceutical markets and regulation. I have published numerous articles on industrial organization, health economics and insurance in journals including the *Review of Economic Studies*, *Review of Economics and Statistics, RAND Journal of Economics,* and *Journal of Health Economics*.

## II. Introduction and Background

CVS Health operates both a pharmacy benefit manager (PBM) and pharmacies. As a PBM, they design pharmacy benefits for employers and health plans, including their own Medicare Part D Plans through subsidiary SilverScript Insurance Company. They also operate over 9,000 retail pharmacies. Aetna is a large, national insurer. Approximately half of their revenues were from Medicare (Medicare Part D and Medicare Advantage) and Medicaid products, while the remainder comes from the commercial market. In the latter market, they may not actually bear risk for medical or pharmacy benefits.

Both firms operate in highly concentrated industries, and the merged entity will have substantial overlap in the Medicare Part D market in particular. The level of concentration in both the PBM market and health insurance markets, in particular, have been the subject of recent antitrust scrutiny. In addition to potential harms from horizontal consolidation, the welfare effects of the merger depend on the impact of vertical integration on consumers.

In these comments, I do not cover all the issues relevant to an evaluation of the proposed merger. Instead, I concentrate more narrowly on the economic theory and empirical evidence on:

1. the extent to which market power is likely to harm consumers.
2. the extent to which foreclosure in PBM and health insurance markets could harm consumers.
3. the potential merger specific efficiencies.
4. the likelihood of pass-through of any savings to consumers.

In addition to summarizing previous research, I will draw conclusions based on economic theory. When doing so, I will make any assumptions explicit and be clear about my predictions regarding post-merger behavior.

## III. Summary of Conclusions

I first review the extent to which the merger is likely to increase concentration in existing markets. Critically, the proposed merger will lead to increased concentration in the Medicare Part D insurance market. In Section IV below, I focus on describing both the market and the potential harms to consumers due to increased consolidation. Currently, Aetna has a 9% market share among Part D plans, with CVS Health (branded as SilverScripts) has an 24% market share; overlap is even greater in a subset of geographic markets. An increase in concentration could increase firm market power, leading to higher premiums. Economic evidence – from the Part D market and others – suggest that premium increases are likely.

Furthermore, I review the level of concentration in various markets in which CVS Health and Aetna currently operate. I describe the PBM industry, noting that approximately 70% of all prescriptions are processed by one of three firms, including CVS/Caremark. I further discuss adjacent markets, focusing on the specialty pharmacy market, in which 60% of all revenues are collected by one of three firms, including CVS.

In addition to these concerns, the proposed merger could also lead to foreclosure in the PBM or retail pharmacy markets. In particular, the merged entity could increase the cost of PBM services to insurers other than Aetna, the cost of prescription drugs to other payers, or make it difficult for other PBMs to attract customers. In doing so, they may reduce the attractiveness or increase the price of rival insurance products or make entry less likely. While the lack of data on these contractual arrangements has prevented careful empirical examination of these issues, I describe the economic theory and potential merger effects below.

However, it is possible that the merger could increase contracting efficiency by aligning incentives within benefit packages to lead to more efficient investment in enrollee health. I discuss the theoretical scope and empirical evidence for benefit design effects. These efficiencies are at least partially specific to integration. However, a potentially large portion of the potential gain could be achieved via contract or the efficiencies could be achieved through the development of an in-house PBM. Given the mix of enrollees in Aetna plans, I also discuss limitations to the size of these efficiencies.

Finally, I explore the extent to which any cost-savings are likely to be passed on to the consumer in the form of lower out-of-pocket costs or premiums. Theoretically, the magnitude of any cost savings for consumers will depend on the nature of competition in the insurance market.

Given the degree of concentration and horizontal consolidation in the insurance industry, it is reasonable to believe that any cost-savings will increase insurer profits, rather than reducing consumer costs. Empirically, there are reasons to be skeptical that the savings will be realized and ultimately captured by the consumer. Therefore, the potential for harm to consumers from this merger is likely to outweigh any gains.

## IV. Pharmacy Benefits in the United States

Health insurance plans typically consist of a "medical benefit" and a "pharmacy benefit," which need not be administered by the same insurer. In particular, health insurers often contract out pharmacy benefits to PBMs, who design formularies, run utilization management programs, establish networks of retail pharmacies, and negotiate rebates from the list prices for pharmaceuticals. Americans obtain pharmacy benefits in a variety of ways. For many, pharmacy benefits are part of the insurance package offered by employers. The insurers who service these contracts with employers may use a PBM to provide drug benefits. There are three large PBMs: Express Scripts, CVS Health, and OptumRx, which is itself owned by UnitedHealth Group. The high level of concentration in the PBM market has attracted attention by antitrust regulators (Brill 2012).

However, not all Americans obtain coverage through an employer. Public financing of pharmacy coverage is also common. In both the Medicaid and Medicare programs, much of the provision of drug coverage is outsourced to private insurers. Duggan and Scott Morton (2006) and Dranove, Ody, and Starc (2018) show that private insurers reduce overall expenditure and prices in the Medicare and Medicaid programs, respectively. However, to understand the impact

of the proposed merger, one must understand prescription drug coverage in the Medicare program in particular.

The Medicare Part D program, enacted under the Medicare Modernization Act in 2003, was introduced in 2006. Medicare beneficiaries can enroll in a 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 enroll in a stand-alone prescription drug plan (PDP) that only covers prescription drugs or they can enroll in a Medicare Advantage (MA) plan. 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. The market share of MA plans have fluctuated over time, primarily because of changes in reimbursement generosity.

