Testimony Regarding CVS Health Corporation's Proposed Acquisition of Aetna Inc.

by

Richard M. Scheffler

at the

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Qualifications

My name is Richard Scheffler. I am a Distinguished Professor 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. My CV is attached to my testimony.

I testified at the California Department of Insurance's 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).

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

Background

In 2018, 43 million of the 60 million people with Medicare have prescription drug coverage under a Medicare Part D plan.[1] 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).[1] In California, 2.3 million people are enrolled in a PDP plan while 2.5 million people are enrolled in a MA-PD plan.[2]

The total drug cost of Medicare Part D claims has increased rapidly since 2013. Nationwide total Medicare Part D drug cost increased from $103.7 billion to $146.1 – a 41% increase – between 2013 and 2016. In California the increase was slightly higher (in percentage terms) with total Medicare Part D drug cost increasing from $10.5 billion in 2013 to $15.1 billion in 2016 – a 44% increase.

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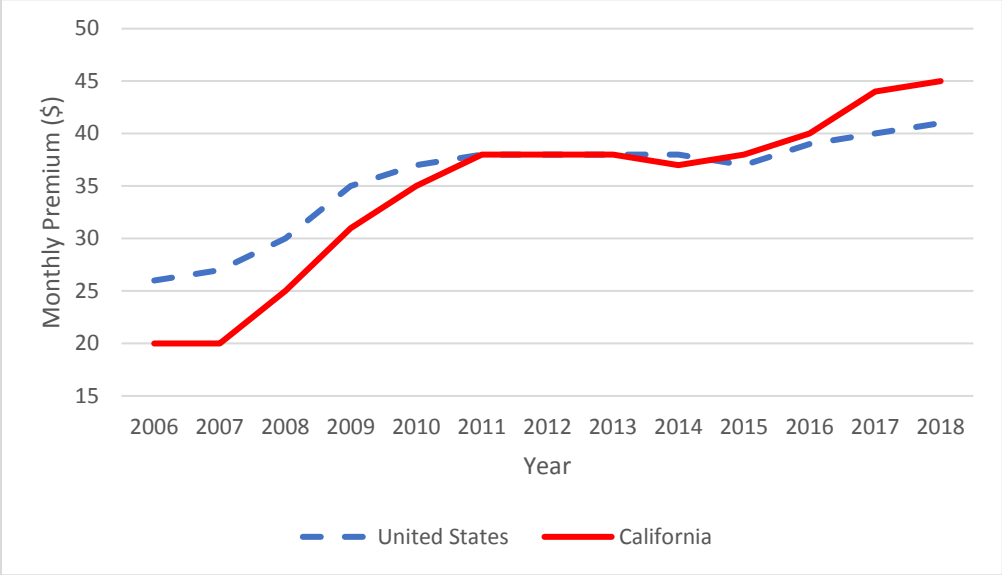
[1] Cubanski, Juliette, Anthony Damico, and Tricia Neuman. "Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing." San Francisco, CA: Kaiser Family Foundation. May 17, 2018. Available from: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/

[2] 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

Additionally, monthly Part D consumer premiums have increased by 58% since the start of the Medicare Part D program in 2006. During this same time period, the Consumer Price Index (CPI) increased by only 24%. In 2006, average monthly consumer premiums were $26 across the United States (see Figure 1). Average monthly consumer premiums leveled out from 2010 to 2015, hovering around $38 the entire time. Since 2015, average monthly consumer premiums rose by 11% (from $37 to $41 per month).

Figure 1 also shows how average monthly premiums for PDPs have changed in California since 2006. In 2006, the average monthly premium in California was $20, which was 23% below the $26 national average. By 2011, however, average monthly premiums in California had caught up to the national average at $38. Similar to national premiums, California premiums were stable from 2011 to 2015. However, since 2015, California premiums have increased by 18% -- from $38 to $45. And today, California premiums are 10% above the national average ($45 vs. $41). Overall, California premiums have increased by 125% since 2006.

