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October 2, 2018

Katharine L. Wade, Commissioner
Connecticut Insurance Department
153 Market Street
Hartford, CT 06103

Dear Commissioner Wade:

I am writing to express support for the proposed merger of Aetna and CVS Health which is currently being considered by the Connecticut Insurance Department, as well as the United States Department of Justice.

As you know, Aetna is one of the nation's leading diversified healthcare benefit providers. Not only are they one of the largest employers in the state, they are critical community partners, helping to improve the health and well-being of the community through the volunteerism of its employees and the charitable work of the Aetna Foundation. Aetna's presence in the Avon community, the Capitol Region, and the State of Connecticut, as a prominent employer, community partner and taxpayer, is widely felt and valued for the role that it plays in both the physical and economic health of our community.

CVS Health employs thousands of Connecticut residents across 175 pharmacy locations and dozens of clinic sites. Not only does CVS play a role as a healthcare provider and an employer of Connecticut residents, its role as a taxpayer provides the state and its municipalities with much needed revenue. Additionally, under the umbrella of the CVS Health Foundation, the company provides health-related charitable organizations across the state with grant revenue and volunteer power to continue to fulfill missions and create a more health-conscious community.

It is my understanding that if this Aetna/CVS Health merger is approved by the Connecticut Insurance Department and the Department of Justice, the economic benefits to our State could be significant. Keeping in mind the rising cost of health care, it is important to provide opportunities that will ensure a competitive market for private companies to provide consumers with affordable, quality health care options.

I would like to thank you for your consideration of this matter.

Sincerely,

Brandon Robertson
Town Manager

MARCIA A. LECLERC
MAYOR

TOWN OF EAST HARTFORD
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East Hartford, Connecticut 06108

(860) 291-7200
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OFFICE OF THE MAYOR

October 2, 2018

Commissioner Katharine L. Wade
Connecticut Department of Insurance
153 Market St. Hartford, CT 06103

Subject: CVS-Aetna Merger – Statement of Support

Commissioner Wade:

As Mayor of East Hartford, I write to encourage your support for the proposed merger between CVS Health and Aetna. By combining the inherent strengths of these two companies, my constituents and the community I represent would benefit from an improved health care experience as well as a stronger overall economy in the state.

I have lived in East Hartford my entire life and I've dedicated my professional career to helping my home town grow and thrive, serving both on the East Hartford Town Council and as mayor. During this time, and especially over the past eight years, I have worked hard to build a better city for residents and businesses alike. Improving access to and awareness of health care services, creating and supporting local jobs, and fostering economic development have all been vital to that goal. The potential merger between CVS Health and Aetna would complement and build upon these efforts.

As you may know, Aetna's headquarters is located across the Connecticut River, just a few miles from East Hartford. Many of our town's residents work for Aetna, and this merger is crucial to protecting their jobs, as well as the economic contributions the company makes to the entire region. As mayor, supporting job creation and spurring economic development are critical components of my long-term vision for East Hartford. This merger is necessary to maintain the jobs Aetna currently provides while creating new opportunities for our communities.

Moreover, the coming together of these two companies will enhance access to health care while helping to control costs for consumers and patients. It will bring new goods and services to communities that need them most – not only pharmaceutical, but wellness, nutrition, vision, and more. The 175 CVS locations across the state will be transformed into one-stop health care and wellness hubs where people can get the care they need more conveniently and affordably.

Please support the CVS-Aetna merger so East Hartford, all of Connecticut, and the entire country can begin to reap the benefits it will bring.

Sincerely,

Marcia Leclerc
Mayor, East Hartford, Connecticut

ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

STATEMENT OF

CHARLES BELL, PROGRAMS DIRECTOR
GEORGE SLOVER, SENIOR POLICY COUNSEL

CONSUMERS UNION

BEFORE THE

CONNECTICUT INSURANCE DEPARTMENT

ON

THE PROPOSED MERGER OF AETNA AND CVS HEALTH

October 4, 2018

101 Truman Avenue, Yonkers, NY 10703 · (914) 378-2000
www.ConsumerReports.org · www.ConsumersUnion.org

Consumers Union, the advocacy division of Consumer Reports,[1] appreciates the opportunity to submit this statement regarding the proposed merger of CVS Health and Aetna, and its potential impacts on the health care marketplace, and on consumers in particular.

In our testimony that follows below, we share our general concerns about the proposed merger, and the issues that we feel federal and state regulators should investigate. We urge the Connecticut Insurance Department to conduct a thorough investigation and analysis of the merger, and its potential impacts on consumers and the marketplace, and to take all appropriate regulatory actions that are consistent with your authority in this matter. We urge you to share your concerns with the US Department of Justice.

If the Justice Department permits the merger to go forward, we urge the CID to use its regulatory authority where possible to protect and promote competition, and to impose any appropriate conditions to ensure Connecticut residents do not lose access to care or face higher prices or reduced choices as a result of the merger. CID should make sure that any cost savings to the merging companies are to the extent possible passed along to customers, and not achieved on the backs of consumers, through reductions in the quality and availability of health care services.

As part of our national work to protect consumers, in February, our Senior Policy Counsel George Slover testified before a congressional committee on the CVS-Aetna merger.[2] In addition, our colleague Dena Mendelsohn, Senior Attorney in our West Coast office, recently submitted detailed comments to the California Department of Managed Health Care regarding the proposed merger.[3]

At Consumers Union, our mission is to work for a fairer, safer, healthier world for all consumers, and to empower consumers to protect themselves. And one key to empowering

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[1] Consumers Union is the policy and mobilization division of Consumer Reports, an expert, independent, non-profit organization whose mission is to work for a fairer, safer and healthier world, and to empower consumers to protect themselves. Consumers Union works for pro-consumer policies in the areas of antitrust and competition policy, health care, food and product safety, transportation, financial services, telecommunications and technology, privacy and data security, and other consumer issues, in Washington, D.C., in the states, and in the marketplace. Consumer Reports is the world's largest independent product-testing organization, using its dozens of labs, auto test center, and survey research department to rate thousands of products and services annually. Founded in 1936, Consumer Reports has over 6 million members and publishes its magazine, website, and other publications.

[2] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018 (Testimony of George Slover), available at: https://judiciary.house.gov/wp-content/uploads/2018/02/Slover-Testimony.pdf.

[3] Mendelsohn, D., Comments provided to the California Department of Managed Health Care on the Proposed Acquisition of Aetna, Inc., by CVS Health Corporation, May 7, 2018, available at: https://consumersunion.org/research/aetna-cvs-proposed-merger/

consumers to protect themselves is working to ensure meaningful consumer choice, through effective competition.

By meaningful choice, we mean choice that is easy for consumers to understand and compare, and responsive to what's important to consumers. When consumers have meaningful choice, businesses are motivated to provide more affordability, better quality, and new thinking, in response to consumers' wants and needs.

From our founding over 80 years ago, one of our top priorities has been to make quality health care available and affordable for all Americans.

For many consumers, one of the biggest costs they face is for prescription drugs. As part of our work to help consumers reduce that cost, in 2004 we launched Consumer Reports Best Buy Drugs. This program uses evidence-based, systematic reviews of prescription drugs to verify the efficacy and safety of commonly used medicines in over 30 categories, and then combines this information with reliable cost information, helping consumers identify the "best buy."[4]

Best Buy Drugs has also conducted important market research, such as the nationally representative survey of 2000 consumers reported in an August 2016 Consumer Reports article, "Is There a Cure for High Drug Prices?"[5] The survey confirmed that high prescription drug prices are taking a serious toll, leading many consumers to split or skip doses, or to not fill the prescription at all, or to keep using a medication well after its expiration date.

One key piece of advice we give consumers for navigating the prescription drugs marketplace, expressed in the title of an article in our December 2017 issue, is that "to get the lowest drug prices, it pays to shop around."[6] But shopping around only works when consumers are offered a meaningful choice. Because of the lack of transparency in drug pricing, and hidden fees and markups, it is difficult for consumers to do head-to-head pricing comparisons. The situation is challenging now, and further marketplace consolidation may make it much worse.