Typically, enrollees in PDPs receive their medical coverage from traditional Medicare. Part D is heavily subsidized; as a result, it is financially beneficial for most Medicare beneficiaries to enroll in some form of drug coverage. The program requires insurers to provide coverage at least as generous as the "standard benefit," which has a nonlinear structure in which the beneficiary pays differing out-of-pocket costs depending on the phase of the benefit design. Despite the large number of plan offerings typically available, markets are typically concentrated. Over 50% of Part D beneficiaries enroll in plans offered by three carriers.

The private insurers participating in the Medicare Part D program are free to negotiate drug prices with drug manufacturers and distributors. Most famously, PBMs can obtain "rebates" from manufacturers in exchange for preferred placement on formularies. Essentially,

pharmaceutical manufacturers give plans a discount in exchange for PBMs steering consumers to their drugs. Less well appreciated is negotiation with pharmaceutical distributors and retail pharmacies in particular. While many studies of drug pricing have focused on manufacturers' market power, pharmacy companies are increasingly concentrated as well.

## V. Market Concentration

Health insurers sell policies to consumers, often through groups, and purchase services from health care providers. Insurer market power enables an insurer to charge premiums above average costs. Higher premiums could lead to inefficiently low levels of insurance or degradation of insurance quality. In the case of the proposed merger, harm to consumers is likely.

Economists have established that imperfect competition is likely to exist in many insurance markets, with important implications for policy. Leemore Dafny (2010) tests for the presence of imperfect competition in commercial insurance markets and argues that insurer market power is an important feature of the market she studies. In a 2014 paper, I show that the need to establish a credible "brand" and market to consumers can create a barrier to additional entry. As a result, economists typically model insurers as exerting pricing power in markets ranging from Medicare Part D (of particular interest here, see Ho, Hogan, and Scott Morton 2017) to exchanges (Ericson and Starc 2015, Jaffe and Shepard 2018, Tebaldi 2018).

Economists have further shown that the extent of competition varies across local markets, and explore the implications of local variation for consumers. The weight of the research indicates that more competing firms or less concentrated local markets lead to lower premiums. Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan used a merger of two large

national health insurance carriers to measure the effect of changes in local market concentration on employer health insurance premiums (2012). The authors found an increase in local concentration to be statistically associated with a significant increase in employer insurance premiums. As summarized by Leemore Dafny in testimony before the Senate, "There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market (self- and fully insured combined), and Medicare Advantage. A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration" (Dafny 2015).

In the Medicare Part D context, a number of studies point to insurer pricing power. Francesco Decarolis, Maria Polyakova, and Stephen Ryan (2017) estimate mark-ups over costs in the order of 9 percent on average. As documented by both Keith Ericson (2013) and Kate Ho, Joseph Hogan, and Fiona Scott Morton (2018), premiums have increased over time as switching costs and, correspondingly, pricing power, have risen. Ericson finds that firms engage in an "invest then harvest strategy," in which initially low premiums grew over time for plans with larger number of enrollees. Ho, Hogan, and Scott Morton explore the impact of alternative policies that reduce consumer switching costs and decrease premiums. Finally, Anna Chorniy, Daniel Miller, and Tilan Tang (2018) find that "premiums that rise by an average of 5.2% across all market and 7.3% in markets in which the merging parties overlap." They also find limited evidence of lower plan generosity.

The relationship between concentration and the split of consumer and producer surplus is found more broadly. Marika Cabral, Michael Geruso, and Neale Mahoney (2018) find that

higher concentration is associated with higher profitability in the MA market. Leemore Dafny, Jonathan Gruber, and Christopher Ody (2015) show that higher insurer concentration leads to higher premiums in the newly created health insurance marketplaces. David Dranove, Anne Gron and Michael Mazzeo (2003) find that an increase in the number of competing HMOs in a given local market are associated with lower insurer profits.

The PBM market is also highly concentrated. Approximately 70% of all prescriptions are processed by one of three firms: Express Scripts, Caremark (owned by CVS Health) and Optum Rx (owned by UnitedHealth, Fein 2017). Both policymakers and economists have raised serious concerns about the lack of competition in the PBM market and its implications for consumers (Brill 2012, Garthwaite and Scott Morton 2018). Furthermore, the market is characterized by price obfuscation: in the absence of a well-functioning, competitive market, byzantine arrangements may harm consumers. While the nature of contracting also makes it difficult for researchers to evaluate the impact of competition on prices, the simultaneous presence of concentration and high and opaque prices is certainly suggestive. The high level of concentration in the PBM market is likely to persist due, in part, to barriers to entry in the industry. The scale required to negotiate favorable discounts from manufacturers makes it difficult for fringe players to compete.

Similar issues may apply in adjacent markets as well. For example, the specialty pharmacy market represents a growing proportion of drug costs. These pharmacies tend to focus on providing medications for consumers with complex medical conditions, including cancer, autoimmune disorders, cystic fibrosis, and HIV/AIDS. While the number of specialty pharmacy locations has increased over time, the market remains extremely concentrated. Nearly 60% of all specialty pharmacies revenues are collected by three largest firms – owned by CVS Health,

Express Scripts, and Walgreens Boots Alliance (Fein, 2017). While the merger does not entail horizontal overlap in this market, the foreclosure arguments described below are likely to apply in this market as well. For example, Aetna may attempt to steer at least a portion of their consumers to CVS's specialty pharmacy in ways that may harm competition or overall consumer welfare. Anticompetitive behavior is especially concerning in this setting, as it may have important clinical, in addition to financial, consequences.

