

# Aetna-CVS Merger Hearing

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JUNE 19, 2018

CALIFORNIA DEPARTMENT OF INSURANCE



# Dave Jones

## Insurance Commissioner

### opening remarks

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JUNE 19, 2018

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Kristen Miranda, Aetna  
Paul Wingle, Aetna  
Thomas M. Moriarty, CVS Health  
Elizabeth Ferguson, CVS Health

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JUNE 19, 2018

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# Thomas L. Greaney, J.D.

## University of California Hastings College of Law

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# Richard Scheffler, Ph.D.

University of California, Berkeley  
School of Public Health and  
Goldman School of Public Policy

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

**Richard M. Scheffler**

Distinguished Professor of Health Economics and Public Policy

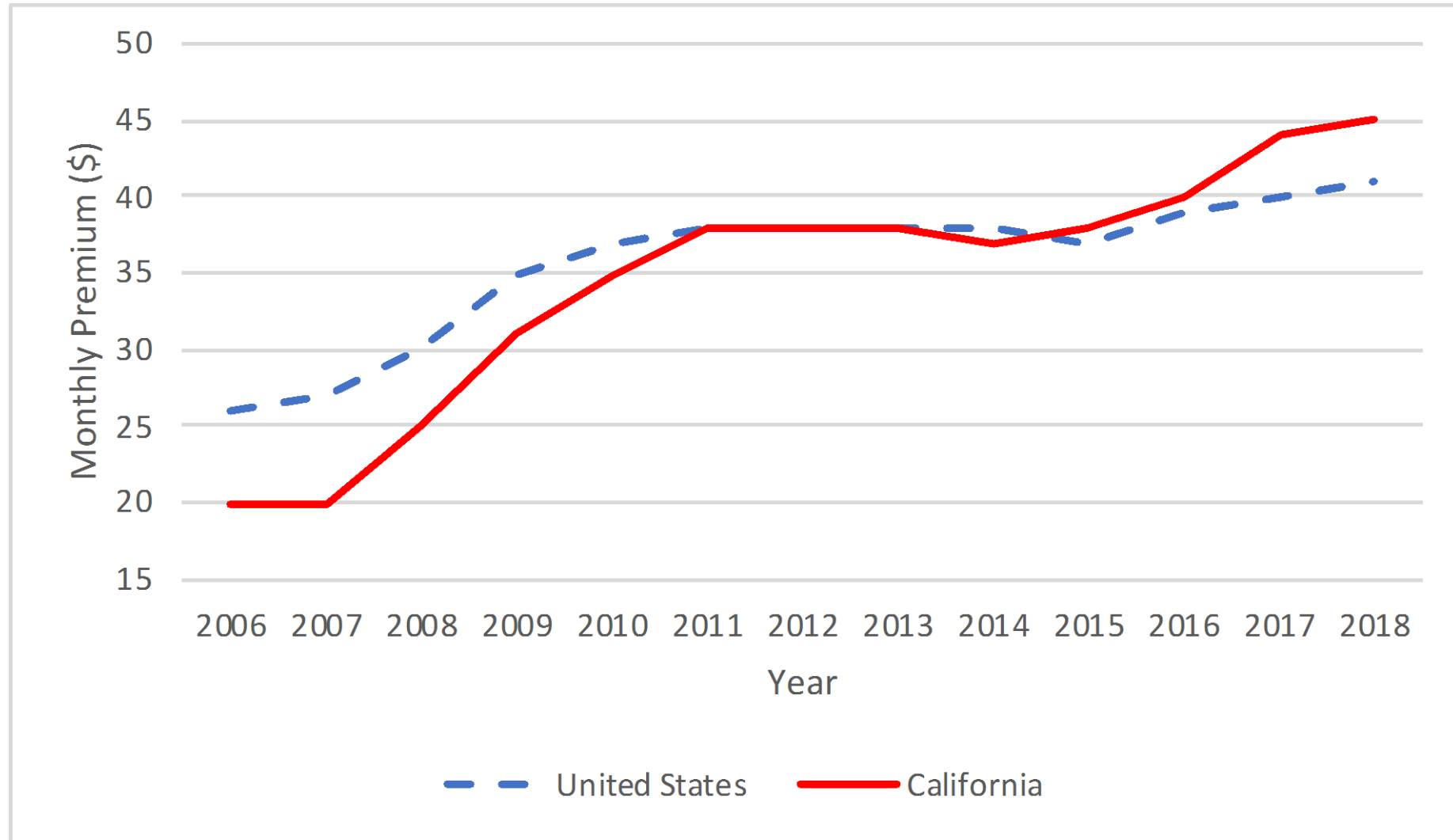
Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (<http://petris.org/> )