Consumers ultimately benefit from there being competition, and meaningful choice, in all parts and all levels of the healthcare marketplace. This is a very complex marketplace, because in most instances, the prices charged for providing consumer healthcare products and services aren't directly and openly paid by the consumer. And the ways that costs are negotiated and shifted among the various commercial actors in the healthcare industry are often obscured from the consumer. For that reason, it is all the more important that there be competitive market forces at

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[4] http://www.consumerreports.org/health/best-buy-drugs/index.htm. Note: We do not do cost-effectiveness analysis. Instead, we present price and cost data alongside the effectiveness, safety, and side-effect data. And then we let consumers – in consultation with their doctors – interpret and adapt these data according to individual preferences, clinical circumstances, and priorities – including their budgets.

[5] https://www.consumerreports.org/drugs/cure-for-high-drug-prices/.

[6] https://www.consumerreports.org/drug-prices/to-get-the-lowest-drug-prices-it-pays-to-shop-around/.

work to discipline these actors' profit-maximizing incentives, to make sure the marketplace works effectively for consumers.

We have watched with concern as the healthcare industry has grown ever-more concentrated over recent years.

Consumers Union supports active antitrust enforcement to promote and preserve competition in all parts of the healthcare marketplace. We've supported antitrust enforcement actions against mergers involving hospitals, involving medical practices, involving health insurers, involving pharmaceutical manufacturers. We've supported antitrust action, and legislation, to stop brand-name pharmaceutical companies from using anticompetitive tactics to block or slow the development and market entry of affordable generic alternatives.

We've also called for greater transparency from pharmacy benefit managers, or PBMs – now a highly concentrated sector – in their dealings with health plans and pharmacies, as to their true costs and markups, including the rebates and other side agreements they have negotiated on the back end with drug makers.

A merger between CVS and Aetna would have a major impact in every one of these parts of the healthcare marketplace. CVS is the second largest retail pharmacy chain, with over 20 percent market share, and almost 10,000 retail locations. It has the largest PBM, CVS Caremark, with over 25 percent market share. It also runs more than 1000 Minute Clinics nationwide. It earned $177 billion in revenues last year.

Aetna is the third largest health insurer, by some measures, with over 23 million subscribers in 2016. It deals directly with hospitals, medical practices, and pharmacies from coast to coast. It earned $63 billion in revenues last year. CVS is paying almost $70 billion to buy it.

Combining these two giants would create an even bigger giant, and perhaps more importantly, would combine them into a new corporate structure, straddling more market sectors and creating new and potentially far-reaching profit-maximizing incentives, so that what before did not make business sense for them separately, now does make sense for them as a combined enterprise. To the extent those new incentives drive the combined company to integrate its resources in new ways to bring costs down and improve the quality of services – what antitrust refers to as "efficiencies" – that can be good for consumers, and good for the overall economy.

And that's the picture CVS and Aetna have been presenting to policymakers, and to the lawyers and economists at the Justice Department's Antitrust Division who are investigating this proposed merger. And some or conceivably even most of that picture might prove to be accurate.

For example, encouraging Aetna policyholders to go to a CVS Minute Clinic for simple routine care in appropriate cases, instead of to a hospital emergency room, will cut expenses for

Aetna. If Aetna saves, maybe those savings might show up in lower premiums or co-pays. And if an Aetna policyholder's employer pays lower premiums, maybe those savings might even show up in a salary increase for the policyholder.

But it's by no means certain that any savings would be passed along, in any of those ways. One key factor is whether there is enough transparency and competition so that the one on the receiving end not only has the awareness of the savings upstream, but also has some realistic ability to insist on a share or to go elsewhere. That would seem unlikely in the healthcare marketplace we currently have in this country.

Furthermore, efficiencies – which companies proposing to merge will always claim – often ultimately are shown, on further examination, to be unsubstantiated, or exaggerated. And importantly for a merger investigation, even the genuine efficiencies can very often be achieved without merging, achieved through arm's-length contract arrangements. In our CVS Minute Clinic example, why does Aetna need a merger to encourage its policyholders to go to a Minute Clinic in an appropriate case instead of to a hospital emergency room?

Moreover, sometimes what are loosely described as efficiencies are revealed, on closer inspection, to involve reducing competition, in ways that harm consumer choice and harm quality. For example, CVS-Aetna might decide to tell Aetna policyholders that their coverage only applies if they go to a CVS Minute Clinic, not to a perhaps better, and equally or more affordable, and more conveniently located, walk-in clinic run by someone else. Or to tell them that they get full coverage only for the Minute Clinic, because it's "in-network," with in-network now meaning it has to be in-house. Or to tell independent clinics who want to be in the CVS network that they must kick back profits, or must cut corners on quality of service, in order to meet new "guidelines."

Similarly, CVS-Aetna might now find it to its advantage to steer as many Aetna policyholders as it can into using CVS to fill their prescriptions. Or to steer them into using CVS Minute Clinics for more of their medical needs, and away from their own primary care physicians – even though the primary care physicians have established relationships with the policyholders and can provide better continuity of care.

Or CVS-Aetna might find it to its advantage for CVS Caremark to negotiate different, better deals on prescription drugs only for those who pay with Aetna insurance, or only for those who fill them at CVS. Because of the black box surrounding PBM rebates and side agreements, this area is particularly vulnerable to anticompetitive abuse.

And these are just a few of the ways in which CVS-Aetna might find it profitable to use its combined resources to make it harder for its rivals to get what they need, or harder for them to reach consumers, or to otherwise interfere in their efforts to compete effectively.

CVS and Aetna insist that they would never do any of those things, that their goals will always be focused on serving as many as they can, as well as they can, as often as they can. But this is not about what their present intentions might be. It is about how their incentives and capabilities would be altered by the new market-straddling corporate structure that the merger would create, and whether this would lead to improved products and services, or would lead to restricted competition and choice, and to poorer products and services.

An independent Aetna would want to encourage its policyholders to use a Minute Clinic in an appropriate case instead of a more expensive emergency room, naturally. But it would also be fine with its policyholders choosing an equally affordable walk-in clinic run by someone else. In fact, that other clinic might be more convenient and familiar to the policyholder, and therefore more likely to be used when appropriate.

But an Aetna merged with CVS would see a trade-off. Every Aetna policyholder who comes to the Minute Clinic brings profits to the merged company. Every Aetna policyholder who goes somewhere else means profits forgone. For the Aetna with no Minute Clinic affiliate, the incentive to discriminate among equivalent clinics is zero. For the Aetna joined with Minute Clinic, the incentive is higher. CVS-Aetna may still be willing to do business with those other clinics, but the terms it wants will change. The line as to where CVS-Aetna can take optimum profit-maximizing advantage, to have its cake and eat it too, will shift. And consumers could find that these other, more convenient and familiar clinics are off-limits, or that they will have to pay more to use them.

This kind of merger is often referred to as a vertical merger, because, for the most part, CVS and Aetna do not currently compete with each other, they deal with each other. It is sometimes said that vertical mergers cannot raise competition concerns, that harm to competition can only result when the merger is horizontal, between two companies that currently compete directly with each other, or that are on the verge of doing so.

But this is not accurate. These concerns are squarely within established antitrust law. There was a time, 30 or 40 years ago, when the harms that could result from a vertical merger were tending to be dismissed by many antitrust scholars, and by the antitrust enforcement agencies and the courts. That was part of what was then considered the "new thinking." But our understanding has evolved and deepened since then, and there is now greater recognition of how a company operating at two levels in the supply and marketing chain, if it has enough market power at one level, can arrange its dealings with the other level in that chain to favor itself at that other level, such as in the Minute Clinic example described above. And if the rivals at that other level don't have meaningful options, that translates into less choice at all levels up and down the chain – including, ultimately, less choice for consumers. Meaningful choice for consumers depends on meaningful choice at all market levels.