## VI. Foreclosure

Vertical mergers may lead a newly integrated distributor to stop selling products to a downstream firm's rivals, a practice known as vertical foreclosure. Such arrangements raise antitrust concerns, since rivals may be excluded from a market altogether or, more commonly, forced to use higher cost means to bring their products to market. Empirical evidence on the extent and impact of foreclosure in the health care industry is limited. Therefore, in this section, I outline the likely effects of integration and highlight the potential for vertical foreclosure in the affected markets.

### a. Insurance Markets

The main concern is that merged entity could raise its rival's costs along two dimensions. First, the merged entity could increase the cost of PBM services to insurers other than Aetna; price increases could be facilitated by the lack of competition and opaque nature of pricing in the PBM market. Although Aetna is the third largest insurer in the United States, foreclosure may be a risky strategy, as it involves not aggressively bidding for a large fraction of the market. Aggressive bidding is unlikely especially to the extent that it will strengthen the position of Aetna's rivals in the downstream insurance market. While high market concentration is often a

cause for concern, it is particularly worrisome in the PBM market. Opaque pricing and the rebate structure give both the pharmaceutical manufacturer and the PBM incentives to allow higher list prices and higher rebates.

Second, and perhaps more important, the merged entity could increase the cost of prescription drugs to other payers. This effect may be especially important in the market for generic drugs, which are generally competitive at the wholesale, but not the retail level and represent a large fraction of total fills. In recent years, prices for some generic molecules (even particularly old ones whose branded equivalents' patents expired decades ago) have increased substantially.

**b. PBM Markets**

The ability to raise rivals' costs has important implications beyond the firms currently participating in the industry. In particular, the potential for vertical foreclosure could reduce the attractiveness of entry in either the PBM or insurance markets. PBMs know that they will have few potential customers absent Aetna, and, perhaps more importantly, non-integrated insurers will face weakly worse terms. Even if the PBM and health insurance markets were competitive, the merged firm could reduce future competition in the insurance market. If the merged entity is successful, future entry may require capabilities to be a payer, PBM, and provider, which may be difficult and especially costly for potential new entrants to replicate. In addition, the merger could make it less likely that fringe PBMs or new entrants can compete effectively for Aetna's business; high concentration and existing vertical arrangements between insurers and PBMs exacerbate the extent to which this will harm the profitability of such players.

Furthermore, the proposed merger may lead to fewer competitors in the PBM space for several reasons. First, Aetna has stated publicly that one alternative to the merger would be to build an in-house PBM (Sabatino 2018). Such a PBM could potentially add a meaningful competitor in a concentrated space. Second, despite claims that larger firms such as Amazon are poised to enter this space, the merger may impede future entry. In addition to the proposed merger, additional consolidation, including Cigna's proposed acquisition of Express Scripts, is likely in this market (Thomas, Abelson, and Bray 2018). Therefore, the merger may have negative implications for consumers in both the health insurance and PBM markets.

## VII. Potential Efficiencies

The welfare impacts of vertical mergers depend on both the potential for foreclosure and the potential for efficiencies. CVS and Aetna have cited a number of potential efficiencies that could result from the merger. The merging entities claim that the combined company "could provide integrated community-based health care that would improve patient health outcomes, increased integration of data and analytics that would lower costs, and improved coordination to treat chronic disease" (Garthwaite 2018). In this section, I explore the extent to which improved coordination through combined contracting is likely to arise and to what extent any such efficiencies may be merger-specific.

The merging parties could better align incentives within insurance contracts. Specifically, PBMs may not always design insurance benefits in order to minimize overall medical expenditure if they are not fully at risk. Insurers that offer combined medical and pharmacy benefits may do more to increase drug adherence and reduce hospitalizations: for example, they

may ensure that patients are taking blood pressure medication to prevent cardiac events and avoid the associated costs.

Empirical evidence supports this hypothesis. In work with Robert J. Town, we find Medicare Advantage Part D (MA-PD) plans that cover drug and medical expenditures tend to be designed to keep consumers out of the hospital, as compared to stand-alone PDPs that only cover drugs. MA insurers charge consumers lower copays for preventative medications—which effectively means sending consumers the right price signals. Outside of the direct impact on plan enrollment, the PDPs have little incentive to consider the influence of their benefit design decisions on enrollee medical care utilization.

A potentially large portion of the potential gain could be achieved via contract. An insurer could put the PBM at risk for at least part of medical spending. Under such a contract, there will be an implicit trade-off: as the PBM faces higher powered incentives, they must also be compensated for taking on additional risk. Because insurers will not fully internalize the benefits of optimal insurance design across treatment modalities, it is impossible to achieve the savings without fully internalizing the risk associated with total spending – without taking on all of the risk associated with medical expenditure. Furthermore, as the health care landscape changes and emphasizing paying for value more and more, contracting issues are likely to become more acute.

These efficiencies could be achieved via merger or, alternatively, by developing an in-house PBM. Other players have pursued the latter approach. The savings are also potentially limited to the set of contracts joint to Aetna and CVS in which Aetna does not already control the formulary: plans in which the merged entity is *at risk* for both medical and pharmacy benefits.