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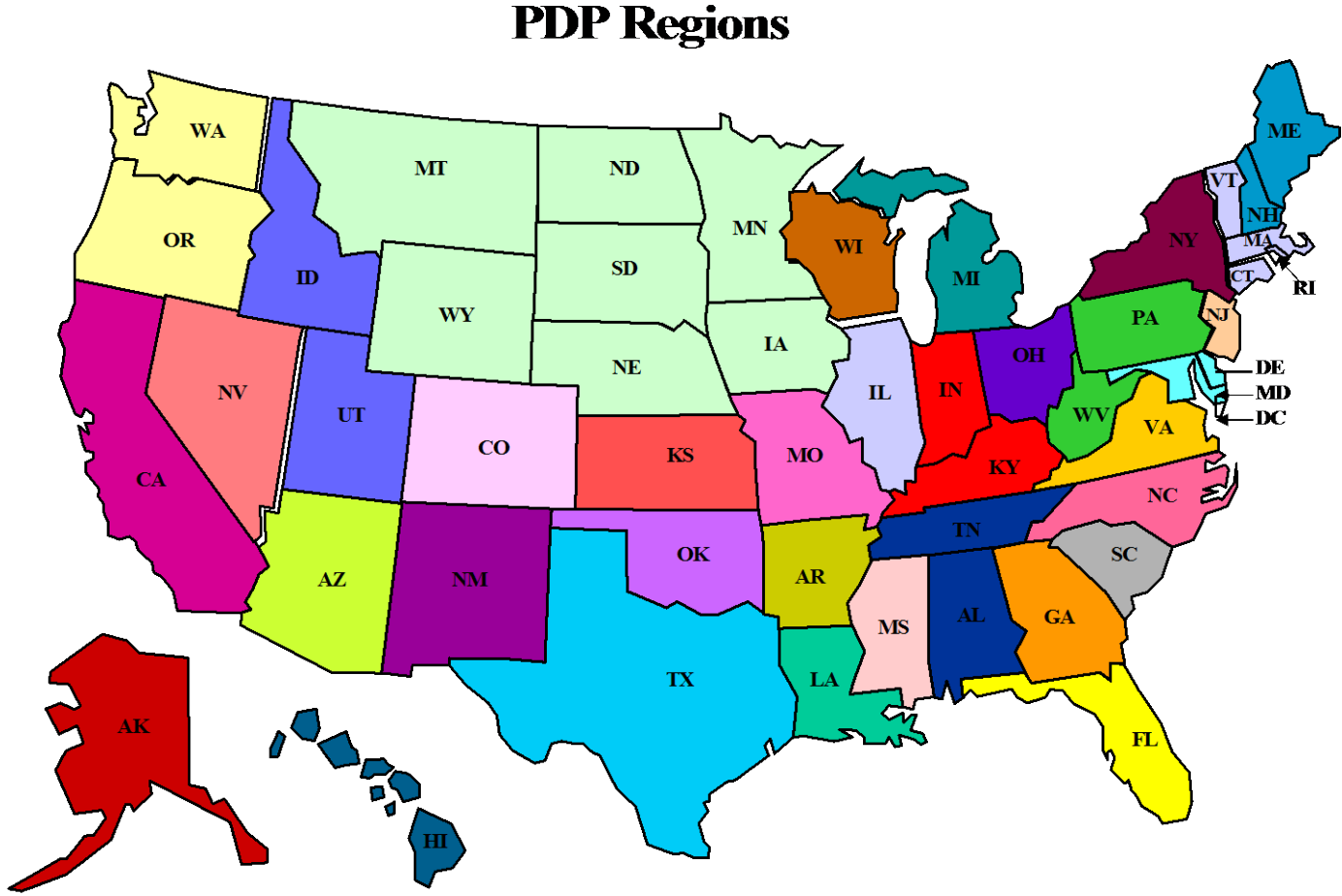
**Figure 1. Average Monthly Premium for PDPs, 2006-2018**



**Source:** Kaiser Family Foundation analysis of Medicare plan enrollment and premium data files.

**Notes:** PDP=stand-alone prescription drug plan.

**Figure 2. PDP Regions**



Note: Each territory is its own PDP region.

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



**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.

**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%
<b>TOTAL*</b>	<b>24,033,256</b>	<b>96.3%</b>

**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.

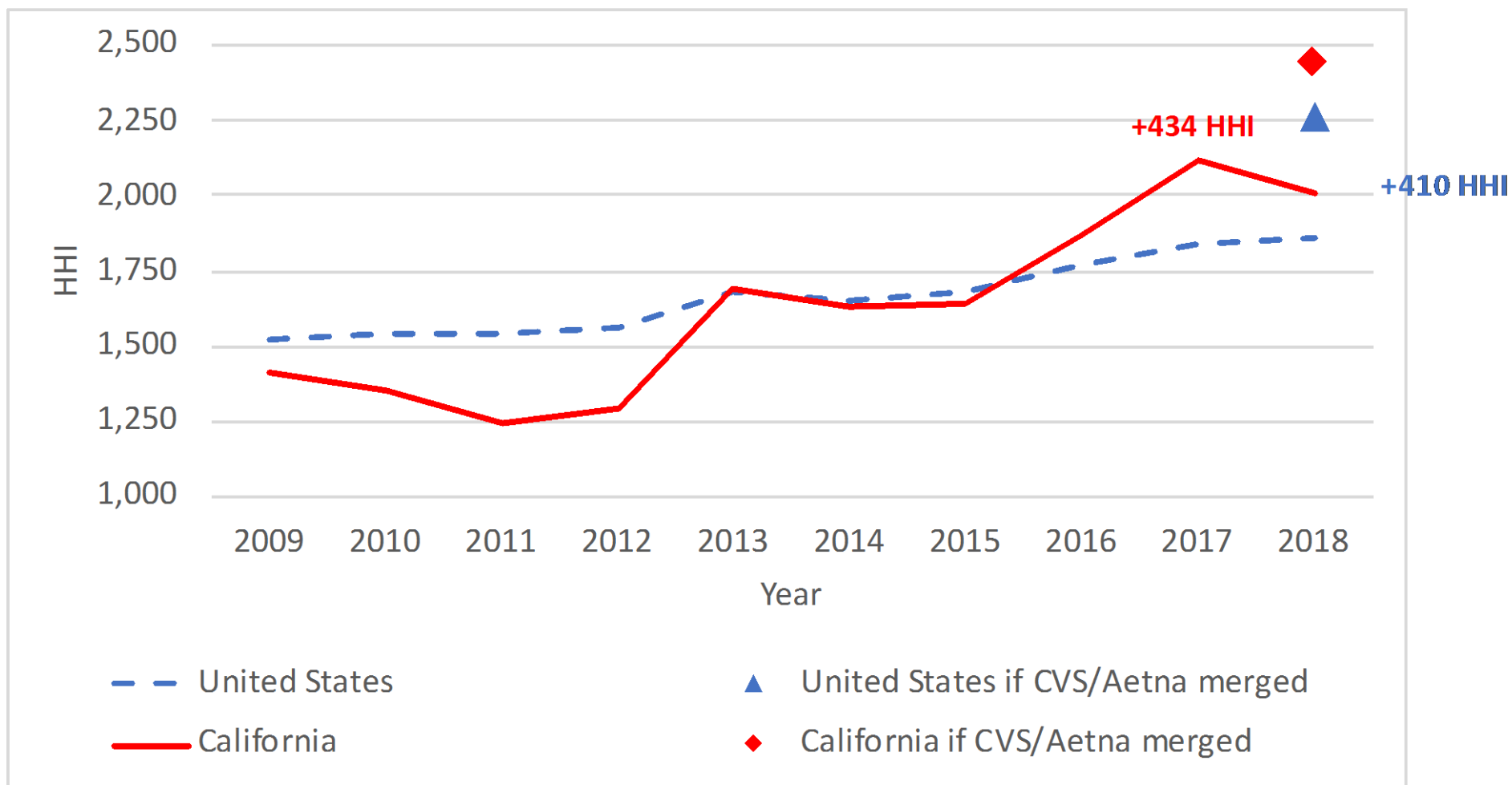
**Table 3. California PDP Enrollment and Market Shares, 2018**

<b>Parent Organization</b>	<b>Enrollment</b>	<b>Market Share</b>
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%
<b>TOTAL*</b>	<b>2,228,413</b>	<b>98.5%</b>

**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. 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/MCRAAdvPartDEnrolData/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. PDP Market Concentration, 2018 (by PDP Region)**

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

**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/MCRAAdvPartDENrolData/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.