Finally, there *is* also a horizontal dimension to this merger investigation. One of the attractions of this merger to Aetna is that it would get its own in-house PBM, in CVS Caremark. But it doesn't need a merger to get one, that's just a shortcut route. If this merger is challenged and doesn't go through, Aetna is in a very good position to establish its own in-house PBM. And that would add some much-needed competition to this highly concentrated market sector. The Department will also be taking that prospect into consideration.

If the merger goes forward – and Aetna does NOT establish or contract for its own competitive PBM – there may be significantly less competition for PBM services in many states and local markets across the country, including Connecticut. As noted by Dr. Neeraj Sood of the University of Southern California, there are a significant number of metro areas across the country where Aetna is the number 1 or 2 insurer, and where Anthem/Wellpoint also operates.[7] This is significant because CVS Caremark recently signed a 5-year contract with Anthem/Wellpoint to provide PBM services for Anthem/Wellpoint customers, through an Anthem unit called IngenioRX.[8] So in these local markets – which include several large metro areas in Connecticut such as Hartford, New Haven, Bridgeport, Danbury, and Waterbury – CVS Caremark will in effect be directly providing up to 50-60% of PBM business for insured customers, which could potentially have a damaging impact on competition, pricing, and choice for customers in these markets.

The respective market shares for Anthem and Aetna in Connecticut are shown in the following table:

Table 1 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2014. Combined HMO+PPO+POS+EXCH (Total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Connecticut	2493	WellPoint	39	Aetna	20
Bridgeport-Stamford-Norwalk, CT	2333	WellPoint	32	Aetna	22
Danbury, CT	2291	WellPoint	32	Aetna	22
Hartford-West Hartford-East Hartford, CT	2515	WellPoint	40	Aetna	20
New Haven-Milford, CT	2745	WellPoint	44	Aetna	20
Norwich-New London-Westerly, CT-RI	3109	WellPoint	49	UnitedHlthcare	22
Waterbury, CT	2718	WellPoint	43	Aetna	20

We do not prejudge the outcome of the Department of Justice investigation now underway. But we hope and expect the investigation to be thorough. To get to the bottom of the issues

[7] Sood, Neeraj, Ph.D., "Potential Effects of the Proposed CVS Acquisition of Aetna on Competition and Consumer Welfare," June 14, 2018, p.9-13, available at: https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-8-7-Letter-to-Delrahim-CVS-Aetna-Merger.pdf

[8] "CVS Health Signs Five Year Agreement with Anthem Inc. To Provide Services to Support IngenioRX," CVS Health media release, October 18, 2017, available at: https://www.prnewswire.com/news-releases/cvs-health-signs-five-year-agreement-with-anthem-inc-to-provide-services-to-support-ingeniorx-300538665.html

identified above, the lawyers and economists in the Justice Department's Antitrust Division will need to investigate in detail how the health care delivery system, including the clinics, medical practices, emergency rooms and other facilities, that consumers might want and need as choices, would be impacted by the merged company's altered profit-maximizing incentives. They will need to understand the details about how CVS Caremark interacts with all of the health plans, not just Aetna but also the health plans that compete with Aetna, and how Aetna interacts with pharmacies other than CVS. They will know about the rebates and side agreements CVS Caremark has negotiated with the pharmaceutical companies. They will examine all factors that play into the effects on competition and choice, as those effects vary with the particulars of each affected location.

And at the investigation's conclusion, we are counting on the Department to take whatever enforcement action is warranted to ensure that consumers in Connecticut, and across the country, can benefit from a healthy dose of competition in the healthcare marketplace. That could potentially even require a full challenge to the merger. Or there could potentially be steps short of stopping the merger that the Department determines would be enough to avert the harms to competition and choice that would otherwise result.

But we would caution against thinking that genuine risks to competition can be taken care of with pledges of good behavior. As Assistant Attorney General Makan Delrahim recently noted[9] – and he was far from the first[10] – using behavioral requirements to fix concerns with a merger unrealistically depends on the merged company making *daily* business decisions that run counter to its profit-maximizing incentives. That's why, as AAG Delrahim has re-confirmed, behavioral remedies are disfavored in antitrust enforcement.

Given the size of this merger, and the magnitude of the stakes involved, if the Justice Department ultimately concludes not to challenge this merger, consumers and the public will want to know why. The Department has discretion to explain decisions not to take enforcement action, and this is the kind of case in which an explanation is called for. Of course, if the Department brings an enforcement action, there will be a full explanation in the court filings.

At the state level, we strongly urge the Connecticut Insurance Department to conduct a thorough investigation and analysis of the merger, and its potential impacts on consumers and the marketplace, and to take all appropriate regulatory actions that are consistent with your authority in this matter. We urge you to share your concerns with the US Department of Justice. If the Justice Department permits the merger to go forward, we urge the CID to use its regulatory authority where

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[9] https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-keynote-address-american-bar.

[10] E.g., Behavioral Merger Remedies: Evaluation and Implications for Antitrust Enforcement, John E. Kwoka and Diana L. Moss, American Antitrust Institute, Nov. 2011, at 5-6, http://www.antitrustinstitute.org/content/aai-releases-white-paper-behavioral-merger-remedies-evaluation-and-implications-antitrust-en.

possible to protect and promote competition, and to impose any appropriate conditions to ensure Connecticut residents do not lose access to care or face higher prices or reduced choices as a result of the merger. CID should make sure that any cost savings to the merging companies are to the extent possible passed along to customers, and not achieved on the backs of consumers, through reductions in the quality and availability of health care services.

As you know, some other state regulators have expressed very strong concerns about the proposed CVS-Aetna merger, and potentially damaging impacts on customers, competition, choice and quality. In early August, California Insurance Commissioner Dave Jones urged the Department of Justice to block the merger, stating that it would have "have significant anti-competitive impacts on American consumers and health care and health insurance markets." He expressed strong concerns that the large scale of the merger will likely lead to increased prices and decreased quality of medical care, and said that partial divestitures could be inadequate to adequately protect consumers or address the adverse consequences of a merger.[11]

In addition, New York Department of Financial Services Superintendent Maria Vullo warned in September that the merger could lessen competition and raise prices for consumers. She said the merger could give Aetna an "unfair competitive advantage," because CVS' PBM would have an incentive to give the largest drug discounts to Aetna members, causing "anti-competitive effects" in the rest of the market. She also expressed strong concerns about the high level of concentration in the PBM market, and the loss of Aetna as a potential competitor to existing market giants.[12]

Thank you again for the opportunity to present our views regarding this merger, and its importance to consumers.

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[11] California Department of Insurance, "California Insurance Commissioner Dave Jones Urges U.S. Justice Department to Block Merger of CVS and Aetna," news release, 8/1/18 available at: http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/release085-18.cfm See also: Calfornia Department of Justice letter to the Department of Justice regarding the merger, 8/1/18, available at: http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr085LtrJonestoUSAGSessionsreCVS-AetnaMerger.pdf

[12] "Issues for Consideration in Connecticut DOI's Review of the Proposed Acquisition of Aetna, Inc. by CVS Health Corporation, Superintendent Maria Vullo letter to Commissoner Katherine Wade of the Connecticut Insurance Department, New York Department of Financial Services, l9/17/18, available at: https://www.dfs.ny.gov/about/dfs_cl_09172018_acq_aetna.pdf

Statement of Dena Mendelsohn

Senior Attorney

Consumers Union

to the

Department of Managed Health Care

on the

Proposed Acquisition of Aetna, Inc. by CVS Health Corporation

May 7, 2018

Consumers Union, the advocacy division of Consumer Reports,[1] offers this testimony on the proposed acquisition of Aetna, Inc. ("Aetna") by CVS Health Corporation ("CVS"). From its founding over 80 years ago, Consumer Reports has worked for a fair, just, and safe marketplace for all consumers, and to empower consumers to protect themselves. One of our top priorities has always been to make high quality healthcare available and affordable for all Americans. One key to empowering consumers to protect themselves is ensuring meaningful consumer choice, through effective competition.