In the Part D market, efficiencies will be limited by the (lack of) consumer switching from stand-alone plans to MA-PD plans. In the commercial market, efficiencies will be limited to fully insured contracts; these efficiencies do not apply to administrative services only contracts, which compose a significant fraction of Aetna's business.

## VIII. Pass-Through of Cost Savings

Any savings obtained as a result of the merger could increase insurer profits or reduce premiums and increase plan generosity. Insurers frequently claim that cost savings will be passed through nearly one-for-one to consumers; however, theoretically, incidence will depend on the degree of competition in the market and enrollee selection. Consider pass-through under monopoly. When the monopolist sets price such that marginal cost is equal to marginal revenue, the decrease in price due to a reduction in marginal costs is smaller than under perfect competition because the marginal revenue curve is steeper than the demand curve. Under linear demand and constant marginal costs, we expect a pass-through rate of one-half, as the marginal revenue curve is twice as steep as the demand curve.

In work with Mark Duggan and Boris Vabson, we found that while an increase in MA reimbursement was successful in attracting more providers, it provided lackluster benefit to consumers. Only about one fifth of the additional reimbursement was passed through in the form of lower premiums, co-pays, or deductibles. The remaining 80 percent went to insurers' profits and advertising. While other estimates (Cabral, Geruso, and Mahoney 2018) find greater pass-through of reimbursements to consumers, all estimates in the literature imply incomplete pass-through: at least some of the benefits accrue to the supply side of the market. Similarly, we

should be skeptical of claims that the merged entity will naturally craft more competitively priced insurance products for employers and individual consumers.

Furthermore, a separate set of issues arises in the PBM market, in which confidential rebates may or may not be passed along to the consumer. In a competitive market, we expect PBMs to try to attract consumers by promising them a greater share of rebates. However, given firm behavior and price opacity in the PBM market, it is likely that a substantial fraction of any rebates are retained by the PBM. To the extent that the merger increases concentration in the PBM industry, it is even less likely that savings will accrue to the consumer.

## IX. Conclusions

My comments do not cover all the issues involved in evaluating the proposed merger. Instead, I focus on the research relevant to insurer market power, foreclosure, a subset of the most achievable efficiencies, and their impact on consumer costs.

I argue that the markets in which CVS Health and Aetna operate are typically highly concentrated. I describe concentration in the PBM industry, the specialty pharmacy market, and, critically, the Medicare Part D market, in which the merging firms have substantial overlap. Economic research has shown that concentration in insurance markets leads to higher premiums for consumers. Furthermore, the merged entity has the potential to foreclose future entry or raise the costs of current rivals. Both insurer market power and the potential for foreclosure are likely to have negative impacts on consumer welfare.

There may be potential efficiencies that are created by the merged entity. I focus on one – the alignment of medical and pharmacy benefits – that may only be fully achieved through

integration, but may be partially achieved via contract or achieved through the development of an in-house PBM. I argue that any cost efficiencies are not likely to translate into lower premiums or more attractive benefit packages for consumers. Therefore, I conclude that the potential harm to consumer welfare from the proposed merger is likely to outweigh the potential gains.

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## Lombardo, Paul

**From:** Michael Frank <michael.frank@aquariuscapital.com>
**Sent:** Monday, October 1, 2018 10:12 AM
**To:** Lombardo, Paul; Colburn, Michael; Dave, Tricia; Gozzo Andrews, Susan; He, Qing; Henry, Thomas; Hidalgo, Manuel; Jakielo, James
**Subject:** CVS-Aetna Merger
**Attachments:** Hip Replacement WSJ July 2018.pdf

My name is Michael Frank and I am an actuary in healthcare. I may have met some of you years ago when I did a training class on reinsurance for the Connecticut Insurance Department, which was the Society of Actuaries LEARN program back in September 2012. My reason for contacting you is that I saw the announcement that the Connecticut DOI is doing a hearing on the merger on Aetna-CVS transaction, so wanted to share my story with the hope that you might forward to the appropriate person. I pulled all of your names from the SOA website. This was the announcement below on the hearing being conducted by the DOI on the Aetna-CVS deal, and hope that you will pass this information along to the appropriate parties that are evaluating the transaction, since believe this should be a consideration in the process.

http://www.modernhealthcare.com/article/20180929/NEWS/180929903?utm_campaign=socialflow&utm_source=twitter&utm_medium=social

If possible, could one of you forward to the reviewers at the CT DOI who might want to know about this case.

In regard to my story, I was a victim of health billing fraud (your organization can be the judge if you want on this). I had a 2 hour procedure with no complications and discharged the next day. It was a very routine procedure, but the billed charges were approximately $140,000 and approved payments by Aetna were approximately $80,000. The hospital billed for services not provided and upcoded for other services that clearly are fraudulent, if we use the baseline of the False Claims Act as the definitions of fraud. I was even billed for medical services of other patients, and the hospital has never denied any of it. Their sole argument in the courts was that Aetna paid it, so it made an invalid and fraudulent claim into a legitimate one.

Articles were written about my story by the Wall Street Journal, Propublica, and NPR, plus the Conference of Consulting Actuaries published my story, which are below.