Figure 1. Average Monthly Premium for PDPs, 2006-2018



Source: Kaiser Family Foundation analysis of Medicare plan enrollment and premium data files.
Notes: PDP=stand-alone prescription drug plan.

My testimony focuses on the horizontal overlap between CVS and Aetna in the California PDP market. I specifically measure market concentration before and after the proposed merger and the potential impact on the PDP market in California.

How Part D Premiums Are Determined

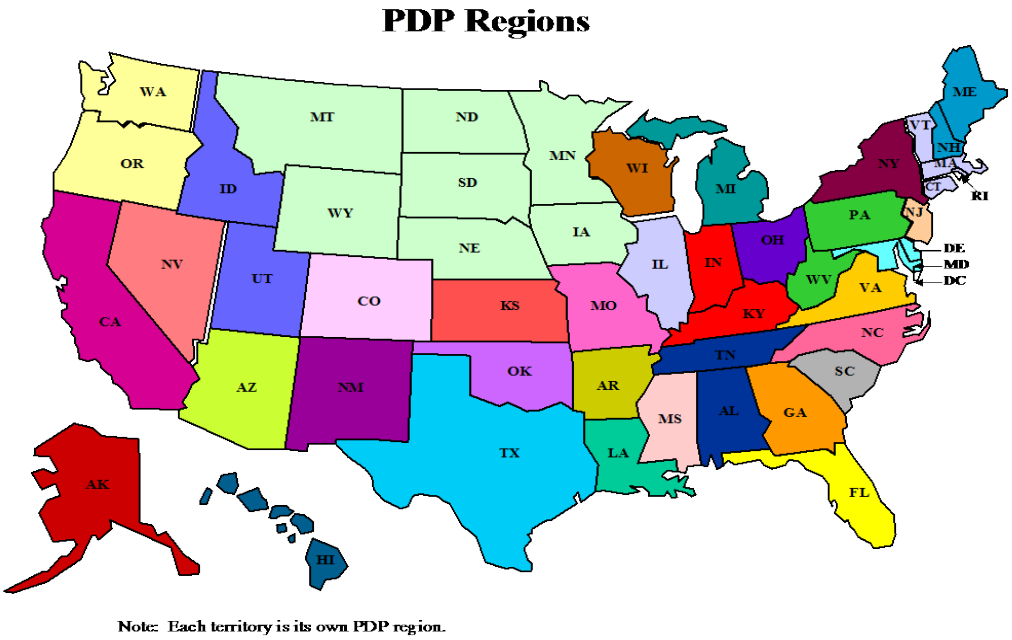
Part D plan sponsors compete on premiums to attract enrollees, but do not set premiums directly.[3] Plan sponsors submit bids to the Centers for Medicare & Medicaid Services (CMS) that represent their revenue requirements (including administrative costs and profit) for delivering basic benefits to an enrollee of average health. CMS then calculates a nationwide enrollment-weighted average among all the bid submissions. The monthly premium an enrollee pays for a plan is a subsidized base premium ($35 in 2018) plus (or minus) any difference between his plan's bid and the nationwide average bid. If an enrollee picks a plan that contains supplemental coverage, the enrollee pays the full price of the additional coverage.

Part D's bidding process also determines the maximum premium amount Medicare will pay on behalf of low-income subsidy (LIS) enrollees.[4] The amount is calculated separately for each of the Part D geographic regions as the average premium among plans with basic benefits, weighted by each plan's LIS enrollment in the previous year. 25 of the 34 nationwide Part D geographic regions (excluding the territories), including California, are a single state (see Figure 2). The remaining 9 regions are comprised of multiple states. The formula used for the LIS program ensures that at least one stand-alone PDP in each region is available to LIS enrollees at no premium.