Meaningful choice can only exist when consumers have access to the information they need to understand and compare the options available to them. Further, when consumers have meaningful choice, businesses are motivated to provide more affordability, better quality, and new thinking, in response to consumers' wants and needs.

Consumers ultimately benefit from competitive marketplaces and meaningful choice, in all parts and all levels of the healthcare marketplace, including where health insurance is sold. The past few years are characterized by a notable increase in health plan and insurer merger filings. We have, as an organization, spoken out when a merger posed particular concern for consumers. In California, we urged our insurance and health plan regulators to oppose mergers that would harm consumers and, if such a merger was finalized anyway, to institute robust contractual undertakings to safeguard the public interest. Nationally, we have supported active antitrust enforcement to promote and preserve competition in all parts of the healthcare marketplace. We have supported antitrust enforcement actions against mergers involving hospitals, medical practices, health insurers, and pharmaceutical manufacturers. And we testified before a Congressional committee on this proposed merger in particular.[2]

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[1] Consumers Union is the advocacy division of Consumer Reports, an expert, independent, non-profit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. Consumers Union works for pro-consumer policies in the areas of antitrust and competition policy, healthcare, food and product safety, transportation, financial services, telecommunications and technology, privacy and data security, and other consumer issues, in Washington, D.C., in the states, and in the marketplace. Consumer Reports is the world's largest independent product-testing organization, using its dozens of labs, auto test center, and survey research department to rate thousands of products and services annually. Founded in 1936, Consumer Reports has over 7 million subscribers to its magazine, website, and other publications.

[2] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018 (Testimony of George Slover).

In our written testimony below, we call to the attention of the Department: (I) that being a vertical merger does not eliminate competition concerns; (II) that consolidation may benefit the merging parties but the value for consumers is unclear; (III) that a merged health plan, pharmacy, and retail establishment may mean worse care for patients and may raise privacy concerns. We close with recommended undertakings to ensure that any proposed merger will not be approved unless it is in the best interests of consumers.

I. Being a vertical merger does not eliminate competition concerns

The merger of two corporations such as Aetna and CVS is often referred to as a vertical merger, because, for the most part, CVS and Aetna do business with each other rather than compete with each other. CVS is the second largest retail pharmacy chain, with over 20 percent market share, and almost 10,000 retail locations. It has the largest Pharmacy Benefit Manager (PBM), CVS Caremark, with over 25 percent market share. It also runs more than 1000 MinuteClinics nationwide. It earned $177 billion in revenues last year.

Aetna is the third largest health insurer, by some measures, with over 23 million subscribers in 2016. It deals directly with hospitals, medical practices, and pharmacies from coast to coast. It earned $63 billion in revenues last year. CVS is paying almost $70 billion to buy it. Aetna has a smaller foothold in California than do some other health plans,[3] but it is a non-negligible presence in the state, and one that could very well grow.

Some claim that vertical mergers rarely, if ever, raise competition concerns, citing horizontal mergers as the threat to consumers. In his testimony before Congress, the Executive Vice President and General Counsel of Aetna reminded the committee of the fact that this is a vertical transaction[4] as if that were *prima facie* a reason for less rigorous review of the transaction. Vertical integration may not always trigger alarm to the same extent as the proposed horizontal merger of Aetna and Humana a few years back. As an expert testifying before Congress stated, "the theory and empirical evidence regarding the positive or negative effects of such mergers on social welfare is ambiguous."[5] In the presence of such ambiguity, it is important that our regulators be vigilant to potential threats to the interest of the public.

Vertical mergers are not always inherently harmful to consumers, but they are also neither innocuous nor *de facto* likely to create social value. As I discuss in greater detail below, a company operating at two levels in the supply and marketing chain, if it has enough market power at one level, can arrange its dealings with the other level in that chain to favor itself at that other level – such as, for example, if Aetna were to self-refer to a CVS MinuteClinic. If rivals outside the CVS-Aetna family cannot get favored referrals, or if cost-sharing is structured to disadvantage those rival providers, there will be fewer choice at all levels up and down the chain – including, ultimately, less choice for consumers.

Finally, despite immediate appearances to the contrary, there is also a horizontal dimension to this merger investigation. One of the attractions of this merger to Aetna is that it would have access to its own in-house PBM, in CVS Caremark. But it doesn't need a merger to get one. Indeed, in choosing to integrate Aetna into

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[3] According to data available via the California Health Care Foundation, in 2016, Aetna had about 680,000 Administrative Services Only enrollees, roughly 140,000 small group enrollees and about 430,000 large group enrollees. California Health Care Foundation, *California Health Insurance Enrollment, 2016*, (February 12, 2018).

[4] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018, (Testimony of Thomas Sabatino, Jr.) at p.6.

[5] *Id.* at p.3.

its portfolio, CVS is choosing against going to the market for the services Aetna provides. Similarly, in agreeing to be acquired, Aetna is opting to use an internal supplier rather than to continue its relationship with other established PBMs or to establish a new relationship with similar services – one of which could be CVS Caremark itself. In the alternative, if this merger is challenged and doesn't go through, Aetna is also in a very good position to establish its own in-house PBM, which would add some much-needed competition to this highly concentrated market sector.

We thank the Department for holding a public meeting and accepting written testimony. We urge the Department to put the full weight of its authority into this regulatory review. If the merger is ultimately approved, undertakings must be carefully crafted to sufficiently compel the merged corporation to act in the interest of its customers.

II. Consolidation benefits the merging parties but the value for consumers is unclear

Some say that mergers within the healthcare system are a necessary response to increased concentration in provider markets, and to conflict and lack of coordination among parts of the system.[6] However, we are not convinced that a mergers arms race is the proper solution, and we are concerned that consumers could ultimately bear the brunt of collateral damage.

Corporate savings from consolidation does not necessarily translate into savings for consumers

While corporations seeking to merge trot out a variety of justifications, a common one is that merging will lead to "efficiencies," with money saved for all. However, we agree with a leading health antitrust scholar that there is "little incentive [for an insurer] to pass along the savings to its policyholders."[7] Furthermore, although it is plausible that stronger market power will strengthen a health plan's negotiating position with providers and pharmaceutical companies, it is also likely that a health plan with control over clinics, pharmacy, and retail space could exercise undue control over the care its members receive, leading to fewer choices and higher prices for that care.

Beyond the prospect of stronger negotiating leverage, the promise of cost-savings being passed along to consumers is not supported by empirical research. We are, therefore, skeptical of the recent statement by CVS's Executive Vice President/Chief Policy and External Affairs Officer/General Counsel, who claimed that this merger would "enhance[the] consumer experience" and "result in cost savings of $6 for every $1 invested."[8] It may be that plans do cut costs by combining some aspects of their operations and by launching new programs. However, evidence suggests that savings from these programs will be limited to small pockets of efficiency. Beyond that, the savings of "more affordable" products could be attributable to lesser quality, reductions in customer service, or excessively narrow provider networks.

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[6] Indeed, in our work on health insurance rate review, we witness a growing chasm between rate increases for northern California versus rate change in southern California,[#] due at least in part to the consolidation of providers in northern California. For the 2016 plan year, for example, Covered California reported that the "weighted average increase for Southern California consumers who stay in their current plan is ... 1.8 percent, while for consumers in Northern California it is 7 percent. Consumers in Southern California can save an average of nearly 10 percent by moving to a lower-cost plan in the same metal tier, while consumers in Northern California would potentially be able to limit their rate increase to an average of 1 percent if they did the same." Covered California press release, 27 July 2015, available at http://news.coveredca.com/2015/07/covered-california-holds-rate-increases_27.html.

[7] Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affairs, 16 July 2015.

[8] Witness statement of Thomas M. Moriary, *infra*, at pp. 4-5.

