STATEMENT

of the

American Medical Association

to the

California Department of Insurance

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

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The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the proposed merger of CVS Health Corporation (CVS), the largest retail pharmacy chain and specialty pharmacy in the United States and one of the two largest pharmacy benefit managers (PBM), and Aetna, Inc. (Aetna) the third largest U.S. health insurer. We commend the California Department of Insurance (the Department) for scrutinizing this massive proposed merger and the potential negative impact it poses to Californian health care consumers.

INTRODUCTION AND SUMMARY OF CONCLUSIONS

This merger is popularly described as vertical when, in fact, horizontal concerns are substantial. Aetna and CVS compete in the Part D Prescription Drug Plan (PDP) market that covers 25 million people nationally. Whether this merger of rivals in the PDP market runs an appreciable risk of substantially lessening competition is easily determined by a straightforward application of the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) 2010 Horizontal Merger Guidelines (Merger Guidelines). [1] University of California, Berkeley, health economics professor Richard Scheffler, PhD, has done that analysis.[2] He finds that under the Merger Guidelines, in all but four of the 34 PDP regional markets, this merger would either be "presumed to be likely to enhance market power" or would "potentially raise significant competitive concerns." Professor Scheffler concludes that "this merger would raise PDP premiums in markets across the country, including California."

In many additional markets, the CVS acquisition of Aetna is "vertical" because Aetna is a buyer of inputs (such as PBM services and pharmacy) that CVS sells. There is an appreciable risk that the created vertical firm, together with the other Big Five health insurers that are also integrated with the dominant sources of PBM services offered in the highly concentrated PBM market,[3] would raise the costs of insurer rivals. This would occur by the merged firm advantaging its Aetna business by reducing the availability of PBM or retail and specialty pharmacy services, or by raising the price of these services to competing health insurers. Any such so-called "input foreclosure"—meaning a refusal to deal with competing health insurers on terms as favorable as those offered a merged Aetna—would substantially harm competition in the highly concentrated health insurance market already dominated by a few firms, including Aetna. In addition, by acquiring Aetna, the country's third largest insurer, CVS would significantly reduce the size of the health insurer market available for competing PBMs and pharmacies (including entrants such as perhaps Amazon) to serve. This customer foreclosure would be severe in the PBM market, if as a result of this merger, all of the Big Five health insurers, i.e., Aetna, Cigna, Anthem, UnitedHealthcare, and Humana, were vertically integrated with PBMs or in the process of becoming so.[4] The customer foreclosure effects are especially painful in the specialty pharmacy market where severely ill Aetna patients are likely to be steered to CVS's specialty pharmacy rather than to pharmacies located in hospitals or physician practices staffed by the patients' treating oncologist or other specialist whose clinical supervision and judgements are needed.

Unless blocked, this merger would likely injure consumers by raising prices, lowering quality, reducing choice and stifling innovation in five poorly performing t markets in California and across the country: Medicare Part D Standalone Prescription Drug Plan, PBM services, health insurance, retail pharmacy, and specialty pharmacy.

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[1] United States Department of Justice and Federal Trade Commission, 2010 Horizontal Merger Guidelines, §1 (August 19, 2010)

[2] Richard Scheffler, PhD, is the distinguished Professor of Health Economics and Public Policy at the School Of Public Health and the Goldman School of Public Policy at University Of California, Berkeley. He holds the Chair in Health Care Markets and Consumer Welfare endowed by the office of the Attorney General for the State of California and is the founding director of the Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare.

[3] Cigna announced its agreement to acquire Express Scripts on March 8, 2018.

[4] Anthem is also in the process of developing its own PBM under a contract with CVS.

AETNA – CVS AS A HORIZONTAL MERGER WITH ANTICOMPETITIVE EFFECTS

The Merger Is Anticompetitive in Markets for the Medicare Part D Prescription Drug Plan, Including in California

The Relevant Product Market is the Medicare Part D Stand-Alone Prescription Drug Plan Market

Medicare beneficiaries can enroll in a Part D private insurance plan that provides prescription drug coverage. For most Medicare beneficiaries not offered a plan by a previous employer, there are two ways to obtain Part D coverage. They can remain in Original Medicare[5] and enroll in a standalone PDP that only covers prescription drugs and pay monthly premiums for the drug coverage or they can enroll in a Medicare Advantage (MA plan) that offers Medicare, prescription drug coverage (MA-PD). In MA plans, Medicare pays most or all of the premiums to a private insurer. Most MA plans are managed care plans; in return for reduced choice of providers and utilization review, the Medicare beneficiary obtains more complete coverage, typically including pharmacy coverage.[6] In 2018, 25 million people nationally and 2.3 million in California are covered under a Stand-Alone PDP plan or (PDP).[7]

At a June 19, 2018 hearing before the Department and California Insurance Commissioner David Jones (June 19 hearing), Professor Scheffler explained how this merger will injure consumers in the PDP market. Aetna and CVS responded that PDP is not a relevant product market but is instead part of a larger market that includes MA-PD because, the merging parties apparently allege, consumers will readily turn to MA in the event of a small PDP price increase. This is highly unlikely: consumers do not switch between MA-PD plans and Original Medicare with PDP in response to small price increases. Although the focus was on health (i.e. medical) insurance markets, *United States v Aetna*, 240 F. Supp.3d 1 (D.D.C 2017) is illustrative and high suggestive. There the court observed that under Supreme Court precedent,[8] markets "must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn."[9] The *Aetna* court found little consumer switching between MA and Original Medicare in response to price increases.[10] Instead, senior consumers have distinct and substantial preferences shaped by their comfort with managed care plans and desire to receive all of his or her benefits from one source (MA) weighed against their ability to shop and choose among providers, as is provided by Original Medicare. Consistent with this determination in *United States v. Aetna*, the evidence to date from Part D suggests that most beneficiaries, once enrolled, tend to stick with the plans they have chosen, even when they are faced *with relatively large* premium increases.[11]

[5] By statute, Congress has provided that seniors can obtain Medicare benefits either "through the original medicare fee-for-service program," or "through enrollment in a [Medicare Advantage] plan." 42 U.S.C. § 1395w–21(a)(1).
[6] Starc Report at 6.
[7] Scheffler Report at 1.
[8] *Times Picayne Publishing Company v. United States*, 345 U.S. 594, 612 (1953).
[9] *United States v Aetna*, 240 F. Supp.3d 1, 20 (D.D.C 2017).
[10] Id. at 42.
[11] To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?, Kaiser Family Foundation, October 10, 2013, available at: https://urldefense.proofpoint.com/v2/url?u=https-3A__www.kff.org_medicare_issue-2Dbrief_to-2Dswitch-2Dor-2Dnot-2Dto-2Dswitch-2Dare-2Dmedicare-2Dbeneficiaries-2Dswitching-2Ddrug-2Dplans-2Dto-2Dsave-2Dmoney_&d=DwIFAg&c=iqeSLYkBTKTEV8nJYtdW_A&r=YXZfhuF5LazfglWur9aEAPmfrPHSGcBoFhGKGQuxCJY&m=mOKiygMKlsziuEiutaB3n4vnDLgvm4sxSeJJYAItUhY&s=CINaEiUZNCFYU5QGaEf6lKViBTaFi8nQ2y5bEJIMsEc&e.