[3] This section relies heavily on the description of how premiums are determined in MedPAC. "The Medicare prescription drug program (Part D): Status report." Ch. 14 in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. March 2018. Available from: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf?sfvrsn=0

[4] In 2018, enrollees can have up to $18,210 in yearly income ($24,690 for a married couple) and up to $14,100 in resources ($28,150 for a married couple) and still qualify for a low income-subsidy. See https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html for details.

Figure 2. PDP Regions



Source: Centers for Medicare & Medicaid Services (CMS). "PDP Regions." Available from: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/PDPRegions.pdf

The importance of the 34 Part D regions in the determination of the maximum premium amount Medicare will pay on behalf of LIS enrollees, plus the fact that plan sponsors must offer a plan in at least one entire region (and cannot pick and choose which geographies within a region it offers plans),[5] makes Part D regions the geographic level at which antitrust authorities are likely to examine CVS and Aetna for overlap in the PDP market. Hence, Part D region-level PDP market concentration is analyzed in what follows.

[5] Event Driven. "AET/CVS: Part D Overlap and Potential Divesture Analysis." February 9, 2018.

Measuring Market Concentration

I used the Herfindahl-Hirschman Index (HHI) to measure PDP market concentration. HHI has been used frequently as a measure of market concentration in merger cases brought by the Antitrust Division of the US Department of Justice (DOJ) and Federal Trade Commission (FTC) and is used in *Horizontal Merger Guidelines* (hereafter Guidelines), authored by these agencies.[6] HHI is calculated by taking the market share of each firm, squaring it, and summing the results. HHI values range from zero to 10,000. The Guidelines consider markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated, and markets with an HHI in excess of 2,500 points to be highly concentrated. Market shares in each of the 34 Medicare Part D regions were calculated based on plan sponsor PDP enrollment.

To address the impact of a CVS/Aetna merger on PDP market concentration, 2018 market concentration was calculated two ways: (1) assuming CVS and Aetna were separate firms (pre-merger HHI) and (2) assuming CVS and Aetna were a single firm (post-merger HHI). Market concentration measures from 2009 to 2017 were also calculated to show the trend in PDP market concentration.

In the context of mergers, the Guidelines assign the highest concern and scrutiny to mergers that would increase the HHI in a market by over 200 points and leave the market with an HHI of over 2,500. Other HHI changes and levels trigger different degrees of concern and scrutiny (see Table 1 for details). Markets that would experience HHI increases of over 200 points and resulting HHIs at or above 1,500 (see yellow cells in Table 1) will be discussed in the analysis that follows.

Table 1. Level of Concern and Scrutiny Based on HHI Change and Resulting HHI Level

		HHI Level		
		< 1,500	1,500 to 2,500	>2,500
HHI Change	<100	Low	Low	Low
	100 to 200	Low	Moderate	Moderate
	>200	Low	Moderate	High

Low: "Unlikely to have adverse competitive effects and ordinarily require no further analysis"
Moderate: "Potentially raise significant competitive concerns and often warrant scrutiny"
High: "Presumed to be likely to enhance market power"

Source: Author's analysis of U.S. Department of Justice and Federal Trade Commission's 2010 Horizontal Merger Guidelines (pg. 19).
Note: HHI=Herfindahl-Hirschman Index.

[6] U.S. Department of Justice and Federal Trade Commission. "Horizontal Merger Guidelines." Washington, DC: DOJ/FTC. August 19, 2010. Available from: https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf

Market Concentration Trends and Post-Merger HHI

Table 2 shows 2018 U.S. PDP enrollment and market share by parent organization. Currently, three parent organizations – CVS, UnitedHealth, and Humana – account for 65% of U.S. PDP enrollment. A combined CVS-Aetna would lead to three parent organizations accounting for 73% of U.S. PDP enrollment.