In fact, it is by no means certain that any savings would be passed along. To start with, the opaque nature of the healthcare marketplace makes it unlikely that there would be adequate transparency and competition. Without these key ingredients, it would be difficult, if not impossible, for consumers to both be aware of the upstream savings, and to be able to insist on a share or else take their business elsewhere. As Professor Garthwaite, an expert in the economics of strategy and healthcare strategy at Kellogg School of Management, explained, "without a competitive market for health insurance, there will be no incentive for the newly merged firm to transfer value to consumers in the form of lower prices."[9]

Furthermore, efficiencies – which companies proposing to merge will always claim – often ultimately are shown, on further examination, to be unsubstantiated or exaggerated. And importantly for a merger investigation, even the genuine efficiencies can very often be achieved by other means without merging, through arm's-length contract arrangements. In the earlier CVS MinuteClinic example, why does Aetna need a merger to encourage its policyholders, in appropriate cases, to go to an alternative care setting such as a retail clinic, instead of to a hospital emergency room? Benefit design with differential cost-sharing and consumer education could accomplish the same purpose.

Moreover, sometimes what are loosely described as efficiencies are revealed, on closer inspection, to involve reducing competition in ways that harm consumer choice and harm quality. For example, CVS-Aetna might decide to tell Aetna policyholders that their coverage only applies if they go to a CVS MinuteClinic, not to a perhaps better, equally or more affordable, and more conveniently located walk-in clinic run by another entity. Or CVS-Aetna might decide to tell Aetna policyholders that they get full coverage only for the MinuteClinic, because it's "in-network," with in-network now meaning it has to be under common ownership. Or CVS-Aetna might decide to tell independent clinics who want to also be in the CVS-Aetna "network" that they must kick back profits, or cut corners on quality of service, in order to meet new "guidelines."

Similarly, CVS-Aetna might now find it to its advantage to steer as many Aetna policyholders as it can into using CVS to fill their prescriptions. Or to steer them into using CVS MinuteClinics for more of their medical needs, and away from their own primary care physicians – even though the primary care physicians have established relationships with the policyholders and can provide better continuity of care.

Or CVS-Aetna might find it to its advantage for CVS Caremark to negotiate different, better deals on prescription drugs only for those who pay with Aetna insurance, or only for those who fill their prescriptions at CVS. Because of the black box surrounding PBM rebates and side agreements, this area is particularly vulnerable to anticompetitive abuse.

We therefore urge DMHC, in the event this merger is approved by antitrust enforcers, to craft undertakings that ensure not only that the asserted "efficiencies" are passed to consumers, but also that any cost savings will not be achieved via reductions in the availability or quality of services.

The unfounded linkage of consolidation and innovation

In our mission to improve affordability and access to healthcare, including high-priced prescription drugs on which more and more consumers rely, we are familiar with the impact of high-cost specialty drugs on

[9] Garthwaite testimony, *supra*, at pp.17-18.

consumers. We are also familiar with, and in support of, new ways of paying for care that prioritize quality over quantity. We therefore welcome Aetna's commitment to "advancing a value-based framework to continue addressing" the important issue of drug costs. However, we question the notion that this insurer must merge with a PBM and retail operator in order to do so. Rather, as with our skepticism that these corporations could achieve efficiencies only after a merger, we also question why a merger is a necessary component to a major health plan giving its members value from their prescriptions. We support innovation that makes high quality products more affordable, improves health outcomes, and makes significant inroads in reducing racial and ethnic disparities. Health plans must be held accountable for assurances such as these so that they are not merely empty, self-interested promises.

Along the same vein, we are skeptical of CVS's assurances that this merger would strengthen "the relationship between the physician and his or her patients."[10] As consumer advocates, we know that a strong doctor-patient relationship is the backbone to high quality care. We do not know, however, why it would take an external PBM and retail business to make that improvement. We also question whether this promise extends to the physician-patient relationship that could exist extramural to a merged CVS-Aetna. And while some of the examples that CVS provided in its testimony to Congress[11] were admirable, it is not clear that CVS intends to offer patients any services that are not already in practice, or why their pharmacists will be better able to "give patients tools to more effectively manage their health"[12] compared to the provider a patient will have already seen before venturing to the pharmacy.

In its review of this proposed merger, we urge the Department to inquire:

- Whether CVS has a detailed plan to achieve an improved doctor-patient relationship;
- Why CVS cannot achieve the same result independent of acquiring the health plan;
- Whether its commitment would remain the same for all its clinic patients and pharmacy customers irrespective of their insurance enrollment and how it will ensure consumers are not unfairly disadvantaged if they are not Aetna enrollees.

<u>The risk that a merged corporation could avoid profit regulations</u>

The Patient Protection and Affordable Care Act (ACA) instituted what is known as the medical loss ratio (MLR) requirements. These regulations require health insurance carriers and plans to spend at least 80% of their premium revenue on medical services of enrollees in the case of individual and small group plans, and 85% in the case of large group plans. Failure to meet or exceed that ratio triggers a mandatory rebate to consumers of the difference. In instituting the MLR, the goal was to rein in insurance and health plan business practices that put profits before patient care.

While MLRs serve as a check on excessive profit-taking, they may be subject to manipulation. As highlighted by Professor Garthwaite before Congress, "there are reasonable concerns that even these MLR ratios serve as ineffective limit on the profits of firms. This is particularly true in markets where insurers and providers

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[10] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018, (Testimony of Thomas M. Moriarty) at p.4.

[11] Witness statement of Thomas M. Moriary, *infra*, at pp. 5-6.

[12] *Id.*, at 5.

are owned by the same firm."[13] Specifically, the concern is that, in a scenario where the health plan (Aetna) and the provider (MinuteClinic) are one and the same, Aetna could raise its premiums as well as its MinuteClinic prices, and in so doing, keep its MLR ratio stable while actually increasing profits, with the cost borne by policyholders.

III. Merged health plan, pharmacy, and retail establishments may mean worse care for patients as well as privacy concerns

A merger between CVS and Aetna would have a significant impact in every part of the healthcare marketplace, combining a major PBM, leading retail and pharmacy chain, and a national health plan into a new type of healthcare entity the likes of which we have not experienced.

Importantly, this merger would combine these entities into a new corporate structure, straddling more market sectors and creating new and potentially far-reaching profit-maximizing incentives, so that what before did not make business sense for each entity separately, now does make sense for them as a combined enterprise. To the extent those new incentives drive the combined company to integrate its resources in new ways to bring costs down and improve the quality of services – what antitrust refers to as "efficiencies" – that can be good for consumers, and good for the overall economy. However, while it is conceivable that some of that picture may prove accurate, it is unlikely that it will be the full scope of changes to how these separate businesses currently operate once the merger alters their incentives. Sitting before Congress, Aetna only offered the hedged assurance that "[o]ur products and services will not initially change."[14] To be sure, it would be surprising for these corporations to merge and make no changes, but we should go into this agreement with our eyes wide open, and without undue reliance on assurances from the parties seeking to merge that doing so will be in the interest of consumers.

As detailed throughout this section, the merger of a pharmacy retailer that regularly tops the list as the most expensive place to fill some prescriptions, a PBM that is known for aggressive practices, and a health plan that in the past has implemented rates found unreasonable or unjustified by the Department, and both of which having recent consumer privacy violations, demands the utmost of regulatory review and begs for undertakings with high benchmarks to ensure the merging corporations do not profit on the backs of consumers.

Vertical integration may limit consumer choice

CVS and Aetna insist that their goals will always be focused on serving as many as they can, as well as they can, as often as they can. However, consideration of whether to allow this merger to occur should not be limited to these corporations' present intentions alone. This review should also be about how their incentives and capabilities would be altered by the new market-straddling corporate structure that the merger would create, and whether this would lead to improved products and services, or would lead to restricted competition and choice, and to poorer products and services.

For example, an independent Aetna would want to encourage its policyholders to use a MinuteClinic in an appropriate case instead of a more expensive emergency room, naturally. But it would also be fine with its

[13] Garthwaite testimony, *infra*, at p.19.

[14] Sabatino testimony, *infra,* at p.6.

policyholders choosing an equally affordable walk-in clinic run by another entity. In fact, that other clinic might be more convenient and familiar to the policyholder, and therefore more likely to be used when appropriate.