# Neeraj Sood, Ph.D.

University of Southern California  
Sol Price School of Public Policy

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

**Neeraj Sood, PhD  
June 19, 2018**

# Disclosures

1. Support for the research cited in this presentation and for my appearance at this hearing was provided by the American Medical Association.
2. This presentation reflects my views and opinions, not necessarily the views of the American Medical Association or of my employer, the University of Southern California.



# About me

- Professor of Health Policy at the Sol Price School of Public Policy and Schaeffer Center, University of Southern California (USC)
- Research focused on health insurance markets, pharmaceutical markets and global health
- Published more than 100 papers and reports
- Associate editor of Journal of Health Economics and Health Services Research
- My work on health care costs and the pharmaceutical supply chain has been cited by the Council of Economic Advisors of President Obama and President Trump.
- Scientific advisor for several organizations in the health care industry

# Today's talk

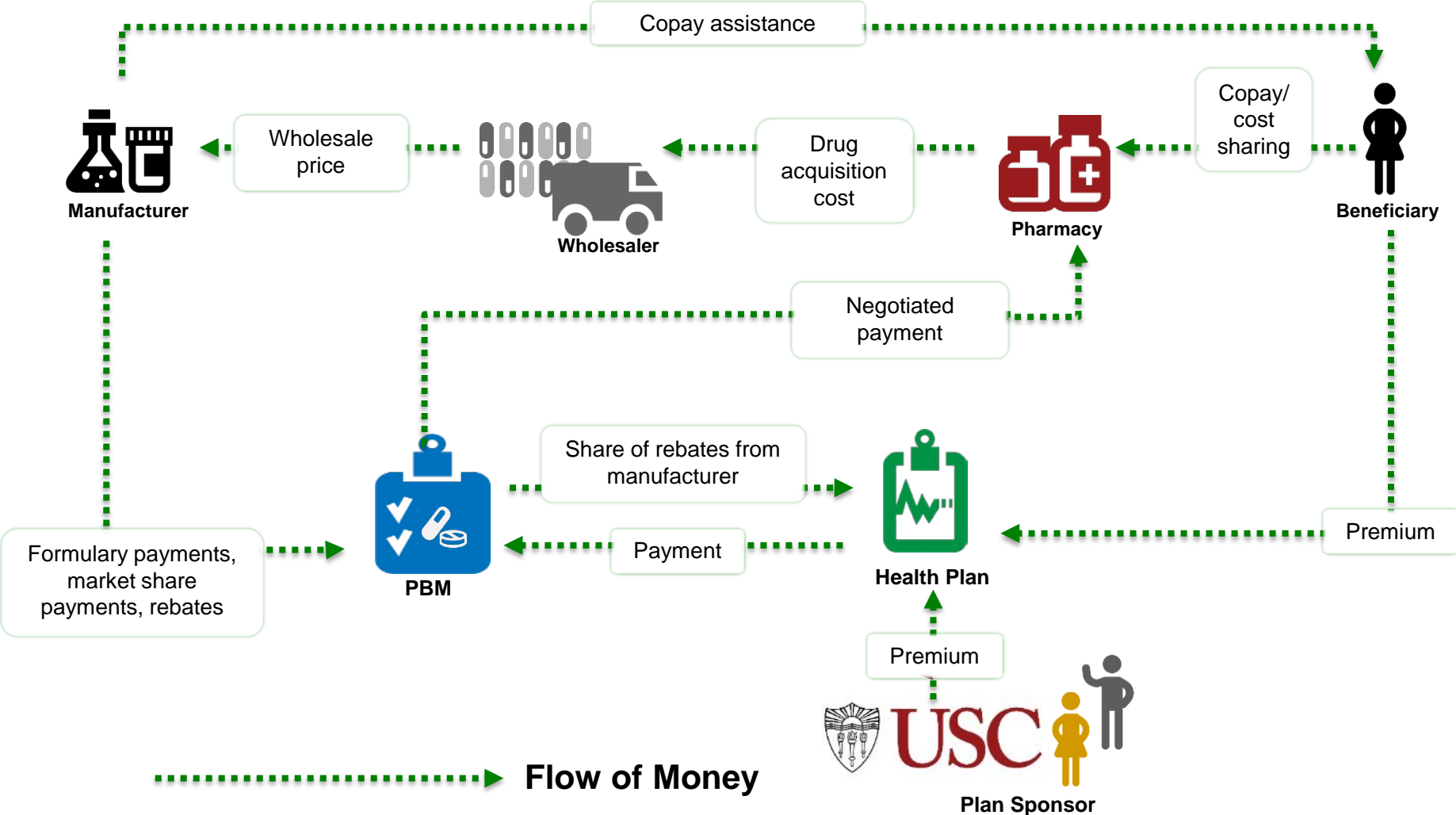
- **Market overview: How do drugs reach from manufacturers to consumers?**
  - **Effects on competition in the insurance market**
  - **Effects on competition in the pharmacy market**
  - **Effects on competition in the PBM market**
  - **Conclusion**
-