The Relevant Geographic Markets

Part D plan sponsors compete on premiums to attract enrollees.[12] This bidding process determines the maximum premium amount Medicare will pay on behalf of low income subsidy (LIS) enrollees. The amount is calculated separately for each of the 34 Part D geographic regions. Twenty-five of the 34 nationwide Part D geographic regions, including California, are single state. The remaining nine regions are comprised of multiple states. 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 they offer plans) makes Part D regions the relevant geographic market.[13]

The Relationship between Market Concentration and Consumer Injury in PDP Markets

Northwestern University professor Amanda Starc, PhD, whose research focuses on health economics and health insurance, particularly on issues involving pharmaceutical markets and regulation, points to numerous studies showing insurer pricing power in the PDP context. [14] Insurer market power in PDP enables an insurer to charge premiums above competitive levels and/or to degrade insurance quality.[15] The weight of the research also indicates that more competing firms or less concentrated local markets lead to lower premiums.[16]

As will be shown below, this merger will vastly increase the concentration in PDP markets. These markets are already lacking in competition and are poorly performing. Nationally, monthly PDP consumer premiums have increased by 58% since the start of the Part D program in 2006. During the same period, the consumer price index increased by only 24%.[17] Since 2015, California PDP premiums have increased by 18%. According to Professor Starc, this merger is likely to lead to further consumer harm.[18]

The Likely Anticompetitive Effect of the Horizontal Merger in PDP Markets

There are at least two ways of measuring market concentration and the degree of danger to competition that a horizontal merger poses. One test, adopted by the 2015 National Association of Insurance Commissioners in its "Model Insurance Holding Company System Regulatory Act," looks to the four firm concentration ratio (NAIC CR4). This concentration ratio is calculated by summing the market shares of the four largest insurers in the market.

Under the NAIC CR4 test, a highly concentrated market is one in which the sum of the market shares of the four largest insurers – the so-called four-firm concentration ratio – is 75% or more of the market. In the California PDP market, the combined shares of the four largest insurers total a whopping 82.9%.[19] In such a highly concentrated state health insurance market, there is a prima facie violation of the NAIC CR4 test (its Competitive Standard) when a firm with a 10% market share merges with a firm with a 2% or more market share. In the instant case, a prima facie violation of the Competitive Standard is easily established: CVS's market share is 25.1% and Aetna's market share is 8.6%.

[12] Scheffler Report at 2.
[13] Scheffler Report at 4.
[14] Starc Report at 7-8.
[15] Id.
[16] Starc Report at 7.
[17] Scheffler Report at 2.
[18] Id.
[19] Scheffler Report at 7 and Table 3.

A different market concentration test is adopted by the FTC and DOJ in their Horizontal Merger Guidelines (Merger Guidelines). The Merger Guidelines use the Herfindahl – Hirschman Index (HHI) to measure market concentration, increases in concentration caused by the merger and the competitive significance of these resulting measurements.[20] Applying this test to the merger easily reveals its anticompetitive effects. Professor Scheffler finds that 30 PDP regions would experience an HHI increase of over 200 points as a result CVS's acquisition of Aetna.[21] Of these 30 regions, 10 would have a post-merger HHI of greater than 2500. Mergers that increase HHI by over 200 points and result in a post-merger HHI of over 2500 are "presumed to be likely to enhance market power," according to the Merger Guidelines. The post- merger HHIs of the other 20 regions that would experience increases of 200 HHI would all be in the 1500 to 2500 range, and thus they are deemed to "potentially raise significant competitive concerns and often warrant scrutiny."

The merger in the California PDP market – with a post-merger HHI of *2,441* and an increase of *434* HHI points – vastly surpasses the 200 point *change* in HHI threshold associated with mergers that are presumed likely to enhance market power under the Merger Guidelines. However, the post-merger HHI of 2441 is roughly 2.3% less than the post-merger HHI threshold of 2500 for the merger to be "presumed likely to enhance market power." While mergers producing post –acquisition HHIs in the 1500 to 2500 range and more than a 100 increase in HHI technically fall into the Merger Guidelines category of "potentially raising significant competitive concerns and often warranting scrutiny," the Merger Guideline thresholds are not to be construed as rigid screens.[22] Instead the operating principle is "the higher the post-merger HHI and the increase in the HHI, the greater are the Agencies potential competitive concerns."[23]

Professor Scheffler unequivocally concludes that the merger would raise PDP premiums in California and other markets across the country:

> I have reviewed a large number of studies that provide evidence that increases in market power raise Medicare Part D premiums [citations omitted]. 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 to the Guidelines. This latter competitive concern was found for California and it is my opinion that this merger would raise PDP premiums in markets across the country, including California.

[20] The HHI is the sum of the squares of the market shares of every firm in the relevant market. The Merger Guidelines divide the spectrum of market concentration into a continuum that ranges from unconcentrated (HHI less than 1500), to moderately concentrated (HHI between 1500 and 500) and highly concentrated (HHI more than 2500). Markets with HHIs less than 1500 are characterized as unconcentrated. Mergers resulting in post-acquisition HHIs of between 1500 and 2500 and experience a change in HHI of more than 100 are deemed to potentially raise significant competitive concerns and often warrant scrutiny. A merger that increases an HHI by over 200 points and results in a post-merger HHI of over 2500 are presumed likely to enhance market power.

[21] Scheffler Report at 8.

[22] Merger Guidelines, Section 5.3.

[23] Merger Guidelines at 19.

The Merger is Likely to Substantially Lessen Competition Because It Would Allow a Merged CVS-Aetna to Control the PBM Services of Anthem

CVS recently entered into a contract effective January 1, 2020, with Anthem to supply it with PBM services as Anthem transitions to supplying PBM services in-house. For CVS to operate a PBM with Anthem, the second largest health insurer both nationally and in California, while owning Aetna, the third largest health insurer both nationally and in the Santa Barbara-Santa Maria MSA, and the fifth largest California-wide, could be highly problematic.[24] For example, in Thousand Oaks California, Aetna is the second largest insurer and faces stiff competition from Anthem which is the largest insurer. Clearly a CVS merger with Aetna while managing Anthem's PBM services could facilitate in already highly concentrated health insurance and PBM markets, price fixing and the anticompetitive sharing of competitive information – the kinds of horizontal market issues that have appropriately attracted close scrutiny by the FTC and the DOJ and condemnation by the courts.

THE PROPOSED TRANSACTION RAISES ANTICOMPETITIVE CONCERNS THAT ARE UNIQUE TO VERTICAL MERGERS

Whether a vertical merger threatens competitive harm requires predictions about the post-merger conduct of the merged firm.[25] The DOJ's 1984 Non-Horizontal Merger Guidelines (1984 Merger Guidelines) provide that a vertical merger may be challenged if the merger may increase barriers to entry, foreclose competitors or facilitate collusion.[26] As discussed below, this merger will likely produce all of these effects in one or more markets. If the resulting combination of CVS and Aetna harms competition in a single market, that would be sufficient under the antitrust laws to enjoin the entire transaction to protect consumers.[27] Likewise, the DOI should condemn health care mergers that harm competition in any single market given the DOI's mission of protecting health insurance consumers.

One recurring issue is what to make of various market foreclosure percentages when there is a dearth of vertical merger case law. Should we condemn this vertical merger where, depending on the market, the foreclosure is in the range of 20 to 30 percent? The temptation is to apply the high foreclosure percentages tests found in vertical restraint exclusive dealing cases. Some of the concerns there are similar to those arising in vertical mergers. Exclusive dealing is an antitrust violation when a significant fraction of buyers or sellers are frozen out of the market by the exclusive deal.[28] Since the Supreme Court's decision in *Jefferson Parish Hospital District No2 v. Hyde, 466 U.S. 2, 45 (1984),* courts have tended to approve exclusive dealing arrangements when the foreclosure is less than 30%.[29] However, there are important differences requiring antitrust condemnation at lower foreclosure percentages in vertical merger cases.[30] The vertical merger is more permanent than exclusive dealing contracts.[31] A merger eliminates the considerable competition that can occur when contracts must be renewed.[32] For example, Barbara McAneny, M.D., President of the AMA – testifying on the behalf of the AMA and

[24] The market share rankings have been determined by the AMA Health Policy group that produces *Competition in Health Insurance: a Comprehensive Study of US Markets* (2017). *See also, United States v Aetna, supra and United States v. Anthem, supra.*

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

[26] 1984 Merger Guidelines at 4.13-3.134.