But an Aetna merged with CVS could see a trade-off. Every Aetna policyholder who comes to the MinuteClinic brings profits to the merged company. Every Aetna policyholder who goes somewhere else means profits forgone. For the Aetna with no MinuteClinic affiliate, the incentive to discriminate among equivalent clinics is zero. For the Aetna joined with MinuteClinic, the incentive is higher. CVS-Aetna may still be willing to do business with those other clinics, but the terms it wants will change. The line as to where CVS-Aetna can take optimum profit-maximizing advantage will shift. And consumers could find that these other, more convenient and familiar clinics are off-limits, or that they will have to pay more to use them.

Given that Aetna is currently under investigation by the California Department of Insurance for how it makes decisions to deny or cover care,[15] it makes sense to question whether the health plan would use this merger as an opportunity to improve care for consumers or to further limit consumers' access to care.

Exactly how that line would shift requires investigation and rigorous review by regulators such as the DMHC, as well as the Department of Justice under its antitrust authority. We urge this Department to investigate:

- Where all the clinics are, and where the medical practices are, and the hospital emergency rooms, and other facilities, that consumers might want and need as choices, and whether and the extent to which consumers' access and/or choices of provider might be reduced to maximize the merging company's profits.
- How CVS interacts with all of the health plans, not just Aetna but also the ones that compete with Aetna, and how it interacts with pharmacies other than CVS. This includes the rebates and side agreements CVS Caremark has negotiated with the pharmaceutical companies.
- All factors that play into the effects on competition and choice, as those effects vary with the particulars of each affected location.

<u>The risk of costly prescription drugs becoming even more expensive</u>

In the course of our work identifying the lowest cost prescription drug options for consumers, Consumer Reports conducts an annual secret shopper survey of 150 pharmacies in six metropolitan areas nationwide. In our most recent survey, we found that the cost of a standard "market basket" of five commonly prescribed drugs was the highest at CVS and Rite Aid, totalling about $900 for the five drugs as opposed to $66 at an online pharmacy, $105 at Costco, and $107 at individual independent pharmacies.[16] As CVS expands into more neighborhoods and communities, independent pharmacies could be pushed out, either because they are unable to obtain the same arrangements with pharmaceutical manufacturers and PBMs, including CVS Caremark itself, or because they are bought out by the pharmacy retail and PBM giant that is CVS. Although CVS in some locations was able to offer discounts that lowered our shopper's costs – when specifically requested by our shopper – that experience was uneven and unpredictable across multiple

[15] California Department of Insurance, *Press Release: Insurance Commissioner Dave Jones Issues Statement Confirming Aetna Investigation*, (February 12, 2018).

[16] Consumer Reports, *Shop Around for Lower Drug Prices*, (April 5, 2018).

locations. This finding is not reassuring for consumers who would be required by the merged CVS-Aetna to shop for the lowest cost within a single retail chain.

There is no clear reason why standard prescription drugs should cost so much more at CVS than at other retailers, and no reason to believe that CVS would lower the price it charges if it were to enjoy the advantage of a larger market share. Although the Aetna Executive Vice President/General Counsel assured a Congressional committee of Aetna's commitment to "advanc[e] a value-based framework to continue addressing [the] important issue" of high prescription drug costs,[17] that assurance seems less reliable in light of Aetna's proposed partner's current pharmaceutical pricing practices. Furthermore, due to the potential perverse incentives detailed in *The Risk that a Merged Corporation Could Avoid Profit Regulations* section of this testimony, at p.5. *supra*, we are concerned that a merged CVS-Aetna may actually be incentivized to keep its prices high or even raise them, thereby leading to higher health plan premiums, increasing out-of-pocket costs for consumers, and further inflating the cost of care at a macroeconomic level.

Finally, over the years, Consumers Union has called for greater transparency from PBMs – a highly concentrated sector – in their dealings with health plans and pharmacies, as to their true costs and markups, including the rebates and other side agreements they have negotiated on the back end with drug makers. We have endorsed numerous bills designed to rein in the ability of PBMs to increase their own profits by restricting pharmacists from helping consumers find the lowest cost option to fill their prescription. We have reason to believe CVS Caremark engages in this anti-consumer practice. We are also aware of accusations that CVS uses its PBM to undermine independent mom-and-pop pharmacies, a practice that puts CVS pharmacies at a competitive advantage but takes away a vital community asset. Each of these raises concerns for us that an even stronger CVS could be further disadvantageous to consumers.

Potential risks to patient privacy and health data security

Consumers have long been protective of their personal health information. And to safeguard the very personal information that each of us accumulates, laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, in California, the Confidential Medical Information Act (CMIA) are in place. Yet, even with these protections, there are lapses where compliance and/or oversight fall short, or where the laws and regulations fail to completely protect consumers. We believe consumers have reason to be wary of the privacy implications of a merger between Aetna and CVS.

One need look no further than this past year to find a striking example of where both CVS and Aetna carelessly exposed sensitive personal information, violating consumers' privacy. In July 2017, Aetna used window envelopes to mail information on filling prescriptions for HIV medication to approximately 12,000 customers, which in some cases was visible through the window opening.[18] Shortly thereafter, and in a completely separate incident, CVS Caremark mailed pharmacy benefit information in window envelopes to approximately 4,000 customers, with a program code that included "HIV" visible for some through the window.[19] These shocking examples of privacy violations clearly failed to meet already-existing privacy

[17] Sabatino testimony, *infra*, at pp. 5-6.

[18] AIDS Law Project of Pennsylvania, *Federal Lawsuit: Aetna's Envelope Revealed HIV Information of 12,000 Customers in 23 States*, (August 28, 2017).

[19] Consumer Watchdog, *CVS Halts Patient Mailings that Revealed HIV Reference Through Envelope Window*, (September 1, 2017).

protections, and could have been avoided by the simple act of using an envelope without a window or, better yet, a security envelope. Yet both companies made the same mistake within a short timeframe. These easily-avoided incidents suggest a corporate culture where consumer privacy is not a priority.

In this age of vast digital collection of customer data, how data may be used, shared, and secured by a merged CVS-Aetna is another area that should be investigated by the Department. Certainly, it is foreseeable that consumers could benefit from having their information shared within a vertically integrated system rather than between separate organizations. At the same time, though, it must be noted that in combining systems, the newly formed corporation would have a potentially unprecedented understanding of each customer – for better or for worse – with a portfolio of data that comprises consumers' health claims, pharmacy purchases, and retail shopping habits. For consumers, consolidation of their data raises red flags, such as: the possibility that it could be used for unwelcome and potentially invasive targeted advertising or the possibility that it could be used to engage in price discrimination, such as by tailoring coupons offered through the CVS Rewards program. Finally, if all of this consumer data – including healthcare and financial information – is combined or digitally stored together, a breach would be all the more harmful.

We, therefore, strongly urge the Department to evaluate with a critical eye:

- How will policyholders' data be stored, and what security precautions will be taken?
- Will the retail shopping data, including CVS ExtraCare rewards program, be combined with other consumer health data? If so, how would the company safeguard personal health information (PHI) from being shared or sold with other less-regulated customer data?
- How could this comprehensive data set be used?

A larger carrier may be less responsive to rate review

Aetna has a notably poor track record when it comes to rate setting in California. In fewer than three years, DMHC deemed four Aetna rate requests unreasonable, unsubstantiated, and unjustified. In fact, in 2015, "[t]wo thirds of the Department's unreasonable premium rate findings have been for Aetna rate increases."[20] DMHC described Aetna's pattern of unreasonable increases as "price gouging in today's market."[21] Each request impacted over 75,000 members, for a total in excess of 300,000 affected consumers. Upon finding that rate request by Aetna unjustified, DMHC noted that the Plan "failed to provide the DMHC with timely and adequate documentation that would justify the rate increase."[22] Despite the Department's objections, Aetna proceeded with each of its unreasonable rate increases. Large rate increases by Aetna are not limited to its Knox-Keene products. According to a report issued by the California Healthcare Foundation, Aetna increased individual health insurance premiums for some of its California Department of Insurance (CDI) products at a rate higher than average in 2011, 2012, 2013.[23] With increased market power from a merger, it seems highly unlikely that the larger company would improve its responsiveness to regulators or sensitivity to consumer rate burdens.