# Conceptual framework: Flow of prescription drugs



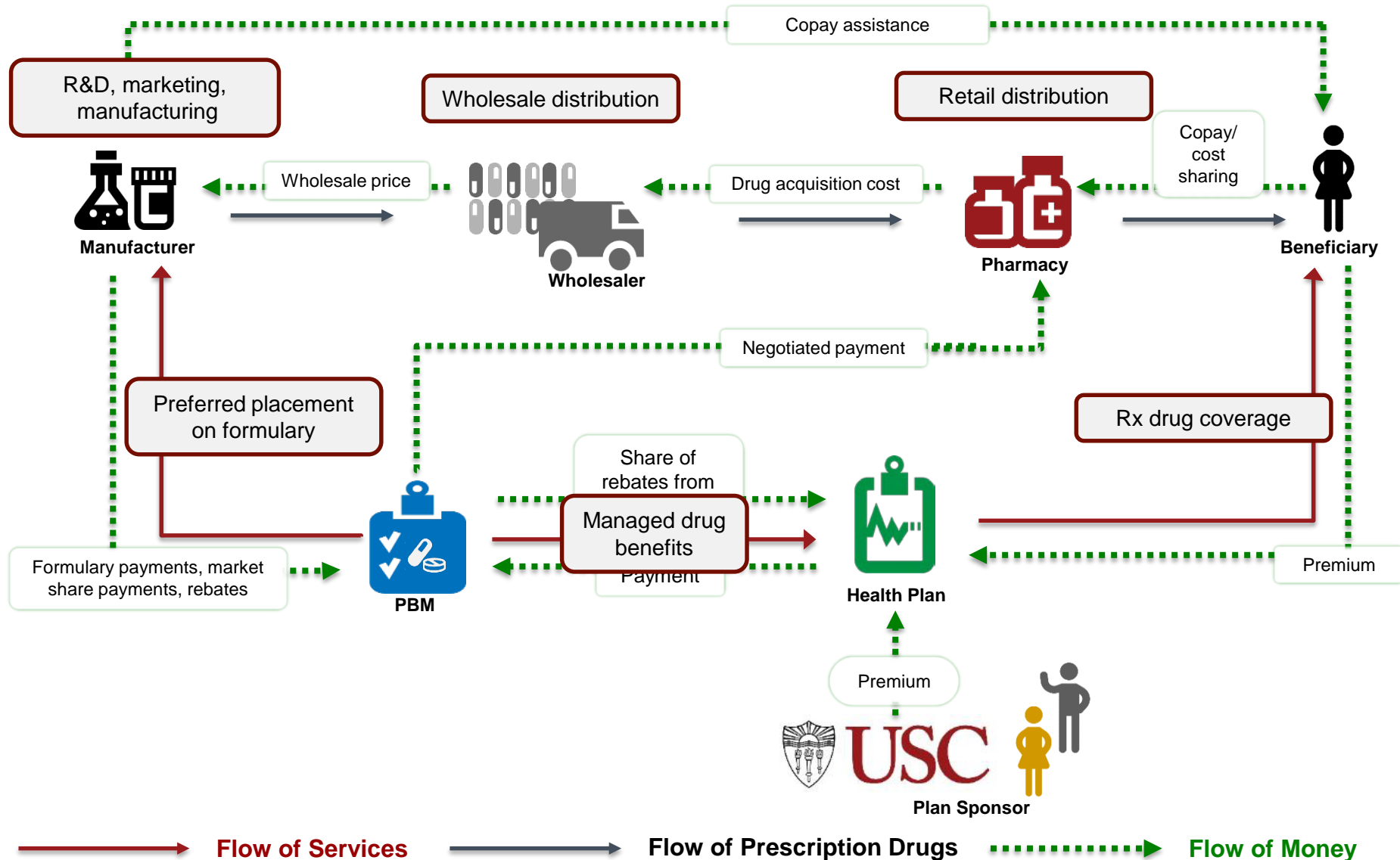
Pharmacies may be mail order or retail, and may be integrated with PBM. Plan sponsors may include employers, unions, managed care orgs, among others.

# Conceptual framework: Flow of money



Pharmacies may be mail order or retail, and may be integrated with PBM. Plan sponsors may include employers, unions, managed care orgs, among others.

# Conceptual framework

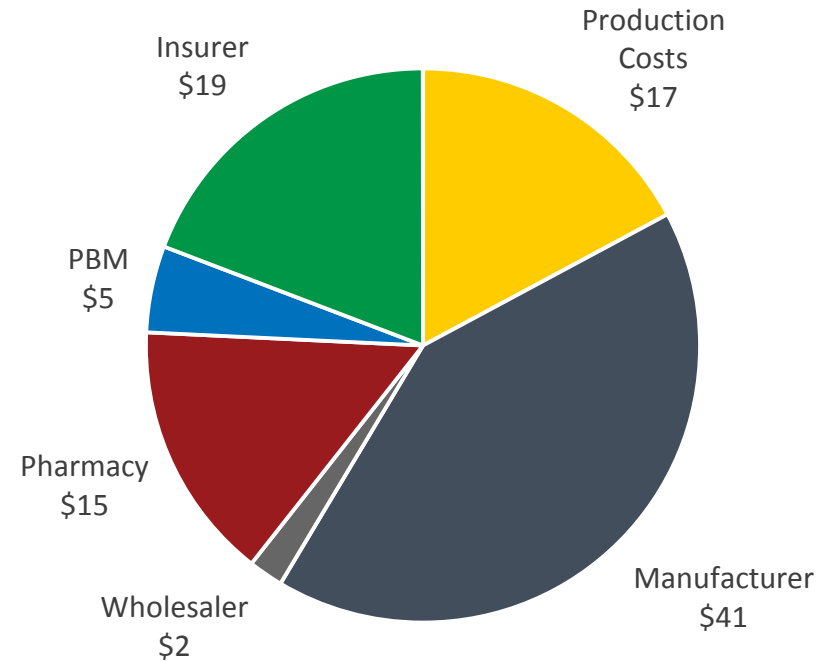


Pharmacies may be mail order or retail, and may be integrated with PBM. Plan sponsors may include employers, unions, managed care orgs, among others.