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

[28] *Jefferson Parish Hospital District No2 v. Hyde*, 466 U.S. 2, 45 (1984) (O'Connor concurring opinion).

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

[30] Id.

[31] Id.

[32] Id.

herself as an oncologist – observed at the June 19 hearing that when quality of care issues arise between her and a PBM concerning one of her cancer patients, she takes the problem to the insurer. As Dr. McAneny explained, at contract renewal time, Aetna is free to weigh her consumer quality demands against financial concerns. However, once Aetna has a permanent ownership interest in CVS, Aetna will have a financial interest in CVS's specialty pharmacy continuing to gain market share, and be less responsive to her consumer demands.

Aetna and CVS, of course, do not acknowledge the substantial competitive consequences of moving from exclusive dealing to vertical merger. For example in defending the transaction at a Congressional hearing on this merger, Aetna's counsel suggested that the merger would not diminish competition in the PBM market given the status quo: "We already rely on CVS to perform pharmacy benefit management functions for the bulk of our members."[33] This statement obscures the significant change in the competitive structure of the market that the merger would cause. The fact that CVS now supplies Aetna with a PBM service is the result of ongoing competition that would be lost in the merger. Even long-term service contracts maintain competition in the marketplace. This is called "competition for the contract," that, in the words of acclaimed antitrust jurist Richard Posner, is a "form of competition the antitrust laws protect."[34] Once the parties merge, that competition for the contract is forever lost.

University of Pennsylvania professor Herbert Hovenkamp, who perhaps is the nation's most preeminent antitrust scholar, observes that "[w]hen the integration occurs by merger … the downstream business becomes part of the colluding firm itself. As a result condemnation on market shares of 25% or perhaps even 20% seems appropriate, provided that entry barriers are high and other market factors indicate that collusion or oligopoly is likely.[35]"

The CVS-Aetna vertical merger should be condemned under Professor Hovenkamp's criteria. The companies operate in concentrated or highly concentrated markets. As a result of the merger, pharmacies competing with CVS in localized markets will likely be deprived of a significant portion of those markets represented by Aetna's health insurance market shares that are frequently in access of 20%. For example in MA, Aetna's market share is greater than 20% in 62 Metropolitan Statistical Areas (MSAs), greater than 25% in 40 MSAs and greater than 30% in 32 MSAs. Moreover, publicly available data suggest that CVS Caremark steers patients to CVS pharmacies.[3637] Similarly, health insurers competing with Aetna and seeking a competitive supply of PBM services will likely experience "input foreclosure" measured by CVS's market share of PBM services of at least 25% in a highly concentrated market. Further, the broader circumstances associated with the CVS-Aetna merger – the concurrent Cigna-Express Scripts merger and United Healthcare's operating its own PBM (Optum) – raises the potential for horizontal coordination among the three largest PBM suppliers controlling 70% of the PBM market. Facing little threat from competing PBMs they would have strong incentives and capacity to coordinate their strategies to disadvantage rival health insurers.[38]

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[33] Statement of Thomas Sabatino, Aetna Executive Vice President and General Counsel, before the House Judiciary Committee at a hearing entitled "Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna" (February 27, 2018) at page 6.

[34] *Methodist Health Services Corp. v. OSF Healthcare System*, 859 F.3d 408 (2017) (PosnerJ) ("competition-for-the-contract is a form of competition that antitrust laws protect"). *See also* Harold Demsetz, "Why Regulate Utilities?", 11 J. Law & Econ. 55 (1968).

[35] Id.

[36] Drug Channels Report (March 2015) based on CVS 10-K SEC Filing available at: https://www.drugchannels.net/2015/03/cvs-health-newest-data-on-retail-pbm.html

[37] Aetna, the third largest health insurer nationally, has slightly lower market shares in commercial health insurance markets. See AMA health insurance market share analysis, Tab E.

[38] University of California at Hastings Law Professor and prominent antitrust in healthcare scholar, Thomas Greaney, at the June 19 hearing.

THE MERGER IS ANTICOMPETITIVE IN THE GENERALLY HIGHLY CONCENTRATED MARKETS FOR HEALTH INSURANCE, INCLUDING IN CALIFORNIA

Health Insurance Markets, including those in California, are Highly Concentrated

It is now well-established that markets for health insurance, including those in California, are highly concentrated with high barriers to entry, and that they are often dominated by one or two insurers.[39] The AMA's 2017 Update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, finds that nearly 70 percent of the combined HMO + PPO + POS + EXCH (commercial) markets are highly concentrated. Moreover, Aetna's market share is either the first or second largest in 57 of the 389 MSAs studied. In a separate analysis of MA insurer markets, the AMA found that 85 percent of MA markets are highly concentrated. Aetna had the first or second largest MA market share in 60 of the 381 MSAs studied. In a total of 94 MSAs, Aetna had the first or second largest share in the commercial market, MA market, or in both of those markets.

The competition picture in commercial health insurance is even worse in California.[40] Seventy-five percent of MSA-level commercial health insurance markets in the state are highly concentrated.[41] Moreover eighty-two percent of MSA-level MA markets in California are highly concentrated. Health insurance markets need new entry. As explained below, however, a vertical merger between a large insurer and a national PBM with scale and buying power will only further raise entry barriers into these highly concentrated California health insurance markets – an anticompetitive result that should be of great concern to Californians.

Merger Ramifications in the Health Insurance Market

According to health economist and University of Southern California professor Neeraj Sood, PhD,[42] the merger "will further strengthen the already dominant position of Aetna and will exacerbate the lack of competition in health insurance markets. This will come from CVS-Aetna's ownership and control of two segments of the pharmaceutical supply chain-PBMs and retail pharmacies."[43]

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

PBM services are an important input into the production and selling of health insurance, an area of the economy that requires more, not less, competition.[44] Aetna rivals and would-be sellers of health insurance need to be able to purchase essential PBM services.

In the event the Aetna-CVS merger were approved, Aetna rivals that decide to rely on drug rebates from CVS are likely to be hurt by the merger, ultimately to the detriment of competition and consumers. PBMs

[39] See *United States v Aetna*, 240 F Supp.3d (D.D.C 2017); *United States v. Anthem*, 835 F 3d 345 (D.C. Cir. 2017).
[40] *Competition in Health Insurance: A Comprehensive Study of US Markets* (2017 update).
[41] Id.
[42] Neeraj Sood, PhD, is Professor of Health Policy and Vice Dean for Research at USC's Sol Price School of Public Policy. He is also a faculty member and past Director of Research of the USC Leonard Schaeffer Center for Health Policy and Economics and a Research Associate at the National Bureau of Economic Research. He has published more than 100 papers and reports on health policy and economics. His research focuses on health insurance and pharmaceutical markets and he is an associate editor for leading journals in his field.
[43] Sood Report at 8.
[44] Given the present structure of the health insurance market, health insurers have the ability unilaterally or through coordinated interaction to exercise market power by raising premiums, reducing service or stifling innovation. See *United States v Aetna*, 240 F Supp.3d (D.D.C 2017); *United States v. Anthem*, 835 F 3d 345 (D.C. Cir. 2017).

are agents of health insurance plans.[45] They help health plans negotiate with pharmacies and pharmaceutical firms. According to Professor Sood, a national expert on pharmaceutical and health insurance markets, if CVS were to merge with Aetna, CVS would be a worse agent for health plans competing with Aetna. The PBM arm of CVS-Aetna would have weaker incentives to control prescription drug costs and overall health care costs for health plans competing with Aetna. Indeed, in Professor Sood's opinion "the PBM arm of CVS-Aetna has an incentive to disadvantage health plans competing with the insurance arm of CVS Aetna in passing rebates from pharmaceutical firms. This will likely result in less competition in the insurance market."[46]