Sample Articles:

1.) Attached is article in July in Wall Street Journal (see PDF) written by Steven Cohen attorney who also experienced similar issues as I did with NYU-Langone, but his insurer was a different insurance company, also with home office in Connecticut.
2.) Article written by Propublic and reported by Propublica and NPR in May - https://www.propublica.org/article/why-your-health-insurer-does-not-care-about-your-big-bills
3.) Article that was published in 2017 by Conference of Consulting Actuaries and posted on my website - http://www.aquariuscapital.com/downloads/Article-by-Michael-L-Frank-on-Healthcare-Fraud-042517.pdf. This article was on the home page of the CCA website during 2017, which is how the other entities ended up picking up the story.

How Excessive Billing Happens:

Below is how the bill was itemized for a 2 hour procedure with no complications and discharge the next day. Some highlights include upcoding of implantable devices and billing for phantom PT/OT services and pharmacy services, which were both not provided. Notice 11 units in code 278 but should have been 1-2 units at most per surgeon. 5 of those units were sutures so incorrectly (intentionally) billed as implantable devices and Aetna reimbursed each suture (stitch) for $2,600 each or $13,000 for the five stitches along. Codes 420, 424 and 434 never happened and was confirmed, but billed. They added a bunch more codes so they can take an inlier (low end of DRG/case rate) and bill as an outlier (high end of DRG/case rate).

NYU Billed Amounts:

| | NYU Service Category | NYU Reported United | NYU Bill Charges |
|---|---|---|---|
| 1 | 0121-MED-SURG-GY/2 BED | 1 | $ 4,564.00 |
| 2 | 0270-MED-SUR SUPPLIES | 2 | $ 300.61 |
| 3 | 0272-STERILE SUPPLY | 1 | $ 185.37 |
| 4 | 0278-SUPPLY/IMPLANTS | 11 | $ 70,456.48 |
| 5 | 0279-SUPPLY/OTHER | 15 | $ 6,789.92 |
| 6 | 0301-LAB/CHEMISTRY | 1 | $ 106.00 |
| 7 | 0305-LAB/HEMATOLOGY | 1 | $ 97.00 |
| 8 | 0320-DX X-RAY | 1 | $ 288.42 |
| 9 | 0360-OR SERVICES | 1 | $ 21,890.00 |
| 10 | 0370-ANESTHESIA | 170 | $ 1,024.85 |
| 11 | 0420-PHYSICAL THERP | 4 | $ 1,118.00 |
| 12 | 0424-PHYS THERP/EVAL | 1 | $ 734.00 |
| 13 | 0434-OCCUP THERP/EVAL | 1 | $ 785.00 |
| 14 | 0636-DRUGS DETAIL CODE | 395 | $ 5,574.27 |
| 15 | 0710-RECOVERY ROMM | 1 | $ 3,506.94 |
| 16 | Private Duty Room | Not Available | $ 390.00 |
| 17 | Surgeon (NYU Employee) | Not Available | $ 17,500.00 |
| 18 | Anesthesiology (NYU Employee) | Not Available | $ 3,200.00 |
| 19 | Lab (NYU Lab) | Not Available | $ 245.00 |
| 20 | **GRAND TOTAL** | **606** | **$ 138,755.86** |

Aetna Adjudicated Claims in 2016:

| Aetna Paid Claims | Patient Billed Amount | NYU Target Payment |
|---|---|---|
| $ 33,944.01 | $ 3,771.56 | $ 37,715.57 |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| $ 25,721.41 | $ 2,857.93 | $ 28,579.34 |
| $ 2,478.78 | $ 275.42 | $ 2,754.20 |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| $ 1,649.99 | $ 183.33 | $ 1,833.32 |
| Part of Case Rate | Part of Case Rate | Part of Case Rate |
| $ - | $ 390.00 | $ 390.00 |
| $ 2,305.84 | $ 256.21 | $ 2,562.05 |
| $ 1,930.50 | $ 214.50 | $ 2,145.00 |
| $ - | $ 122.50 | $ 122.50 |
| **$ 68,030.53** | **$ 8,071.45** | **$ 76,101.98** |

The above costs excluded the additional bills received for pre-op and other DME bills, so total exceeded $140k and paid amount was $80k. My procedure was in December 2015. The article from Steven Cohen will highlight that his billed charges were $175k and $180k for each hip surgery, again one day length of stays for both. His two surgeries were the beginning and end of 2016 at NYU-Langone. If you want market data, visit FairHealth (developed by NY Attorney General post Optum/Ingenix litigitions for consumers) and Healthcare Blue Book. Both can be found online. CMS data is another proxy.

Separate from this story, you may want to consider having law changes requiring that insurance companies disclosure the number of units and utilization, since this was how I was able to determine how the fraudulent and excessive billing practices are done. Note that EOBs do not include units on it, so an individual would never know how many units were billed. In my case, a device that costs $300 to build of which the supplier (Smith & Nephew) charged $1,500 to NYU and NYU then submits billed charges of $70,000+ and Aetna for the one item approves more than $28,000 payable. An average consumer could not figure this out, but took an actuary (who was also former Chief Actuary of a large HMO in CT) more than 2 years to figure out the scam. Even if the Department chooses to do nothing with this, I am happy to come in as a training class (free of charge) similar to the SOA LEARN program and educate your organization on exactly how this is being done and how insurers like Aetna and others are enabling the process.

## Aetna's Role in This

Aetna, although notified of the false billing, chose to ignore and in fact helped enable NYU-Langone to commit its actions. With Aetna have a large portion of its business being self-funded where they are the TPA and even worse were they give other TPAs access to their network, there is less financial incentive for them to properly adjudicate the claims. My claim has been provided to the Department of Health, NYS Department of Financial Services, and Attorney General in NY and each organization has provided me feedback that this is wrong, but

they kind of pass the buck along to the other legislators and regulators. What I have learned through the process is that Aetna was aware of these actions and may have been a co-conspirator with NYU-Langone. If your organization wants to investigate this matter, then I am happy to share my files.