# How do we estimate the flow of money?

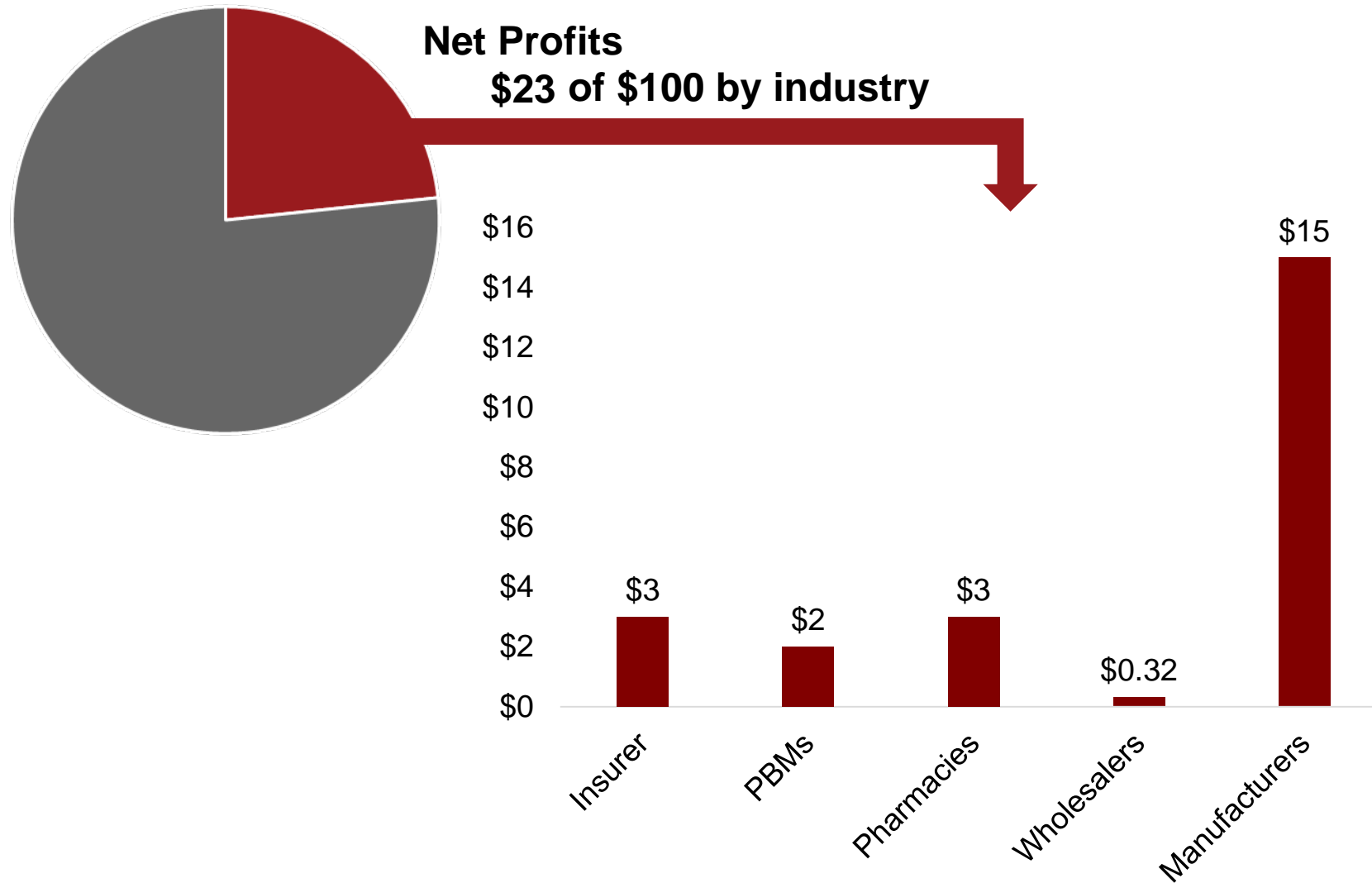
1. Identify top publicly traded firms for each market segment:  
manufacturers, wholesalers, retailers, pharmacy benefit managers, & health plans
2. Use SEC filings of these firms to estimate:
  - Gross profits: Revenue less cost of goods/services sold
  - Net profits: The profits returned to owners after operating expenses
3. Use the conceptual framework and financial data to illustrate the flow of funds for a drug purchased by an insured consumer at a retail pharmacy

# Flow of \$100 spent on pharmaceutical drugs, overall industry



PBM maintains a large network of pharmacies, creates drug formularies and negotiate discounts and rebates with drug makers.

# Net profits, overall industry





# Is anyone in the supply chain making excess returns?

- Do not evaluate directly whether middle men in the pharmaceutical supply chain are making excess returns
- Market concentration is an important indicator of companies' ability to earn excess returns, and several segments of the pharmaceutical supply chain are highly concentrated
  - Top 3 PBMs account for 70% of the market
  - Top 3 pharmacies account for 50% of the market
  - Top 3 wholesales account for 90% of the market
  - Top 3 insurers account for 50% of the market in 33 states

# Market power in the pharmaceutical supply chain can hurt consumers

- Market power manifests itself in practices of intermediaries in the supply chain that potentially harm consumers
  - Price discrimination in the pharmacy market
  - Insurers often charge consumers more in out of pocket costs than the drug acquisition costs of the insurer
  - PBMs often have “gag clauses” which prohibit the pharmacy from disclosing to consumers that they could save money by paying cash for their prescription drugs rather than using their insurance
  - PBMs often do not disclose the amount of rebates they receive from manufacturers raising questions about the extent to which they pass on rebate dollars to health plans
  - PBMs might create pressure to increase drug list prices; high drug prices might offset savings from rebates for health plans and hurt consumers in high deductible health plans who pay the list price of the drug

# Today's talk

- **Effects on competition in the insurance market**
  - **Effects on competition in the pharmacy market**
  - **Effects on competition in the PBM market**
  - **Conclusion**
-

# Health insurance markets in the US are highly concentrated

- The FTC considers markets to be uncompetitive or highly concentrated if the HHI for a market is greater than 2,500
- According to recent data from an AMA study, the vast majority of US health insurance markets had an HHI greater than 2,500
- Data from the Kaiser Family Foundation for the individual, small group and large group market paint a similar picture of highly concentrated markets
- Aetna, the third largest health insurer is a dominant firm in the insurance market
  - Aetna is the number 1 or number 2 insurer in over 70 HMO markets and over 100 PPO markets

# The merger will exacerbate the lack of competition in health insurance markets

- CVS-Aetna will control two key inputs in the health insurance market
  - PBM
  - Pharmacy
- The merger creates the incentive to use the control of these inputs to disadvantage competing health plans
  - Increase in prescription drugs costs and total health care costs for health plans
  - Increase in premiums faced by consumers
- Reduced competition in health insurance markets