Professor Sood observes that the adverse effects of the incentives for CVS-Aetna to disadvantage competing health plans are exacerbated by the fact that the PBM market is highly concentrated. Health plans competing with CVS-Aetna do not have many options to switch PBMs. Most desirable sources of PBM services are firms like CVS and Express Scripts that are large enough to drive the biggest discounts in drug prices. Given the recent announcement of Cigna's agreement to acquire Express Scripts, if Aetna were to merge with CVS, all of the large PBMs would either have been acquired by the Big Five insurers or have otherwise become an in-house service of these insurers.[47]

Aetna rivals or new market entrants could easily fall victim to a strategy known in antitrust parlance as "raising rivals costs." The PBMs owned by (or that own) a health insurer could refuse to deal with other health insurers except on discriminatory terms that lessen competition in the health insurance market. Facing little threat from competing PBMs, they would have strong incentives and capacity to coordinate their strategies to disadvantage rival health insurers.[48]

The end result of this input foreclosure for health insurers seeking PBM services will be a less competition in an already highly concentrated health insurance market.In the words of Professor Sood: the merger will further strengthen the already dominant position of Aetna and will exacerbate the lack of competition in health insurance markets.[49] Professor Starc foresees increased barrier to entry:

> Even if the PBM and health insurance markets were competitive, the merged firm could reduce future competition in the insurance market. If the merged entity is successful, future entry may require capabilities to be a payer, PBM, and provider, which may be difficult and especially costly for potential new entrants to replicate.[50]

Aetna-CVS respond to these input foreclosure concerns by contending that Aetna would comprise a small fraction of their combined revenue and the merged firm would never follow the risky strategy of not aggressively bidding for a large fraction of the market. [51] However, the strategy is hardly risky given the high PBM market concentration and the strong incentives for the major vertically integrated health insurers to coordinate their strategies to disadvantage rival health insurers. Moreover, opaque pricing and the rebate structure give both the pharmaceutical manufacturer and the PBM incentives to allow higher

[45] Sood Report at 8.
[46] Sood Report at 10.
[47] United Healthcare now operates Optum RX2; Humana has Humana Pharmacy Solutions; Anthem is developing its own PBM service with the help of CVS; and CIGNA operates CIGNA Pharmacy Management, in addition to proposing to acquire Express Scripts. See also Sood Report at 10.
[48] University of California at Hastings Law Professor and prominent antitrust in healthcare scholar, Thomas Greaney, at the June 19 hearing.
[49] Sood Report at 8
[50] Starc Report at 11.
[51] See e.g. Thomas Moriarty Esq., testimony before the US House Judiciary Committee at a hearing entitled "Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna (February 26, 2018).

list prices and higher rebates. [52] How an Aetna competitor would ever detect whether it was being given a bid less desirable deal than that given Aetna is unclear. Finally, the size of the incentives for CVS-Aetna to disadvantage health plans competing with the insurance arm of CVS-Aetna is substantial. Professor Sood concludes "that one insurance customer is as valuable as 14 PBM customers; providing strong incentives for CVS Aetna to disadvantage competing health plans to gain insurance customers even if it risks losing some PBM customers."[53]

A Merged Aetna-CVS is Likely to Foreclose Aetna Rivals by Refusing to Supply Retail Pharmacy Services to them or by providing them those Services on Disadvantageous Terms

Just as a merged CVS-Aetna is likely to disadvantage insurer competitors needing PBM services, the merged firm may also foreclose competing insurers from access to CVS "must have" retail pharmacies, either entirely or by offering terms that are not competitive with those offered Aetna. Professor Sood reasons that CVS-Aetna could leverage its must-have pharmacy network to disadvantage competing plans.[54] Health plans that do not have CVS in their pharmacy network will be less attractive to consumers, especially in markets where CVS has a dominant market share. CVS-Aetna could exploit this fact to charge higher prices to health plans competing with CVS-Aetna. This effect, says Professor Starc, may be especially important in the market for generic drugs, which are generally competitive at the wholesale, but not the retail level and represent a large fraction of total bills.[55] In recent years, prices for some generic molecules (even particularly old ones whose branded equivalents' patents expired decades ago) have increased substantially. According to Professor Sood, if health plans refused to accept the high prices and do not include CVS-Aetna pharmacies in their network, they risk losing customers. If they accept the high prices, then they face higher health care costs, which might result in higher premiums and lower market share for these health plans. This will result in less competition in the insurance market.[56]

The likelihood of the merged firm's pharmacy customers falling victim to the merged company's favoring the Aetna side of its business is enhanced by "the numbers." Professor Sood has found that "one insurance customer is as valuable as roughly nine pharmacy customers; providing strong incentives for CVS-Aetna to disadvantage competing health plans to gain insurance customers even if it risk losing some PBM customers."[57]

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

If CVS were to merge with Aetna, then health plan entrants and Aetna rivals seeking PBM partners would essentially be forced to share sensitive information with insurer competitors – something they may be loath to do even with the promise of information firewalls.

For example, if the merger were approved, Aetna could potentially have access to the prescription drug experience of Aetna's competitors, which might help it engage in cream-skimming. Aetna could determine the illness profile of its competitors' covered populations. If Aetna determines that those populations consist of desirable insureds, it can design formulary profiles and other health insurance benefit design features to attract them. But if they have high drug expenditures, Aetna could steer them away.

[52] Starc Report at 11.
[53] Sood Report at 12.
[54] Sood Report at 11.
[55] Starc Report at 11.
[56] Sood Report at 10 and Starc Report at 11.
[57] Sood Report at 12.

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

THE MERGER IS ANTICOMPETITIVE IN THE PBM MARKET

The PBM Market is Highly Concentrated, CVS is One of the Two Largest PBMs, and the Likelihood of Oligopoly or Collusion is High

PBMs are agents of health insurers and employers. They provide two key services to them.[58] First, they negotiate rebates with manufacturers in exchange for preferred formulary placement (lower co-pays or coinsurance) for the manufacturer's drugs as compared to drugs from competing manufacturers.[59] Second, they negotiate contracts with pharmacies and thus decide whether a pharmacy will be in the network and the reimbursement the pharmacy will receive for dispensing drugs to the insured consumer.[60]

California health plans are faced with a national market for PBM services that is highly concentrated. The top three PBMs account for at least 70% of the market.[61] CVS has a large share that places it as one of the two largest PBMs. There is research and anecdotal evidence that the PBM market is not competitive.[62] A February 2018 report from the President's Council of Economic Advisers (CEA Report) states that the existing market structure allows PBMs "to exercise undue market power."[63] A major factor in entrenching PBM market power is the high market entry barrier associated with the ability of large PBMs to offer exclusive distribution contracts and to negotiate the deepest volume discounts and rebates from drug firms.[64] Both policymakers and economists have raised serious concerns about the lack of competition in the PBM market and its implications for consumers.[65] In the absence of a well-functioning competitive market, the market is characterized by price obfuscation and byzantine arrangements that may harm consumers.[66] Moreover, the CEA Report points out that "[p]ricing in the pharmaceutical drug market suffers from high market concentration in the pharmaceutical distribution system and a lack of transparency."[67] In sum, the PBM market is highly concentrated, entry barriers are high and collusion or oligopoly is likely.

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[58] Neeraj Sood, PhD, "Potential Effects of the Proposed CVS and Aetna Merger on Competition and Consumer Welfare" (May 23, 2018).

[59] Id.