In my case, I was sued by the hospital without even receiving a subpoena, and the hospital was getting assistance from behind the scenes obtaining documents from Aetna to help in my case, yet Aetna told me that I would be provided nothing from them and would have to subpoena them to get it.

The reason that the CVS-Aetna merger becomes concerning is if Aetna is the party responsible for being the check and balances with adverse billing practices with a healthcare provider like NYU-Langone, then how will Aetna going forward manage the claims practices of CVS. Who will be the checks and balances for the pharmacy benefit manager (CVS)? The Fox owns the Hen House.

In regard to my case, the fraud unit at Aetna is well aware of this, since they informed me that they are investigating, but that they will NOT be sharing any of the results with me. Aetna's CEO is also aware of the matter and sent me to another area, which pretty much told me to go away.

Hope you find helpful. If you think the story is worth covering, then please let me know and happy to provide further detail. Also, please forward within your organization, so that you can use for investigative purposes or at least a teaching moment. There are others besides me that are a victim of this type of fraud and involves insurers with home offices in your state (Connecticut), which I have come to learn from this through social media.

Best wishes,

Michael L. Frank, ASA, FCA, MAAA
President & Actuary
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OPINION | COMMENTARY | CROSS COUNTRY

# You Can't Put a Price on a Hip Replacement, and That's a Problem

Andrew Cuomo's FAIR Health was supposed to make costs transparent. It hasn't worked out.

PHOTO: GETTY IMAGES/ISTOCKPHOTO

*By Steve Cohen*

July 13, 2018 6:45 p.m. ET

How much does a new hip cost in New York? The answer isn't at all clear, despite Gov. Andrew Cuomo's efforts to improve price transparency. Confusing insurance deductibles and balance billing mean that the actual amount patients pay can vary widely and unexpectedly, often with a painful shock.

That's what happened to Michael Frank, a 52-year-old Westchester County executive who had his left hip replaced in 2015. The Manhattan hospital charged roughly $140,000. The insurance company paid a discounted rate of about $76,000, and his share—a 10% copay, plus a couple of uncovered expenses—was a bit more than $8,000. Mr. Frank, an actuary, was outraged. The hospital, he was sure, had inflated his bill, and then his insurer had negotiated a lower rate. That smacked of collusion.

Mr. Frank called me because my name had appeared in the media regarding a lawsuit against a different insurer. After hearing his story, I told Mr. Frank what I thought was an odd twist: I'd recently had two hips replaced, six months apart, at the same hospital that had treated him.

"What did they cost you?" Mr. Frank asked.

"Just my deductible," I answered.

But then he asked what the total price had been, and I had to admit, sheepishly, that I didn't know.

My policy didn't have a 10% copay, like Mr. Frank's, so I didn't pay much attention to the overall cost. But I told him I'd check. Eventually I learned that the hospital had charged $175,000 for my right hip and $180,000 for the left. The insurance company had paid discounted rates of $75,000 and $77,000.

That should have been the end of the story, save for my momentary guilt knowing that healthy young people's premiums were paying to replace my decaying baby-boomer parts. But I wondered: If I *were* facing a 10% copay, would I have been so quick to get into the operating room? Would I have shopped for a lower-cost alternative? What is the real market price for a hip replacement?

This last question should have been relatively easy to answer. In 2009, New York's then-attorney general, Andrew Cuomo, announced the creation of a nonprofit organization called FAIR Health. Its mandate is to provide consumers accurate pricing information for all kinds of medical services.

I found the FAIR Health website and queried its database. It reported that the out-of-network price for a hip replacement in Manhattan was $72,656, close to what Mr. Frank's and my insurance companies had paid. The problem: We were both in-network, and FAIR Health estimated that cost as only $29,162.

Something didn't make sense, so I called FAIR Health. "Maybe you had complications," the spokesperson suggested. Happily, I hadn't. I was discharged from the hospital each time in under 24 hours, with no issues and no need for a home health aide. How many data points did FAIR Health use to calculate its price estimate? I was told "4,500 in Manhattan over the last six months." Who submitted these prices? "The insurance companies."

I never did figure out the reason for the difference in pricing—but somebody ought to. Giving consumers predictability in health-care costs is a smart idea, and although FAIR Health is trying, clearly there's a disconnect. Rather than relying on insurers, it might be more effective if FAIR Health collected pricing information directly from hospitals and doctors. That way the data would be less susceptible to selective reporting or massaging. That's what happened in the early 2000s, when class-action lawsuits revealed the main pricing database was being manipulated to the advantage of insurance companies.

Along with prices, FAIR Health should report the number of procedures performed by each hospital and physician's practice. Together, these data would give consumers real comparative shopping power. Knowing whether a hospital is performing a particular procedure regularly or only occasionally would help patients make informed decisions about where to seek treatment.

Many policy experts believe transparent pricing is central to any attempt at controlling health-care costs. Nationwide, more than 300,000 people a year undergo hip replacements. If a fraction of them have an experience similar to Mr. Frank's and mine, that's a lot of confusion and inefficiency clogging up the system. Real change won't come until patients have better information—data that are both accurate and granular.

How much does getting a new hip cost in New York? I've spent months trying to figure that out. Best I can tell, nobody really knows.