Table 2. U.S. PDP Enrollment and Market Shares, 2018

Parent Organization	Enrollment	Market Share
CVS Health Corporation	6,029,689	24.1%
UnitedHealth Group, Inc.	5,311,049	21.3%
Humana Inc.	4,876,657	19.5%
Express Scripts Holding Company	2,440,926	9.8%
Aetna Inc.	2,130,380	8.5%
WellCare Health Plans, Inc.	1,063,742	4.3%
CIGNA	765,870	3.1%
Rite Aid Corporation	513,664	2.1%
Health Care Service Corporation	349,325	1.4%
BCBS MN, MT, NE, ND, WY, Wellmark IA and SD	277,860	1.1%
Anthem Inc.	274,094	1.1%
TOTAL*	24,033,256	96.3%

Source: Author's analysis of April 2018 enrollment data published by CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html)
Notes: PDP=stand-alone prescription drug plan. *Only includes parent organizations with greater than 1 percent market share.

Table 3 shows 2018 California PDP enrollment and market share by parent organization. Currently, three parent organizations – UnitedHealth, CVS, and Humana – account for 74% of California PDP enrollment. A combined CVS-Aetna would lead to three parent organizations accounting for 83% of California PDP enrollment.

Table 3. California PDP Enrollment and Market Shares, 2018

Parent Organization	Enrollment	Market Share
UnitedHealth Group, Inc.	629,798	27.8%
CVS Health Corporation	568,888	25.1%
Humana Inc.	484,290	21.4%
Aetna Inc.	195,096	8.6%
Anthem Inc.	126,121	5.6%
WellCare Health Plans, Inc.	94,478	4.2%
Express Scripts Holding Company	82,600	3.7%
California Physicians' Service	47,142	2.1%
TOTAL*	2,228,413	98.5%

Source: Author's analysis of April 2018 enrollment data published by CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html)
Notes: PDP=stand-alone prescription drug plan. *Only includes parent organizations with greater than 1 percent market share.

Figure 3 shows the average PDP market HHI (weighted by PDP enrollment) from 2009 to 2018 across the United States. In 2009, U.S. HHI was 1,519 – just above the Guidelines' 1,500 threshold for a moderately concentrated market. By 2018, U.S. HHI had increased to 1,861 – an increase of 342 HHI (23% increase).

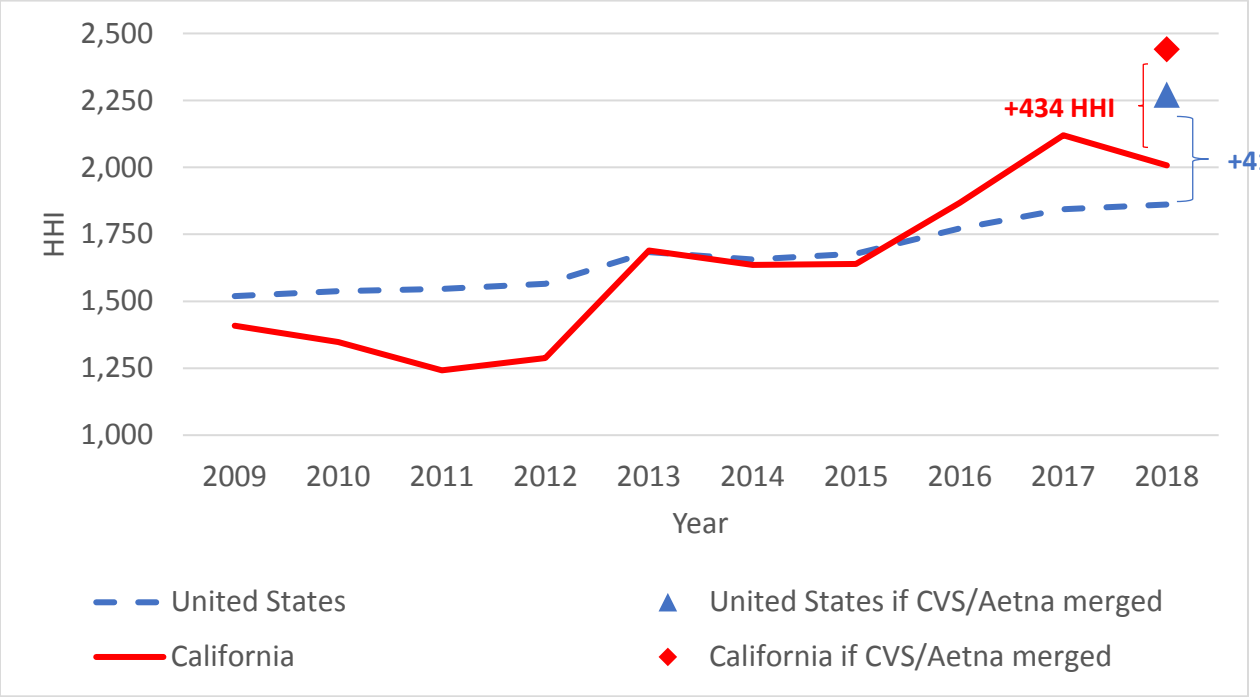
The triangle in Figure 3 represents U.S. HHI in 2018 if CVS and Aetna are treated as a single firm in HHI calculations. If CVS and Aetna were a single firm, U.S. HHI would be 410 points higher in 2018 than it currently is (2,271 vs. 1,871, 22% increase). Mergers that lead to an HHI change of over 200 points and a resulting HHI of between 1,500 and 2,500 "potentially raise significant competitive concerns and often warrant scrutiny" according to the Guidelines (see Table 1).