[60] Id.

[61] http://www.drugchannels.net/2017/12/the-cvs-aetna-deal-five-industry-and.html, accessed May 22, 2018. https://www.google.com/search?biw=1536&bih=726&tbm=isch&sa=1&ei=4AYXW8GhB8b-jwSAraGYDA&q=pbm+market+shares+2018&oq=pbm+market+shares+2018&gs_l=img.3...6596.8649.0.9312.5.5.0.0.0.0.104.321.4j1.5.0....0...1c.1.64.img..0.1.103...0i30k1.0._e9ubyaYAS8#imgrc=xO

[62] See e.g. Garthwaite, Craig and Fiona Scott Morton. "Perverse market incentives encourage high prescription drug Prices." Pro-Market Blog. November 1, 2017.

[63] Council of Economic Advisers, Reforming Bio Pharmaceutical Pricing at Home and Abroad (February, 2018) at 10. *See also*, Sood, N., Shih,T., Van Nuys, K., and Goldman, D. 2017. "The Flow of Money through the Pharmaceutical Distribution System." Leonard Schaeffer Center for Health Policy and Economics, University of Southern California.

[64] Starc Report at 9 ("The high level of concentration in the PBM market is likely to persist due, in part, to barriers to entry in the industry. The scale required to negotiate favorable discounts from manufacturers make it difficult for fringe players to compete"). *See also*, American Antitrust Institute correspondence to the Hon. Makan Delrahim, Assistant Attorney General (March 26, 2018) at 5.

[65] See e.g. Brill, Julie. "Dissenting Statement of Commissioner Julie Brill concerning the proposed acquisition of Medco Health Solutions Inc. by Express Scripts Inc." FTC file No. 111-0210, April 2, 2012; Garthwaite, Craig and Fiona Scott Morton. "Perverse market incentives encourage high prescription drug prices". Pro-Market Blog. November 1, 2017.

[66] Id.

[67] CEA Report at 10.

Merger Ramifications in the PBM Market

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

As recommended by the CEA Report, "policies to decrease concentration in the PBM market … can increase competition and further reduce the price of drugs paid by consumers."[68] Allowing a CVS-Aetna merger would be at war with policies to decrease concentration in PBM markets.

By acquiring Aetna, CVS could prevent Aetna from entering the PBM market as a CVS competitor. National health insurers either have brought PBM services in-house or are in the process of doing so. But to achieve that goal, a large insurer such as Aetna need not resort to PBM acquisitions that would deprive the marketplace of a new PBM competitor. Instead, it could develop its own in-house PBM services – e.g., Aetna could follow Anthem's strategy of developing its own PBM capabilities with the help of a standalone PBM. Aetna might also partner with another company, such as Amazon.com, Inc. (Amazon).

Aetna would likely find it much easier to enter the PBM market, as compared to de novo PBM market entry by another firm. At a February 26, 2018, U.S. House Judiciary hearing on the proposed merger, Aetna's General Counsel acknowledged that Aetna has considered entering the PBM marketplace but rejected this alternative in favor of merging with CVS. Consequently, the CVS-Aetna merger may be deemed anticompetitive because it would arguably deprive the market of one of its most likely entrants – Aetna.[69]

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

Given that Aetna is the third-largest insurer, its merger with CVS would significantly reduce the size of the health insurer customer market available to PBMs as sellers and thus would reduce incentives for new PBMs to enter the market. [70] A much needed new PBM market entrant, which could include, but certainly need not be limited to, Amazon, today finds that Aetna is the sole Big Five insurer that neither has its long-term PBM supply needs served in-house nor is transitioning to in-house as in the case of Anthem. A CVS acquisition of Aetna would foreclose the one remaining major customer opportunity for would-be CVS PBM competitors. Indeed, there are reports in the Wall Street Journal that CVS is acquiring Aetna to tie-up that business before Amazon can enter the market.[71]

In sum, if this merger is approved, the door to new PBM entry will be closed. According to Professor Sood, "standalone PBM entry is unlikely" and entry would instead require that the firm be vertically integrated with a health plan. [72] Given the high barriers to entry into health insurance, it is highly improbable that a new PBM entrant could successfully enter both the PBM and health insurance markets simultaneously.

[68] CEA Report at 10.
[69] Crucial evidence for the fact finder here, and on other issues, is in the possession of the merging parties (e.g., documents reflecting business plans to enter the market).
[70] See Sood Report at 16.
[71] See, e.g. "A Force behind the Aetna Bid: Amazon," the *Wall Street Journal*, (October 27, 2017).
[72] Sood Report at 16.

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

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

For example, a new PBM entrant could compete on transparency and service efficiencies in an environment that is currently plagued by the black-box nature of PBM activities, as evidenced by the numerous state bills on PBM transparency and at least one ongoing lawsuit alleging PBM overcharging. One expert has concluded that most of the increase in drug pricing can be attributed to rebates pocketed by PBMs.[73] Without new entry and competition, PBMs can continue to keep secret the size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients.[74] Because a CVS acquisition of Aetna would reduce the likelihood of needed PBM market entry, the likelihood of new efficiencies and improved PBM market performance would be diminished.

THE MERGER IS ANTICOMPETITIVE IN LOCAL PHARMACY MARKETS

Local Pharmacy Markets Appear Highly Concentrated and CVS Likely Has Market Power in Some of Those Local Markets

Retail Pharmacy

Pharmacy markets in the US are uncompetitive or highly concentrated.[75] CVS has the status of being one of the nation's two largest pharmacy chains.[76] CVS's share of drug sales (retail and specialty) in the United States is roughly 24%.[77] Together with Walgreens Company (Walgreens), the two chains control about 40% of national drug sales.[78]

Those *national* shares mask larger market shares at the local level. A 2015 Business Insider article entitled, "CVS and Walgreens Are Completely Dominating the US Drugstore Industry," reports that even before CVS acquired 1660 Target Corporation pharmacies, CVS and Walgreens together controlled between 50% and 75% of the retail pharmacy markets in Los Angeles, San Francisco, and Riverside/San Bernardino.[79]

[73] "Robert Goldberg, "Drug Costs Driven by Rebates," Center for Medicine in the Public Interest, http://bionj.org/wp- content/uploads/2015/11/drug-costs-driven-by-rebates.pdf.
[74] CEA Report at 10.
[75] *See*, expert report of Neeraj Sood, PhD, Professor Of Health Policy and Vice Dean for Research at The Sole Price School of Public Policy, University of Southern California ("Pharmacy markets in the us are uncompetitive or highly concentrated")
[76] See e.g. Corey Stern, "CVS and Walgreens Are Completely Dominating the US Drugstore Industry," *Business Insider* (July 29, 2015) available at http://www.businessinsider.com/cvs-and-walgreens-us-drugstore-market-share-2015-7.
[77] See, http://www.drugchannels.net/2018/02/the-top-15-us-pharmacies-of-2017-market.html.
[78] Id.
[79] "CVS and Walgreens Are Completely Dominating the US Drugstore Industry", Business Insider (July 29, 2015), http://www.businessinsider.com/cvs-and-walgreens-us-drugstore-market-share-2015-7.

Moreover, CVS's high local market shares understate the likelihood of market power. CVS pharmacy chains may be considered "must have" pharmacies. They are "must have" because health plan sponsors prefer geographically comprehensive networks – pharmacies located in close proximity to their patient population. Reportedly, 76 percent of the population of the U.S. lives within five miles of a CVS pharmacy. In its 2015 U.S. Securities and Exchange Commission (SEC) form 10-K filing, CVS disclosed that it operated in 98 of the top 100 U.S. drugstore markets and held the number one or number two market share in 93 of these markets.[80]

In sum, in a number of local markets, CVS's shares and its status as "must have pharmacy" in highly concentrated retail pharmacy markets, likely enables it to exercise market power either unilaterally or through coordinated interaction.