*Mr. Cohen is an attorney at Pollock Cohen LLP in New York*

**JOHN B. LARSON**
FIRST DISTRICT, CONNECTICUT

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# Congress of the United States
## House of Representatives
### Washington, DC 20515-0701

September 26, 2018

The Honorable Katharine L. Wade
Insurance Commissioner
State of Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816

Dear Commissioner Wade:

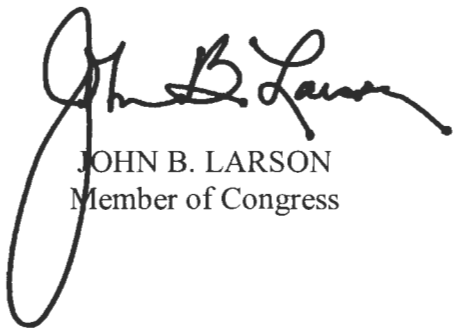
As the Member of Congress representing the First District of Connecticut, I have had the pleasure of representing Aetna and thousands of its employees for the past twenty years. As you know, Aetna has been a bedrock institution in Connecticut since its founding in 1853 and has been an integral part of the Hartford community ever since. With the proposed acquisition of Aetna by CVS Health, it is my hope that if approved, Aetna's robust presence in Hartford will not only continue for decades to come, but that the coming together of these two New England companies will make our region a powerhouse for positive changes in health care. It is my understanding that a change in control document (Form A) is currently before the Connecticut Department of Insurance outlining both the benefits and rationale for the proposed Aetna/CVS Health merger, as well as necessary financials. As a part of that process, I wanted to communicate with you my experience with Aetna and the value they've brought to the state of Connecticut.

I know that the Department is rightfully engaged in a rigorous examination of the proposed transaction and its potential impact on consumers. In my experience interacting with Aetna, and especially their Chairman and CEO Mark Bertolini, I have found them to be driven by a focus on innovating to improve quality, outcomes, and to find ways to coordinate care for individuals with chronic health conditions. Aetna has also long championed the idea that it is not just an insurance company, but that it is a health care company that practices what it preaches. Under the leadership of Mr. Bertolini, who I consider to be a national thought leader, this philosophy has extended to its employees right here in Connecticut who benefit from a $16 an hour minimum wage and a generous employee health plan that seeks to reduce workers' out-of-pocket costs. In addition, its longstanding commitment to the greater Hartford community cannot be understated. From the contributions their employees make to the community, to spurring development in downtown Hartford and supporting the Civic Center and Hartford Whalers for so many years, to the recent $50 million commitment to the city they made with The Hartford and Travelers, Aetna has been vital to Greater Hartford.

As you are well aware, the national health care landscape has been rapidly changing, and clearly Aetna and CVS believe that together, they can innovate to help their customers along the entire continuum of care. For Connecticut, my hope is that this acquisition, if approved, will mean not only sustaining the existing workforce of highly-skilled individuals and commitment to Hartford, but continued growth and investment in the Greater Hartford area. I realize that the process the Department is currently engaged in will look carefully at the benefits and risk of such a merger. I agree that such a process must consider any potentially negative impacts on consumers and that the Department will make a sound, independent judgement based on this assessment. I hope this letter will be considered as a part of that process, providing one perspective of Aetna as someone who has represented the First Congressional District for the past twenty years.

Thank you for allowing me to share my experiences and for the work that this Department is undertaking. Please do not hesitate to contact me should you have any questions or need any additional information. I can be reached through my Chief of Staff, David Sitcovsky, at (202) 225-2265 or David.Sitcovsky@mail.house.gov.

Sincerely,



JOHN B. LARSON
Member of Congress

**Aetna Retirees Association, Inc**
PO Box 280165
East Hartford, CT 06128

*Helping Aetna Keep its Promises*

September 24, 2018 Jared T. Kosky

Katharine L. Wade, Commissioner
Connecticut Insurance Department
153 Market St., 7th Floor
Hartford, CT 06103

Re: Proposed CVS acquisition of control of Aetna

Dear Commissioner Wade;

I plan to appear on behalf of the Aetna Retirees Association at the October 4, 2018 hearing concerning the proposed merger/acquisition of Aetna by CVS. I have submitted a copy of this letter to Jared T. Kosky, Esq. as a Statement to be introduced at the public hearing on October 4, 2018 at 9:00 a.m. in the Gershon Fox Ballroom at 960 Main Street, Hartford, CT. CONCERNING THE PROPOSED ACQUISITION OF CONTROL OF AETNA LIFE INSURANCE COMPANY, AETNA INSURANCE COMPANY OF CONNECTICUT, AETNA HEALTH AND LIFE INSURANCE COMPANY, AETNA HEALTH INC. (A CONNECTICUT CORPORATION) AND AETNA BETTER HEALTH INC. (A CONNECTICUT CORPORATION), SUBSIDIARIES OF AETNA INC. by CVS HEALTH CORPORATION.

Very recent news greatly concerns the Aetna Retiree Association Board of Directors who represent thousands of Aetna retirees in Connecticut as well as around the country. We believe that it requires your urgent attention.