# How can control of PBMs and pharmacies increase health care costs for competing health plans

- The PBM arm of CVS-Aetna might reduce pass through of rebate dollars
- The PBM arm of CVS-Aetna might not optimize formulary design
- The PBM arm of CVS-Aetna might slow down claims processing
- The PBM arm of CVS-Aetna might not negotiate hard with pharmacies, especially CVS-Aetna pharmacies
- The pharmacy arm of CVS-Aetna might charge higher prices to competing health plans

# What if competing health plans want to switch to other pharmacies and PBMs

- PBM market is highly concentrated so health plans do not have many options to switch
- Several of the largest PBM competitors for CVS-Aetna, such as OptumRx, Humana Pharmacy Solutions, and Prime Therapeutics are also owned by health plans
- CVS pharmacies are the dominant pharmacies in many markets so might be difficult to exclude CVS from pharmacy network

# CVS-Aetna PBM has strong incentives to disadvantage competing health plans even it risks losing PBM customers

- Consider a consumer whose total health care cost is \$10,000 and prescription drug cost is \$1,000
- Given a net profit margin of 2.3% for PBM services, if CVS-Aetna were to lose this consumer as a PBM customer it would lose roughly **\$23** in profits
- Given a net profit margin of 3% for insurance services, if CVS-Aetna were to gain this consumer from a competing health plan it would gain roughly **\$323** in profits
- Therefore, **1 insurance customer is as valuable as 14 PBM customers**
- CVS has **94 million** PBM customers of which potentially **22 million** are Aetna subscribers



# CVS-Aetna has strong incentives to disadvantage health plans even it risks losing pharmacy customers

- Consider a consumer whose total health care cost is \$10,000 and prescription drug cost is \$1,000
- Given a net profit margin of 4% for pharmacy services, if CVS-Aetna were to lose this consumer as a pharmacy customer it would lose roughly **\$40** in profits
- Given a net profit margin of 3% for insurance services, if CVS-Aetna were to gain this consumer from a competing health plan and that customer filled prescriptions at CVS-Aetna pharmacies it would gain roughly **\$363** in profits
- Therefore, **1 insurance customer is as valuable as 9 pharmacy customers**

# Is lack of competition in health insurance markets good for consumers?

- An amicus brief filed by me and other leading health economists related to the merger of Anthem and Cigna summarizes the past empirical research as follows: “This body of work finds that ***consolidation in health insurance markets does not, on average, benefit consumers.*** Although, greater insurance market concentration tends to lower provider prices, there is no evidence the cost savings are passed through to consumers in the form of lower premiums. To the contrary, premiums tend to rise with increased insurer concentration.”

# Potential efficiencies in the health insurance market

- Post-merger CVS would have a stronger incentive to be a better PBM for Aetna
- The magnitude of savings depends on whether CVS performs core PBM functions such as formulary design and rebate negotiations for Aetna
- Aetna's financial statements to the SEC state that *"We also perform various pharmacy benefit management services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs .."*
- **Therefore, it seems that Aetna already performs its core PBM functions and thus the potential efficiencies from merging with the PBM arm of CVS would be minimal**

# Summary of key findings for health insurance market

- **In my opinion, the potential costs of the merger due to foreclosure in the insurance market outweigh the potential efficiencies in the insurance market**
  - CVS-Aetna will control two key inputs
  - CVS-Aetna have a dominant position in each of these input markets
  - The number of consumers who stand to lose from the merger is much greater than the number of consumers who stand to gain from the merger
  - The profits from gaining an insurance customer are much higher than the loss in profits from losing a PBM/Pharmacy customer
  - The potential efficiencies are minimal

# Today's talk

- **Effects on competition in the pharmacy market**
  - **Effects on competition in the PBM market**
  - **Conclusion**
-

# The merger might reduce competition in pharmacy markets

- Pharmacy markets are highly concentrated or uncompetitive
  - CVS and Walgreens control between 50 and 75 percent of the drugstore market in each of the country's 14 largest metro-areas
- CVS has a dominant position in several markets
  - CVS financial statement "We currently operate in 98 of the top 100 United States drugstore markets and hold the number one or number two market share in 93 of these markets"
- The health insurance arm or PBM arm of CVS-Aetna could disadvantage pharmacies competing with CVS by excluding them from their pharmacy network or through other business practices
- This will further strengthen the already dominant position of CVS in the pharmacy market and will exacerbate the lack of competition in pharmacy markets

## How might CVS-Aetna disadvantage competing pharmacies

- Promote CVS-Aetna pharmacies or exclude competing pharmacies in outreach/communication with CVS-Aetna insurance subscribers
- Reduce reimbursement to competing pharmacies; subsequently buy them when they are in financial distress
- Exclude competing pharmacies from CVS-Aetna pharmacy network
- Have preferred status for CVS-Aetna pharmacies

## But CVS is already the PBM for Aetna so they might already be favoring CVS pharmacies?

- Aetna currently does not have the incentive to favor CVS pharmacies and might resist the arrangement if it hurts Aetna
- Post merger the incentive to resist reduces as Aetna will be part of CVS
- The vertical merger is more permanent than a contract and this eliminates competition that occurs when contracts need to be renewed
- The anticompetitive effects will be larger in markets where Aetna has a dominant position



# Potential efficiencies in the pharmacy market

- CVS argues that the merger will lead to lower health care costs through integration of pharmacy and medical data
- One potential efficiency is that providing medical data to pharmacists will allow them to better counsel patients
- However, CVS-Aetna will likely not have access to electronic health record data for the vast majority of its subscribers. True integration of pharmacy and medical data to guide medical management of patients either in doctors' offices or pharmacies will prove difficult without access to such data
- Another efficiency is that integration of pharmacy and health plan data might lead to better benefit design
- But Aetna can get this data without a merger

# Summary of key findings for pharmacy market

- In my opinion, the potential costs of the merger due to foreclosure in the pharmacy market outweigh the potential efficiencies in the pharmacy market.
  - Pharmacy markets are concentrated
  - The potential efficiencies are minimal
  - Aetna has a dominant position in certain insurance markets

# Today's talk

- **Effects on competition in the PBM market**
  - **Conclusion**
-

# The merger might reduce competition in PBM market

- PBM markets in the US are uncompetitive or highly concentrated
- Currently Aetna contracts with CVS for some PBM services
- The merger will make this contract more permanent
- This will contract the size of PBM market by reducing Aetna as a potential customer
- Reduced market size will deter entry of new PBM
- In addition, new PBMs will have to be vertically integrated with health plans as most major incumbent PBMs will be vertically integrated

# Today's talk

- **Conclusion**
-

## Summary of key findings

**Within each of the specific markets -- insurance, pharmacy and PBM -- in which the merger is likely to have anticompetitive effects, there are no potential benefits of sufficient magnitude and certainty that would outweigh the anticompetitive effects of the merger**

# Diana Moss, Ph.D.

## American Antitrust Institute

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# Lawton R. Burns, Ph.D.