Specialty Pharmacy

CVS is the largest specialty pharmaceutical firm in the United States.[81] Specialty pharmacy is driving the pharmacy industry's revenue growth[82] and represents a growing proportion of drug costs.[83] According to Pembroke Consulting, "the growth of specialty drugs is reshaping the pharmacy and pharmacy benefit management industries."[84]

Specialty pharmacies tend to focus on providing medications for patients with complex medical conditions, including cancer, auto immune disorders, cystic fibrosis, and HIV/AIDS.[85] Specialty pharmacy drugs are typically high cost and have special development, handling, administrative and medical monitoring requirements.

Data indicate that specialty pharmacies operate in a concentrated and oligopolistic market.[86] Nearly 60% of all prescription revenues from specialty pharmaceuticals are collected by the three largest firms – owned by CVS Health, Express Scripts, and Walgreens Boots Alliance.[87] In 2017, CVS reportedly had a 25% specialty pharmacy market share, measured by specialty pharmaceutical revenues.[88] CVS's specialty pharmacy market share appears to be growing, as described in the CVS Health 2017 Annual Report:

> We remain the largest specialty pharmacy by a considerable margin, resulting in greater scale and stronger purchasing economics . . . Looking at 2018, we expect to continue outpacing the marketplace by adding another $4 billion in specialty revenue.

CVS Acknowledges that CVS Pharmacy and CVS Specialty Pharmacy Appear to Possess Market Power

In its form 10-K filed with the SEC for the fiscal year ended December 31, 2016, CVS informs investors of the antitrust risks intrinsic to its appearance of market power. CVS states:

[80] See CVS Health Corp., Annual Report (Form 10K) for fiscal year ended December 31, 2016 (February 9, 2017) at 9 (citing CVS health Corp., Annual Report (Form 10K) at 6 (February 10, 2015)).
[81] https://www.drugchannels.net/2018/03/the-top-15-specialty-pharmacies-of-2017.html.
[82] Outlook for Specialty Pharmacy Prescription Revenues, Drug Channels (subsidiary of Pembroke Consulting), April 11, 2017, *http://www.drugchannels.net/2017/04/our-exclusive-2021-outlook-for.html.*
[83] Starc Report at 9.
[84] Id.
[85] Id.
[86] Starc Report at 9 (Specialty market "remains extremely concentrated".)
[87] Id at 10.
[88] https://www.drugchannels.net/2018/03/the-top-15-specialty-pharmacies-of-2017.html.

> To the extent that we appear to have actual or potential market power in a relevant market or CVS pharmacy or CVS specialty plays a unique or expanded role in a PBM product offering, our business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.[89]

Merger Ramifications in the Markets for Retail and Specialty Pharmacy

Retail Pharmacy

Professor Sood has opined that "the merger of CVS and Aetna will further strengthen the already dominant position of CVS in the pharmacy market and will exacerbate the lack of competition in pharmacy markets."[90]

In addition to owning pharmacies, CVS through its PBM, also contracts with independent pharmacies to be in its pharmacy network, promising access to plan subscribers in return for the pharmacies discounting their fees for filling prescriptions. Thus, CVS is both a competitor and a critical customer of independent pharmacies.

If CVS were to acquire Aetna and the latter were to require that patients use CVS-owned pharmacies, independent pharmacies may be foreclosed from the market and point-of-sale drug prices may rise. Indeed, there is some evidence that CVS has already used its market power in the PBM market to disadvantage independent pharmacies that compete with CVS-owned pharmacies. A January 23, 2018, American Prospect article entitled, "Abusing Drugs: How CVS Uses Its Market Power to Destroy Competing Independent Pharmacies," authored by David Dayen, reports that:

> CVS's existing combination of a pharmacy (which dispenses drugs) and a pharmacy benefits manager (which reimburses other pharmacists for dispensing drugs) is a disaster for competition and access, particularly in underserved communities. Adding a health insurer like Aetna would further concentrate market power and narrow the networks people depend upon for medical care.[91]

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

The AMA encourages the Department to investigate whether CVS has engaged in predatory behavior, as reported in the American Prospect article. If accurately reported, the Department could weigh this prior conduct and the dominant market positions that CVS now possesses in PBM and retail pharmacy markets.

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[89] CVS Health 2017 Annual Report at 20.

[90] Sood Report at 13.

[91] David Dayen, "Abusing Drugs: How CVS Uses Its Market Power to Destroy Competing Independent Pharmacies," *American Prospect* (Jan 23,2018) at https://urldefense.proofpoint.com/v2/url?u=http-3A__prospect.org_article_abusing-2Ddrugs&d=DwIFAg&c=iqeSLYkBTKTEV8nJYtdW_A&r=YXZfhuF5LazfglWur9aEAPmfrPHSGcBoFhGKGQuxCJY&m=FDJ9rI1hwFVMepr1zb2N4aRTip5sKlsAHo7J4GPO4zU&s=y9khpj6sXs3L6fNCKrAjuMTWgN80081bnBGd6PvwZrw&e=

The Department could consider whether, by locking up all of Aetna's prescription volume, CVS would have a dangerous probability of acquiring and exercising market power in retail pharmacy markets.

Specialty Pharmacy

The merger has worrisome ramifications in the specialty pharmacy market.[92] Post-merger, Aetna would have a direct and permanent financial interest in incentivizing or forcing Aetna patients wanting insurance coverage, without crushing coinsurance requirements on extraordinarily expensive drugs, to utilize CVS's specialty pharmacy for the dispensing and administration of specialty drugs rather than obtain the drugs in treatment settings such as physician practices, hospitals and health systems.[93] The latter treatment settings dispense and administer drugs where patient compliance with dosing amounts and intervals can be monitored, side effects evaluated and, if necessary, critical drug dosages adjusted. These are clinical services that patients receiving specialty drugs often need to stay alive.

While CVS's specialty pharmacy might for some patients be a lower cost setting for obtaining and/or administering drugs,[94] there can be adverse clinical consequences in addition to financial ones.[95] Professor Starc warns:

> Aetna may attempt to steer at least a portion of their consumers to CVS' specialty pharmacy in ways that may harm competition or overall consumer welfare. Anticompetitive behavior is especially concerning in this setting, as it may have important clinical, in addition to financial, consequences.[96]

Today Aetna is free to weigh the quality demands of patients against financial concerns at for example, contract renewal time, as compared to a merged Aetna with a permanent ownership interest in CVS's specialty pharmacy.[97] CVS's status as one of the two largest PBMs has allowed it to steer patients and third-party payers to utilize CVS as their specialty pharmacy.

Tying CVS specialty pharmacy to adequate health insurance is among the allegations against CVS in a class action filed in the United States District Court for the Northern District of California. While not couched as an antitrust tying claim, the suit alleges, in part, that many enrollees in health plans where CVS controls and administers the pharmacy benefits are told they are required to obtain their HIV/AIDS medications from CVS's California specialty pharmacy, a wholly-owned subsidiary of CVS. Patients allegedly are "told that they must either pay more out of pocket or pay full price with no insurance benefits whatsoever-thousands of dollars or more each month-to purchase their medications at an in network community pharmacy where they can receive counseling from a pharmacist and other services they may need to stay alive."[98] While these claims are yet unproven allegations in litigation, similar allegations of CVS's tying its specialty pharmacy services to its PBM services appear in a second lawsuit, this one pending in the Southern District of Florida.[99] There the plaintiff alleges that CVS forces "patients and third-party payers to utilize CVS as their specialty pharmacy."[100]

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[92] See Starc Report at 10.
[93] Id.
[94] See Dafny in the NEJM: https://www.nejm.org/doi/full/10.1056/NEJMp1717137?query=TOC
[95] *See*,Complaint in *John Doe One et al v. CVS Health Corporation,* case 2:18-CV-01280-RS WL-J PR, filed February 16, 2018.
[96] Starc Report at page 10.
[97] See discussion of physicians on behalf of patients advocating with health insurers and how that advocacy is adversely affected when the insurer has an ownership interest in furnishing the specialty drugs. Supra, page 6.
[98] Id.
[99] *Sentry Data Systems v. CVS Health et al*, Case 0:18-cv-60257, filed February 5, 2018.
[100] Id.