Figure 3 also shows California HHI from 2009 to 2018. From 2009 to 2013, California HHI lied below the national average. Between 2013 and 2015, California HHI was almost completely in line with the national average. Since 2015, California HHI has moved above the national average. This mirrors the pattern I discussed earlier between U.S. and California PDP premiums (see Figure 1). That is, the observed HHI increase is similar to the increase in premiums over the same time period. Today, California HHI is 2,007 – 136 HHI above the national average.

The diamond in Figure 3 represents California HHI in 2018 if CVS and Aetna are treated as a single firm in HHI calculations. If CVS and Aetna were a single firm, California PDP market HHI would be 434 points higher in 2018 than it currently is (2,441 vs. 2,007, 22% increase).

Mergers that lead to an HHI change of over 200 points and a resulting HHI of between 1,500 and 2,500 "potentially raise significant competitive concerns and often warrant scrutiny" according to the Guidelines (see Table 1).

Figure 3. Average Part D Region-Level PDP Market Concentration (Weighted by PDP Enrollment), 2009-2018.



Source: Author's analysis of April 2018 enrollment data published by CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html)
Notes: PDP=stand-alone prescription drug plan. HHI=Herfindahl-Hirschman Index. The HHIs shown in the figure are a weighted-average of the HHIs of Medicare Part D's 34 regions (weighted by PDP enrollment).

Table 4 shows how pre-merger and post-merger HHIs for each of the 34 Part D regions. Overall, 30 Part D regions would experience an HHI increase of over 200 points as a result of CVS's acquisition of Aetna. Of these 30 regions, 10 would have a post-merger HHI of greater than 2,500. Mergers that increase in HHI by over 200 points and result in a post-merger HHI of over 2,500 are "presumed to be likely to enhance market power" according to the Guidelines (see Table 1). The post-merger HHIs of the other 20 regions that would experience increases of 200 HHI would all be in the 1,500 to 2,500 range, and thus the merger would trigger moderate concern in these regions according to Table 1. The merger in California – with a post-merger HHI of 2,441 and an increase of 434 HHI – is one of the 20 regions and falls just below being "presumed to be likely to enhance market power" according the Guidelines.