Wharton Center for Health  
Management and Economics,  
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# Limits on Consumer Benefits from Proposed Merger of Aetna, Inc. into CVS Health Corporation

LAWTON ROBERT BURNS, PH.D., MBA

TESTIMONY BEFORE THE CALIFORNIA DEPARTMENT OF INSURANCE

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SAN FRANCISCO, CA

JUNE 19, 2018



## Disclosure

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Support for the research cited in my testimony, and for my appearance today as an expert witness, was provided by the American Medical Association (AMA)

This testimony reflects my views and opinions, and not those of the AMA or the Wharton School

# My Background

James Joo-Jin Kim Professor at the Wharton School

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Professor of Health Care Management

Director – Wharton Center for Health Management & Economics

Co-Director – Vagelos Program in Life Sciences & Management

Published up to 200 academic papers and six books

Teach core course at Wharton on U.S. healthcare system

Expert witness in antitrust for DOJ, FTC and several State AGs

# Thrust of My Testimony

- ◆ Other witnesses have opined on merger's anti-competitive effects
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- ◆ If found to be anti-competitive, I argue that the merger fails to deliver any offsetting or compensating consumer benefits that might nevertheless justify the merger
- ◆ I am often asked to testify in anti-trust cases about the possible presence of such offsetting benefits
- ◆ My analysis does not support any of the supposed benefits flowing from the retail clinics operated by CVS Health

# Some General Observations

The proposed merger is based on the corporate strategy of vertical integration. There is no *prima facie* evidence for consumer welfare benefits flowing from this strategy.

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Indeed, in the healthcare industry, this strategy usually leads to higher prices, higher costs, and higher utilization. Sometimes it also results in greater market power.

Based on the research evidence, one cannot assume consumer benefits will automatically flow from such a merger.

There is a disconnect between the rationales espoused by company executives and those enunciated in academic theory and research. In the past, such disconnects can portend strategic failures to deliver on promised benefits.

# Specific Conclusions

One must examine the specific merger benefits advanced by the parties

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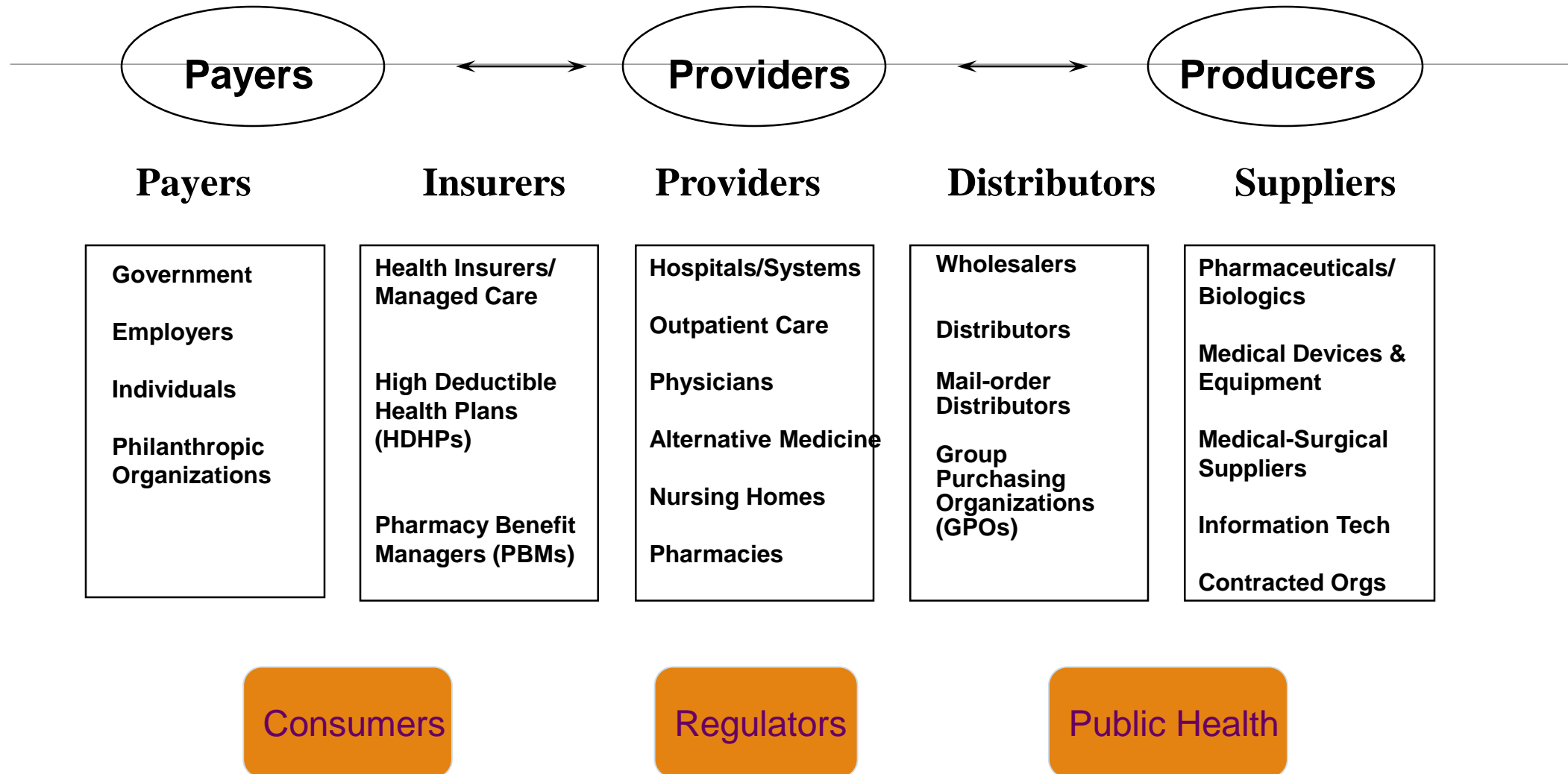
The specific benefits espoused by company executives are unlikely to be achieved. The numerous benefits cited lack any documentation and are contradicted by the research evidence.