The augmentation of market power in the already concentrated and oligopolistic specialty pharmacy market created by the Aetna health insurance acquisition exacerbates these concerns.[101] If past is prologue, a significant fraction of local health insurance markets represented by Aetna's market shares will be foreclosed to specialty pharmacies administering specialty drugs. In addition, a significant fraction of patients will be deprived of the clinical settings they prefer for legitimate quality reasons.

CLAIMED EFFICIENCIES ARE INSUFFICIENT TO OFFSET THE LIKELY ANTICOMPETITIVE EFFECTS OF THE PROPOSED MERGER

CVS-Aetna argue that any anticompetitive effects under Section 7 of the Clayton Act resulting from the proposed merger will be outweighed by efficiencies created by the increase in the capacity of CVS's retail clinics to provide primary care services. However, the U.S. Supreme Court has never approved an efficiencies defense to a section 7 claim.[102] For example, in *FTC v. Procter & Gamble Co*., 386 U.S. 568 (1967), the U.S. Supreme Court stated that "[p]ossible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition."[103]

Although the U.S. Supreme Court has never recognized this efficiency defense, the Sixth, District of Columbia, Eighth, and Eleventh U.S. Courts of Appeals "have suggested that proof of post-merger efficiencies could rebut a Clayton Act § 7 prima facie case."[104] Nevertheless, as the Ninth Circuit recently noted, even in those circuits, no federal appellate court had ever found any such efficiencies sufficient to rebut a prima-facie case:

> However, none of the reported appellate decisions have actually held that a § 7 defendant has rebutted a prima facie case with an efficiencies defense; thus, even in those circuits that recognize it, the parameters of the defense remain imprecise.[105]

But even in those circuits that allow the possibility that sufficient evidence of efficiencies might rebut a section 7 prima facie case successfully established by a plaintiff, courts place a significant restriction on the kinds of evidence that a plaintiff can use to support an efficiency rebuttal. Merely "claimed" efficiencies do not suffice—only verifiable efficiencies count.[106] Further,

> Efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means. Projections of efficiencies may be viewed with skepticism, particularly when generated outside of the usual business planning process. By contrast, efficiency claims substantiated by analogous past experience are those most likely to be credited.[107]

Under the Merger Guidelines[108], only efficiencies that are "cognizable" may be considered. Cognizable efficiencies are those that are likely to be accomplished with the proposed merger and unlikely to be

[101] The potential for abuse is largest in the commercial market. However, Aetna's Medicare Advantage enrollees-for whom Aetna is responsible for drug utilization regardless of the site of administration-could be affected as well.
[102] *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.,* 778 F.3d 775, 789-780 (9th Cir. 2015).
[103] *Id.* at 789, citing *FTC v. Proctor & Gamble*, 386 U.S. 568, 580 (1967). See also 4A Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 950f, at 42; id. ¶ 970c, at 31.
[104] Id.
[105] Id.
[106] Id. at 790 citing *FTC v. CCC Holdings Inc*., 605 F. Supp. 2d 26, 74-75 (D.D.C. 2009).
[107] Merger Guidelines, §11.
[108] We reference the Horrizontal Guidelines and not the 1984 Non-Horrizontal Merger Guidelines because the efficicieny discussion in the latter has not been updated in 34 years

achieved in the absence of the merger." [109] To escape federal antitrust merger enforcement, cognizable efficiencies must be of a character and magnitude such that the merger is not likely to be anticompetitive in *any* relevant market"

Potential Efficiency in PBM/Health Insurance Market Does not Justify This Merger

Some economists, including Craig Garthwaite, PhD, in earlier Congressional testimony favoring this merger, are citing economic research (Starc and Town 2015) that suggests a benefit of insurer-PBM integration in the MA and Part D markets.[110] Their research suggests that MA Prescription Drug (MA-PD) plans, which cover both drug and medical expenditures, tend to be designed to offset medical expenditures, as compared to stand-alone PDP plans which only cover drugs. They find MA-PD insurers charge consumers low co-pays for preventive medications-which effectively means sending consumers the right price signals. The findings are consistent with the idea that firms that only cover drugs and are at no risk for higher medical costs would have little incentive to consider the influence of their benefit design decisions on enrollee medical care utilization, whereas firms that cover both would have an incentive to lower medical costs.

To better understand the Starc and Town research cited in the Congressional testimony and the extent to which the so-called "alignment of medical and pharmacy benefits" efficiency might favor this merger, AMA has consulted Professor Starc, the lead co-author. In her report, she concludes that a merged CVS-Aetna entity has the potential to foreclose future entry or raise the cost of current rivals in the PBM industry, the specialty pharmacy market, and critically the Part D market. She further concludes that the potential for foreclosure is likely to have negative impacts on consumer welfare.[111] Ultimately, it is her opinion that "the potential harm to consumer welfare from the proposed merger is likely to outweigh the potential gains"[112]

Professor Starc reached her opinion condemning this merger while at the same time concluding that the alignment of medical and pharmacy benefits is an efficiency that can only be *fully* achieved through *integration* within a firm. However, the efficiency does not meet the Merger Guidelines' "cognizable" standard. According to Professor Starc, the integration efficiency could be fully achieved "by developing an in-house PBM", an approach pursued by other players.[113]Indeed, as described by Professor Sood, "Aetna's own financial statements to the SEC indicate it that already performs its core PBM functions."[114]

Even assuming the efficiency were merger specific it would not be of a magnitude that would justify the merger. According to Professor Starc, Aetna already contracts with CVS for PBM services. It could redesign that contract to put CVS at risk for at least part of medical spending.[115] Professor Sood observes that it is unclear if Aetna already has access to CVS's pharmacy data and if so, the extent to which the merger would lead to better integration of data[116]

[109] Merger Guidelines, Section 10
[110] See Garthwaite, testimony before House Judiciary Committee at a hearing entitled " Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna", February 27, 2018 , available at https://judiciary.house.gov/wp-content/uploads/2018/02/Garthwaite-REVISED-Testimony and citing Starc A. and Town B. *Internalizing Behavioral Externalities: Benefit Integration in Health Insurance*, 2017, NBER Working Paper No. 21783.
[111] Starc Report at 15.
[112] Starc Report at 16.
[113] Starc Report 13-14.
[114] Starc Report at 9.
[115] Starc Report at 13.
[116] Sood Report at 16.

Finally, the magnitude of any alignment of medical and pharmacy benefits is, according to Professor Starc, further limited to the set of contracts joint to Aetna and CVS's PBM plans in which the merged entity is at risk for both medical and pharmacy benefits. In the Part D market, this will be limited by the (lack of) consumer switching from stand–alone plans to MA plans. In the commercial market, this will be limited to fully insured contracts, primarily in the small-group market. [117]

Unlikely Pass –Through of Cost Savings

Most importantly, Professor Starc concludes that any cost efficiency created by the merger would not likely translate into lower premiums or more attractive benefit packages for consumers. [118] Even Dr. Garthwaite concedes that consumers will only benefit from the Starc and Town identified efficiency, or any other that might result from the merger, if there is a competitive market in health insurance.[119] This is rarely present, and thus health insurers generally have very little incentive to pass savings along to consumers rather than pocket the total reduction in healthcare costs. [120] This has been shown in the history of horizontal health insurer mergers: "If past is prologue," notes Professor Leemore Dafny, PhD, "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums."[121] Therefore, the adverse ramifications in the health insurance market of a combined CVS-Aetna, discussed earlier, are likely to swamp any merger associated cost efficiency.