On September 23, 2018, the New York Times Sunday edition contained a lengthy interview with Mark T. Bertolini, Chairman and Chief Executive Officer of Aetna Inc. The article was titled "Mark Bertolini's Path to Enlightenment." You can read the article at https://www.nytimes.com/2018/09/21/business/mark-bertolini-aetna-corner-office.html

The last question was whether Aetna's culture is going to survive after the sale to CVS. Mr. Bertolini's response was:

> "That's the big question. If there's one thing I worry about, it's that. When we were getting near signing the merger agreement, they [CVS] wanted to change our benefits immediately. I said 'No. You can do whatever you want to the executives. Everybody is going to do really well. But not the front-line employees.' So I don't know."

Unfortunately, Aetna's retirees have some unfavorable experience with after-retirement reduction in benefits. While our recent relationship with Aetna has been favorable for a number of years, this was not always the case.

Fourteen years ago, on February 6, 2004, Aetna announced the elimination of all subsidies for dental coverage for all Aetna retirees. Without belaboring the details, this was done notwithstanding absolute promises to pre-1988 and pre-1994 retirees that Aetna's subsidy would, depending on the date of retirement, be either 100%--or 70 to 80% for Medical-Dental-- and in spite of the fact that medical and dental was not split into separate plans until after January 1, 1992.

The Aetna Retirees Association, Inc. was formed on July 26, 2004 with the mission of "Helping Aetna Keep Its Promises" by protecting the medical, dental, vision, prescription drug and life insurance benefits as well as the pensions that Aetna committed to Aetna retirees. Aetna ultimately made some concessions on dental benefits, albeit short of their promises, to avoid litigation, negative publicity and legislative action.

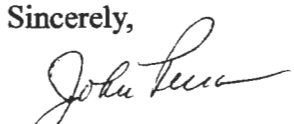
While we have enjoyed a good relationship with Aetna since a rocky start in 2004, we are very concerned that the proposed CVS acquisition of Aetna may again imperil retiree benefits.

When the Aetna CEO does not know what may happen to benefits, but notes that CVS was talking about "change" to Aetna benefits during merger negotiations, this is quite worrisome to Aetna's retirees.

ARA represents the interests of thousands of Aetna retirees who have a vested interest in life, health, dental, vision, pension and supplementary pension benefits. We believe that CVS should be required to honor Aetna's commitments to all its retirees without change now or in the future. This is not a financial distress situation for them, but rather an acquisition/merger that is being sought between two very successful companies. It is unnecessary, and would be unfair, if CVS were allowed to reduce or renege on Aetna's obligations and promises to its retirees, now or in the future.

We urge you to require that CVS stipulate its intentions concerning retiree benefits, and that the approval process require CVS's assurance that it will retain Aetna retiree benefits as they now exist.

Sincerely,



John Perra
Chairman, Aetna Retirees Association johnperra@gmail.com

c: Jared T. Kosky, Esq., Connecticut Insurance Department

National Association of Hispanic Nurses

*Promoting Hispanic Nurses to Improve the Health of Our Communities*

Katharine L. Wade, Insurance Commissioner
State of Connecticut
Attn: Jared Kosky
Insurance Department
153 Market Street, 7th Floor
Hartford, CT 06103

Subject: CVS Health's Public Health Commitments

Commissioner Wade:

I am writing today to offer public comments in advance of the hearing scheduled for September 12, 2018 that the Department will hold on CVS Health's proposed acquisition of Aetna. I want to highlight the positive benefits that CVS Health has brought to communities in Connecticut and communities across America.

In Connecticut, CVS Health provides an accessible, supportive and personalized health care experience through its over 176 stores, 19 MinuteClinics, 47 nurse practitioners and over 4,500 employees. These stores and MinuteClinics provide access to high-quality, affordable care and health advice for patients.

Beyond its pharmacies and clinics, CVS Health has long been a leader in putting patients' health first and improving public health here in Connecticut. Key CVS Health initiatives include:

- **Removing tobacco from their stores:** As a result of CVS Health's 2014 decision to stop selling all tobacco products at their stores nationwide, 95 million fewer packs of cigarettes were sold just eight months after the end of tobacco sales. And through its five-year, $50 million Be The First initiative, CVS Health is working to support youth smoking prevention and deliver the first tobacco-free generation. In March 2018, CVS Health announced $10 million in new grants and investments to support this endeavor, including a $1,400,000 grant to Yale University's play2PREVENT Lab.

- **Educating and serving the Sickle Cell community:** CVS Health's support of our New Sickle Cell Center, will enable the SCDAA Southern Connecticut to employ new and innovative resources to continue our revolutionary work coupling awareness with our crisis prevention program, the latter the first of its kind in the country. This support from CVS Health will furthermore allow us to direct resources to the unique needs of the sickle cell community to minimize the devastating impacts of the social determinants that play a role in compromising the quality of life of the sickle cell community and contributing to possible avoidable and preventable acute care utilization that may impede both housing and employment opportunities.

1100 Sunday [illegible] Suite 102 Ralei[illegible]
Phone 919-5 3-5[illegible] ax 919-[illegible]7-4916

- **Helping fight against the opioid epidemic:** More recently, CVS Health has demonstrated its commitment to public health by expanding their multi-front fight against the opioid epidemic through enhanced opioid utilization management practices that follow the Centers for Disease Control Guidelines, as well as an expanded drug disposal collection program.

As an organization that strives every day to advance the health of all residents of Connecticut, we strongly support these important initiatives and CVS Health's ongoing commitment to our communities and our state. And as an advocate for the Sickle Cell Disease Association of America Southern Connecticut, we are proud to call them a partner.

Sincerely,

Cresta Archuletta

Cresta Archuletta
Executive Director
National Association of Hispanic Nurses