Table 4. PDP Market Concentration, 2018 (by PDP Region)

PDP Region #	States	2018 HHI	2018 Post-Merger HHI	HHI Change
33	Hawaii	4,898	6,263	1,364
19	Arkansas	1,984	2,844	861
10	Georgia	1,977	2,772	794
20	Mississippi	2,006	2,722	716
18	Missouri	2,015	2,645	630
24	Kansas	2,045	2,669	624
8	North Carolina	1,700	2,249	549
22	Texas	1,769	2,299	530
23	Oklahoma	1,996	2,468	471
15	Kentucky, Indiana	1,647	2,107	460
21	Louisiana	1,717	2,175	458
9	South Carolina	1,687	2,144	456
5	District of Columbia, Delaware, Maryland	1,797	2,250	453
32	California	2,007	2,441	434
3	New York	1,844	2,273	429
14	Ohio	1,755	2,181	426
2	Connecticut, Massachusetts, Rhode Island, Vermont	1,610	2,029	419
7	Virginia	1,606	2,004	398
6	Pennsylvania, West Virginia	1,702	2,095	394
12	Alabama, Tennessee	1,602	1,986	384
26	New Mexico	1,717	2,087	370
16	Wisconsin	1,588	1,947	358
11	Florida	2,292	2,628	336
27	Colorado	2,256	2,582	325
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	2,145	2,466	321
17	Illinois	1,547	1,839	292
28	Arizona	1,866	2,149	283
29	Nevada	2,383	2,638	255
4	New Jersey	2,320	2,551	231
31	Idaho, Utah	1,836	2,053	217
30	Oregon, Washington	1,614	1,814	199
13	Michigan	1,795	1,957	162
1	Maine, New Hampshire	1,546	1,691	145
34	Alaska	2,715	2,740	26
	AVERAGE (weighted by PDP enrollment)	**1,861**	**2,271**	**410**

Source: Author's analysis of April 2018 enrollment data published by CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html)
Notes: PDP=stand-alone prescription drug plan. HHI=Herfindahl-Hirschman Index. 2018 HHI treats CVS and Aetna as separate firms. 2018 Post-Merger HHI assumes CVS and Aetna are a single firm in HHI calculations.

Impact of Proposed CVS-Aetna Merger On Medicare Part D Premiums

I have reviewed a large number of studies that provide evidence that increases in market power raise Medicare Part D premiums.[7] Based on these studies and my own analysis, the proposed merger of CVS and Aetna will have important and significant impacts on the concentration of the Medicare Part D stand-alone prescription drug plan (PDP) market. In 10 of the 34 PDP regional markets, the merger should be "presumed to be likely to enhance market power" according to the Guidelines. In an additional 20 of the 34 PDP regional markets, the merger will "potentially raise significant competitive concerns and often warranty scrutiny" according the Guidelines. This latter competitive concern was found for California and it my opinion that this merger would raise PDP premiums in markets across the country, including California.

[7] See e.g. Chorniy, Anna, Daniel P. Miller, and Tilan Tang. "The impact of horizontal mergers on plan premiums and drug formularies in Medicare Part D." April 2018; Lucarelli, Claudio, Jeffrey Prince, and Kosali Simon. "The welfare impact of reducing choice in Medicare Part D: A comparison of two regulation strategies." *International Economic Review* 53, no. 4 (2012): 1155-1177; Decarolis, Francesco, Maria Polyakova, and Stephen P. Ryan. "The welfare effects of supply-side regulations in Medicare Part D." No. w21298. National Bureau of Economic Research, 2015; Marzilli Ericson, Keith M. "Consumer inertia and firm pricing in the Medicare Part D prescription drug insurance exchange." *American Economic Journal: Economic Policy* 6, no. 1 (2014): 38-64; and Ho, Kate, Joseph Hogan, and Fiona Scott Morton. "The impact of consumer inattention on insurer pricing in the Medicare Part D program." *The RAND Journal of Economics* 48.4 (2017): 877-905.