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[20] DMHC Press Release, *DMHC Declares Premium Rate Increase by Aetna Unreasonable*, (July 16, 2015).

[21] *Id.*

[22] *Id.*

[23] California HealthCare Foundation, *Individual Health Insurance Premium Growth in California*, (March 1, 2017). In the same timeframe, Aetna increased premiums at a rate below average for three of its smaller products.

We therefore urge the Department to pursue undertakings that hold Aetna accountable for any unjustified rate increases, and that compel Aetna to provide all the required documentation—as defined by state and federal rate review regulations—and to be responsive to regulators throughout the rate setting process.

Recommended steps to protect the interests of consumers should the merger be approved.

If this merger is finalized, consumers need assurances that the newly combined CVS-Aetna corporation will lift up consumer interests and improve their lot—on access, affordability, and quality—rather than leaving consumers carrying the weight of this deal. Undertakings Consumers Union recommends for your consideration include, but are not limited to:

- Health insurance rates: The merged company should agree to not move forward with rate increases in any market segment that DMHC deems unjustified or that contain inaccurate or incomplete information. Given the high risk that the bigger merged company will have higher premiums, it should agree to providing even greater detail, publicly available, to aid DMHC in especially close rate review, particularly during the first years after the merger, and perhaps beyond. Moreover, it should agree that proposed rate increases will be quantified based on Aetna's prior plan year rates, not as a new health plan altogether. CVS-Aetna must not be permitted to finalize proposed premium rate increases deemed unreasonable or unjustified by the Department, and instead should confer with regulators until a reasonable and justified rate is set. This should apply to all lines of business subject to rate review at the time the rate is filed.
- Upholding profit regulations: To safeguard against circumvention of the medical loss ratio, Aetna must commit to inspection by the Department of any potential relationship between how much it spends on enrollee healthcare claims and how it prices its healthcare services and prescription drugs. The Department should also consider whether it is appropriate to tailor a specialized medical loss ratio that would capture claims costs incurred as a result of one branch of the corporation raising healthcare costs on the health plan branch of the organization.
- Enhancing networks: The merged company should commit to improving the network of providers available to consumers, which could include CVS providers such as the MinuteClinics and pharmacy retail centers, but would not be limited to those providers.
- Quality improvement and cost containment initiatives: Existing state law requires that each plan's rate filing include "any cost containment and quality improvement efforts since the last filing for the same category of health benefits plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period".[24] That requirement is unfortunately often honored more in the breach than the observance. CVS-Aetna must be required not only to reinvest profits appropriately in quality improvement and cost containment initiatives, but also to provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each directly benefits policyholders.

[24] California Health and Safety Code Section 1385.03(c)(3).

- Improved quality and consumer satisfaction ratings: Achieving above-average quality ratings as measured by NCQA, Covered California, the Right Care Initiative, the Office of Patient Advocate Quality Report Card, and the Medi-Cal Managed Care Health Care Options Consumer Guide, by no later than the performance measurement period ending December 31, 2019, should be a required condition.
- Protecting consumer privacy: The merged company should commit to creating a corporate culture that values healthcare information privacy and keeps it top-of-mind, from major decisions down to selecting envelopes for mass mailings. Additionally, prior to merging, CVS and Aetna must design and legally bind themselves to undertake a healthcare data security plan that would, for example, require that the merged company store healthcare data separately from financial data, and not combine data from their retail data collection with data from their healthcare providers and health plan.
- Dedicated staffing for transition issues: Whether due to network shifts, information technology glitches or other operational issues, mergers inevitably have bumps in the road that will affect CVS-Aetna and the newly merged company's customers. Consumers Union recommends that DMHC require dedicated, increased staffing—in California and anywhere else trouble spots in the company may arise and need to be rectified—such as personnel to craft provider directories, provide customer service, and ensure that protected health information is continuously secured during the transition and thereafter.

Conclusion

Californians rely on their regulators to act in their best interest. After conducting a thorough investigation, the Department must take whatever enforcement action is warranted and available to the Department to ensure that consumers can benefit from a healthy dose of competition in the healthcare marketplace. If the merger is not blocked under the antitrust laws, we urge the Department to secure substantive undertakings with sufficient teeth to avert potential harms to competition and choice that could result. Genuine risks to competition cannot be contained with pledges of good behavior alone. Although we would be pleased to see the many promised benefits of this integration come to consumers, we are mindful that if they do not, and if this merger in fact erodes access to affordable high-quality care for Californians, that failure to hit the mark will be most keenly felt by consumers. To avoid such an outcome, we urge the Department to use its regulatory authority to positively reinforce, and enforce, any commitments that CVS-Aetna has made in the run-up to their proposed merger. Thank you again for the opportunity to submit in writing our analysis of the risks to consumers from this proposed merger.

Sincerely,

Dena B. Mendelsohn

Dena B. Mendelsohn
Senior Attorney
Consumers Union

CPA CONNECTICUT PHARMACISTS ASSOCIATION

CONNECTICUT DEPT OF INSURANCE
RE: CVS HEALTH/AETNA INC MERGER

TESTIMONY OF NATHAN TINKER, PhD
CEO, CONNECTICUT PHARMACISTS ASSOCIATION

OCTOBER 4, 2018
HARTFORD CT

Good morning,

My name is Nathan Tinker and I am the CEO of the Connecticut Pharmacists Association. We represent nearly 1,000 pharmacists, pharmacy technicians, and pharmacy students across the state of Connecticut.

On behalf of the pharmacists we serve and their patients, **we strongly oppose the merger of CVS Health and Aetna.**

I realize that this may not be a popular position to hold sitting here in Hartford, the headquarters of Aetna. However, as an organization, we feel strongly that we must look beyond merely the local economic benefits and understand the devastating impact that this merger may have on access to patient care nationwide.

In short, CPA is very concerned that increased vertical integration in the healthcare industry will contribute to higher costs, negatively impact patient choice, and drive independent pharmacies out of business.

Provider Choice for Patients
The proposed CVS Health/Aetna Inc. merger raises serious questions about its impact on provider choice for patients. Aetna is the third largest health insurer in the nation, with revenues of more than $60 billion. And in the PBM arena, CVS Health is the second largest entity controlling more than 1/3 of the entire market and reporting 2018 first quarter revenues of $32.2 billion. Bringing the insurance company and its pharmacy benefit manager together in-house is tantamount to the "fox watching the henhouse" - there will be little incentive to control costs or to pass any perceived savings on to patients.

The potential for damage, both to patients and local pharmacies, is clear. CVS Health operates the largest pharmacy chain in the United States with approximately 9,700 retail locations and has significant share in many markets. In Connecticut, CVS Health alone operates some 176 retail stores — compared to just 151 independent community pharmacies statewide. Many of the CVS locations include CVS Minute Clinics, further consolidating key elements of the healthcare value chain under one roof.

See Addendum A for more information on the economic impact of independent pharmacies in Connecticut.

This impact may be felt especially hard here in Connecticut, where CVS/Caremark is currently the PBM for the state employee health program.

Currently, this significant market share allows CVS/Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves. Community pharmacies have very little negotiating power when contracting with PBMs like CVS/Caremark, and routinely must agree to take-it-or-leave-it contracts to be a part of the PBM's pharmacy network. In some cases, even if a pharmacy is willing to accept onerous contract terms, the PBM will exclude certain pharmacies from their networks altogether, limiting patient choice.

Indeed, Aetna has already engaged in problematic practices with respect to its pharmacy networks. CMS sanctioned the company in 2010 and again in 2015 for misleading seniors about which pharmacies were in-network.[1]

The upshot has been that patients across the US have received letters from CVS/Caremark indicating that a recently used pharmacy is no longer part of the network without identifying the name of the pharmacy. Many patients assume it is the pharmacy they use most frequently and make plans to use one of the pharmacies suggested in the letter. Pharmacists have been forced to scramble to determine if they have in fact been removed from the network, and then communicate to their patients that they have *not* been removed. But by the time this has been completed, the damage is done—a patient has moved to a new pharmacy when there was no need to do so.