Retail clinics hosted in CVS pharmacies cannot effectively serve as a healthcare hub for patients and consumers.

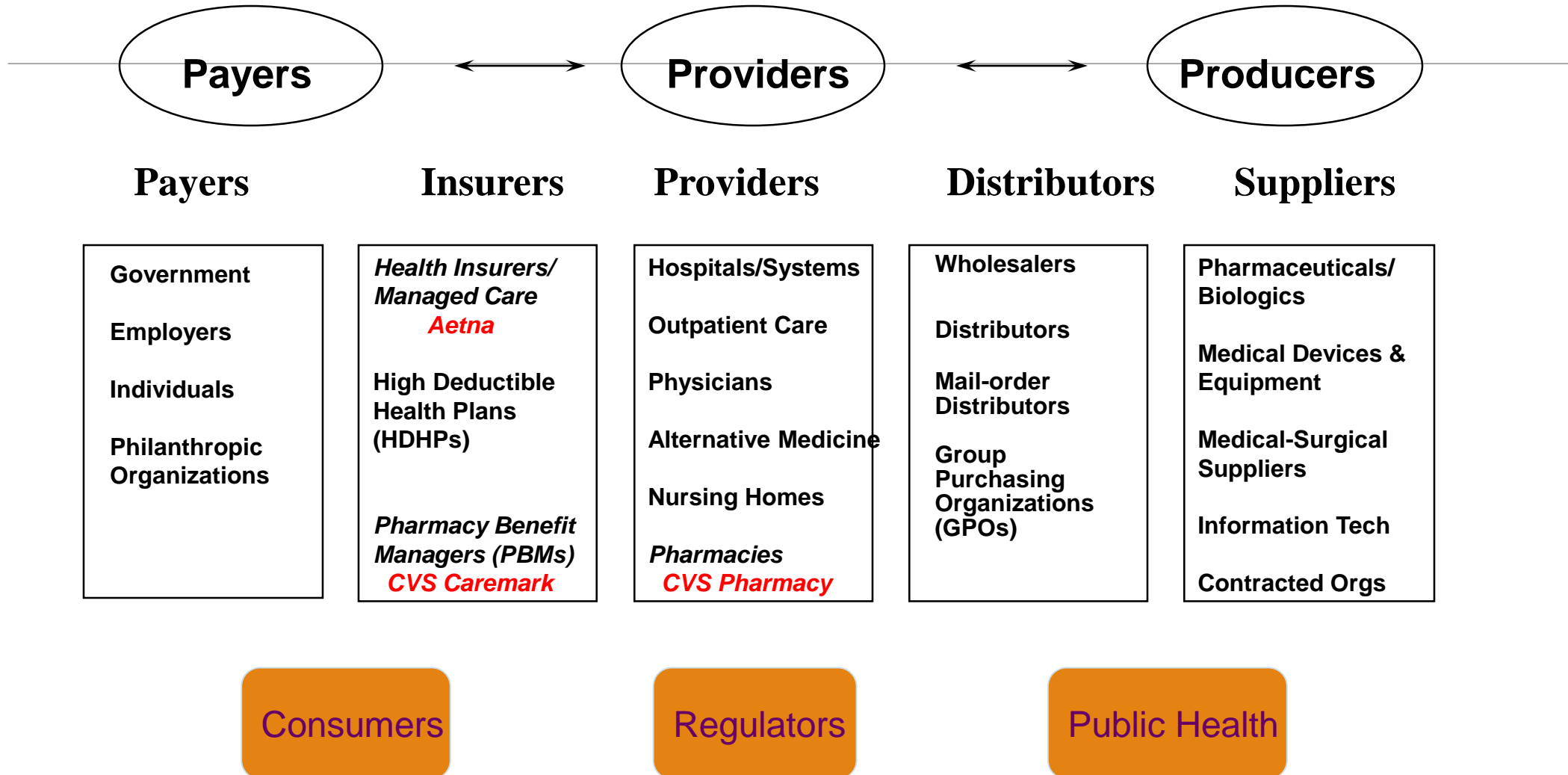
CVS is unlikely to leverage its retail clinics and pharmacies to “reach out into the community where most of consumer health is determined”

Retail clinics and pharmacies are unlikely to “transform” healthcare, improve quality, improve health outcomes, or reduce cost of care.

# The Health Care Value Chain



# Aetna and CVS Roles in the Health Care Value Chain





# Supporting Arguments (1)

## Defensive Nature of Proposed Merger

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- ◆ CVS losing business to Walgreens
- ◆ CVS fear of market entry by Amazon
- ◆ Aetna failure to grow via proposed merger w/ Humana in 2016-17
- ◆ Aetna failure to keep pace with UnitedHealthcare acquisitions of MDs

# Supporting Arguments (2)

## Enormous Hype Surrounding Retail Clinics

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- ◆ Forecasted growth has not transpired
- ◆ Growth stagnant for last three years (both retail clinics & pharmacies)
- ◆ Not a booming industry
- ◆ May supply only 1-2% of all primary care
- ◆ MinuteClinic generates <1% of CVS retail pharmacy dispensing \$\$
- ◆ Often unprofitable

# Supporting Arguments (3)

## Major Shortcomings of Retail Clinics

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- ◆ Failure to serve the underserved (poor, Medicaid, rural residents)
- ◆ Failure to target the chronically ill
- ◆ Inability to address chronic illness
- ◆ Inability to succeed in wellness and prevention
- ◆ Inability to conduct medication therapy management
- ◆ Failure of community health centers (US and WW)

THANK YOU FOR LISTENING

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# Barbara L. McAneny, M.D.

President, The American Medical  
Association

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# Long Do, J.D.

## Legal Counsel, The California Medical Association

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# Dena Mendelson, J.D.

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# Yasmin Peled

## Health Access California

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# Ben Powell, J.D.

## Litigation Attorney, Consumer Watchdog

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# Public Comment

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# Closing Remarks

## Dave Jones

### Insurance Commissioner

*please send comments to:*

[mergercomments@insurance.ca.gov](mailto:mergercomments@insurance.ca.gov)

*by Friday, June 22, 2018*

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# Thank you

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