The potential for abuse of the system, and therefore the potential of damage to patients and local pharmacies, is clear. Will the merged entity be able to use this dominant position to increase payments to CVS pharmacies? Conversely, will health plan competitors, in turn, exclude CVS pharmacies from *their* plans?

Based upon what we have seen in the pharmacy world, might Aetna adopt a plan design that points Aetna customers exclusively to CVS Minute Clinics (or raise costs to competitors who want access to the clinics for their beneficiaries)? Will those patients also be incentivized to use the CVS pharmacy where the Minute Clinic is located, leaving them with little choice in where they receive their healthcare and prescriptions?

The merger presages a dangerous slippery slope out of just the pharmacy sphere and into general medical practice. There are serious questions as to whether patients will continue to have access to their preferred pharmacies and other healthcare providers and whether quality and service will be hurt.

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[1] Manos, Diana, Healthcare Finance, CMS issues sanctions against Aetna, Apr. 12, 2010, available at http://www.healthcarefinancenews.com/news/cms-issues-sanctions-against-aetna.

Patients' Healthcare Costs
The merging parties have stated that the proposed transaction will create efficiencies and save hundreds of millions of dollars for consumers. They have not, however, explained whether those purported savings will be passed on to consumers. The largest PBMs already claim their size enables them to achieve significant efficiencies and cost savings. As patients' out-of-pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers.

We already know that patients often cannot afford their medications, resulting in thousands of deaths each year, and a vertically-integrated, monolithic, centralized system is not the answer.

Viability of Healthcare Providers
CPA also has serious concerns that local and independent pharmacies will not be able to survive the integration of CVS and Aetna.

On October 26, 2017,[2] pharmacists across the country noticed a sudden, drastic drop in reimbursement as they dispensed generic medications and submitted claims for Medicaid Managed Care patients in the seven health plans managed by CVS/Caremark. Many pharmacies saw reimbursements of 40% or more BELOW COST. Many could not replace inventory and predicted they would be forced to close their doors because CVS/Caremark controlled 70% to 80% of prescriptions dispensed at these pharmacies.

The drop in reimbursement brought many independent pharmacies to the breaking point. Unbelievably, on November 9, pharmacies in this weakened state received store purchase offers from CVS/Caremark.

When pharmacies are reimbursed 40% below wholesale cost, they cannot afford to maintain inventory and certain medications inevitably become unavailable. Patients such as those who have been stabilized on medications were at risk of losing access to necessary medications and at risk of needing treatment in emergency rooms or in hospitals. Just as suddenly, hospitals were at risk of losing thousands of dollars in incentive payments they would otherwise earn under the Medicaid Redesign initiative.

What happened during these few weeks demonstrates the wide-ranging impact one PBM can have over pharmacies and healthcare as a whole. In our view, the experience makes a convincing case for federal and state regulation of pharmacy benefit managers and serious concerns with vertical integration within the system. NO state or federal law is currently in place to protect consumers, pharmacies or entire health delivery systems from the destabilizing actions of one, two or all three of the large pharmacy benefit managers.

Conclusion
CPA recommends that the proposed merger between CVS Health and Aetna Inc. be closely examined to ensure a decision is made that puts the patient's healthcare access

[2] See also *Wall Street Journal*, Editorial, "Why CVS Loves Obamacare," https://www.wsj.com/articles/why-cvs-loves-obamacare-1527633490

and choice first and foremost. ALL patients have the right to local, personal relationships with healthcare providers. If this integration moves forward, local pharmacies will no longer be able to compete with these large, integrated PBM/insurer systems that will dominate the market.

We recommend that strong STATE legislation be enacted that requires pricing and practice transparency, and that allows the Department to regularly and aggressively audit the system. It should be stipulated that savings engendered by negotiated drug prices should be directly passed on to consumers.

Last year, Connecticut passed legislation requiring PBMs to report rebates to the Department of Insurance. However, the legislation did not include the ability to audit, and we are left simply to trust that such rebate reports are appropriate and accurate. **Strong oversight by regulators is not only warranted but vital to ensure that financial efficiencies promised by CVS and Aetna will indeed trickle down to patients.**

As the healthcare system continues to consolidate, healthcare costs continue to increase, and patients have fewer choices. The Department should be concerned with this trend.

We encourage the Department to work closely with the Office of the Healthcare Advocate and the Governor's Healthcare Cabinet to protect consumers from the consequences, both intended and unintended, of this mega-merger.

Thank you for the opportunity to provide testimony today.

Nationwide, independent community pharmacy represents an $80 billion health care marketplace and employs more than 250,000 people. More than 80 percent of independent pharmacies are located in communities of 50,000 population or less, providing essential health care services in underserved areas.

Connecticut

Number of independent community pharmacies:	151
Total sales:	$546,463,564
Pharmacy sales:	$504,932,333
Front-end sales:	$41,531,231
Number of full-time employees:	1,419
Total prescriptions filled:	9,021,646
Part D prescriptions fillied:	3,247,793
Medicaid prescriptions filled:	1,443,463
Additional economic activity* generated by independent community pharmacy in state of Connecticut:	
Sales:	$491,817,208
Employment:	568

Financial data represented here is for the 2016 tax year.
For more information, please contact the NCPA Advocacy Center at karry.laviolette@ncpanet.org.

**Additional economic activity refers to the increase in economic activity – usually at the local level – that results as pharmacy employees spend and invest their earnings. The effect of that spending is campaunded as workers spend their money at lacal businesses. Those businesses in turn have additianal income to invest locally. As each round of spending weaves thraugh the economy, community pharmacy's impact is multiplied.*

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Cantor Colburn LLP

September 21, 2018

Commissioner Katharine L. Wade
Connecticut Department of Insurance
153 Market Street
Hartford, CT 06103

Dear Commissioner Wade:

As a businessman and a passionate supporter of economic growth in our state, I write in strong support of the proposed merger between Aetna and CVS. I am very familiar with both companies, given that Aetna is headquartered here in Hartford and CVS is based in Rhode Island. Both have strong track records as community partners for reliability and corporate responsibility, and both are vital to our local economy. I believe the innovative plan the two companies propose will help our communities in Connecticut thrive.

Cantor Colburn is the fourth largest patent law firm in the country. We are headquartered in Hartford and employ in excess of 300 people, the vast majority of whom work in Hartford. Clients have entrusted us with their inventions and innovations for more than 30 years. I serve as the Chair of Connecticut Innovations by appointment of Governor Dannel Malloy, and lead the state's efforts to grow high tech businesses in the state. I know ingenuity and innovation when I see it. This is not the typical corporate merger where one company simply takes over another to maximize value—these companies offer truly complementary services. Their combination represents a compelling vision for the future of health care, as coupling CVS's retail footprint and customer service with Aetna's networks and analytic capabilities could create a new and transformative approach to providing care, especially for urban and under-served communities.

Only time will tell just how successful this particular model will be; but right now, what is certain is that Connecticut residents and businesses need more health care options. Increasing access to quality, affordable health care is imperative. With 175 stores in Connecticut alone, CVS is poised to connect more people than ever to the care they need to remain healthy and live fulfilling, happy lives.

For the Greater Hartford area, there are also very persuasive economic arguments in favor of the merger. Both companies are among the biggest employers in our communities and contribute millions in state and local tax revenues. This merger will also vastly increase the likelihood of keeping Aetna's jobs in our area, and could even help create more economic opportunity with the addition of CVS.

This merger is what some would call a "no-brainer." It's good for both the health and wealth of area residents. I urge you to help move this plan forward as quickly as possible.

Sincerely,

Michael A. Cantor
Co-Managing Partner, Cantor Colburn LLP
Chair, Connecticut Innovations