Summary of the Efficiency Defense in the Relevant Health Insurance, PBM Markets and Pharmacy Markets Where Competitive Harm Caused by the Merger is Likely

Perhaps Professor Sood most succinctly summarizes the verdict on this merger in the health insurance, PBM and pharmacy markets:

> 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.[122]

Claimed Healthcare Provider Efficiencies

CVS-Aetna however urged the Department to consider their efficiency claims in providing medical services. Post-merger the company would route patients needing basic urgent care to walk-in clinics. This, the merging parties say, would keep patients out of expensive hospital emergency rooms. CVS has 1100 Minute Clinics in its pharmacies. The clinics are staffed by nurse practitioners and physician assistants who provide routine care such as flu shots. "Think of these stores as a hub of a new way of accessing healthcare services across America," says CVS Chief Executive Officer Larry Merlo. "We're bringing healthcare to where people live and work."[123]

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[117] Starc Report at 14.
[118] Starc Report at 14.
[119] Craig Garthwaite and Fiona M. Scott-Morton, "Perverse market incentives encourage high prescription drug prices". Pro-Market Blog. November 1, 2017.
[120] As explained earlier, competition in health insurance would be made even less likely post a CVS-Aetna merger.
[121] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?", Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.
[122] Sood Report at 17.
[123] "CVS to Buy Aetna for 67.5 Billion, Remaking Health Sector," *Bloomberg Markets* (December 3, 2017), available at https://www.bloomberg.com/news/articles/2017-12-03/cvs-is-said-to-buy-aetna-for-67-5-billion-remaking-industry.

Claimed Health Care Provider Efficiencies Would Not Occur in Markets in which the Effects of the Merger May Be Substantially to Lessen Competition and thus Cannot Justify the Merger

The CVS-Aetna claimed healthcare hub -provider efficiencies are irrelevant to whether this merger may substantially lessen competition in the relevant Medicare Part D PDP, health insurance, PBM, retail pharmacy and specialty pharmacy markets. As a matter of law, likely efficiencies must occur *in the specific markets in which the merger is likely to have its anticompetitive effects*. The U.S. Supreme Court made this point clear in *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963), in which the U.S. Supreme Court ruled against a proposed bank merger because it would likely have "the effect of substantially lessening competition in the relevant market."[124] In that case, after concluding the effect of the proposed merger would be substantially to lessen competition, merger proponents argued that the bank merger was justified because it would give the merged bank countervailing market power, which would enable it to compete with large out-of-state banks for very large loans.[125] The Court rejected this "out-of-market efficiencies" justification, stating that:

> If anticompetitive effects in one market could be justified by procompetitive consequences in another, the logical upshot would be that every firm in an industry could, without violating § 7, embark on a series of mergers that would make it in the end as large as the industry leader.[126]

Courts have followed the *Philadelphia National Bank* Court's rejection of out-of-market efficiencies as a cognizable merger justification. As the court in *Law v. NCAA*, 902 F. Supp. 1394 (D. Kan. 1995) stated:

> Procompetitive justifications for price-fixing must apply to the same market in which the restraint is found, not to some other market. See *United States v. Topco Assoc., Inc*., 405 U.S. 596, 610, 31 L. Ed. 2d 515, 92 S. Ct. 1126 (1972) (competition "cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy"); *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 370, 10 L. Ed. 2d 915, 83 S. Ct. 1715 (1963) (anticompetitive effects in one market cannot be justified by procompetitive consequences in another); *Sullivan v. National Football League*, 34 F.3d 1091, 1112 (1st Cir. 1994) (it seems "improper to validate a practice that is decidedly in restraint of trade simply because the practice produces some unrelated benefits to competition in another market"), [**32] cert. denied, 131 L. Ed. 2d 133, 115 S. Ct. 1252 (1995).[127]

Even if CVS-Aetna could demonstrate that health care hubs will be established as claimed and result in efficiencies, such efficiencies would occur in the market for the provision of primary care services. But such primary care efficiencies are out-of-market in relation to those markets in which the effect of the proposed CVS-Aetna merger may be to substantially lessen competition i.e. the markets for Part D PDP, health insurance, PBM, retail pharmacy and specialty pharmacy. Consequently, under existing case law, any primary care efficiencies that the merged CVS-Aetna might create are neither relevant to, nor justification for, the proposed merger.

[124] *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 323-324 (1963).
[125] Id. at 370.
[126] Id.
[127] *Law v. NCAA*, 902 F. Supp. 1394,1406 (D. Kan. 1995),

The Claimed Health Care Provider Efficiencies are also Wildly Speculative

Notwithstanding their antitrust irrelevance, the CVS-Aetna claim that retail clinics hosted in CVS pharmacies can effectively serve the healthcare hub for patients and consumers were examined by Wharton professor Lawton R. Burns, PhD.[128] In a detailed, richly annotated report, Professor Burns reaches the following conclusions:

> The proposed merger between CVS Health and Aetna is unlikely to yield a long list of benefits advanced by executives from both companies. The documentation on how these benefits are to be achieved is lacking; their evidence base in the scientific literature is questionable; and the implementation challenges are enormous…. Any effort to achieve such benefits through the use of retail clinics and analytics is unlikely to succeed. More generally, the strategies of vertical integration and diversification that underlie the merger lack a firm evidence base for any consumer benefits.[129]

David Blumenthal, MD, President of the Commonwealth Fund has similarly found the CVS-Aetna claim that the merger would create strong efficiencies with respect to primary care services to be wildly speculative. He observes in the December 14, 2017, Harvard Business Review:

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

A recent study of 1.3 million Aetna enrollees found that retail clinics result in higher healthcare spending.[130] A Bloomberg news article entitled, "CVS's Megadeal to Change U.S. Healthcare Faces Stiff Challenges," cautions: "There are serious challenges to CVS's proposal. Revamping the stores could cost several billion dollars."[131] Also noteworthy is that reputable financial analysts covering the health care industry have dismissed claims of efficiencies in this merger and see the merger as "defensive." For example, Leerink analyst Anna Gupta writes that the "Aetna/CVS deal is still viewed as primarily a defensive play."[132] Bloomberg reports that "Jeff Goldsmith, who runs the healthcare consulting firm Health Futures Inc. is skeptical of the strategy behind the deal, calling it 'flat out baffling,' and says that the minute clinics 'lack the clinical acumen or trusting relationships with patients to effectively manage care' and does not 'see it generating new customers for the acquirer or the acquiree, or leverage to lower health costs.'"[133] MorningStar points out that "CVS has significantly overpaid for Aetna," roughly double

[128] Professor Burns is the James Joo –Jin Kim professor at the Wharton school of the University of Pennsylvania. He is a professor in the Department of Management and Department of Healthcare Management. He teaches courses on the US healthcare system in the industrial organization of healthcare. These courses cover the entire value chain of healthcare including hospitals, managed care organizations, insurers, pharmacies, retail clinics, pharmacy benefit managers and pharmaceutical and medical products.

[129] Burns Report at 26.

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

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

[132] "Aetna-CVS Deal a Defensive Play As Amazon Threat Looms" Bloomberg First Word (Dec 15, 2017).

[133] See, note 19.

its standalone fair value. The Department should consider whether the price paid for Aetna reflects an anticompetitive defense of CVS market power and increases the likelihood that the merger will have anticompetitive effects.

CONCLUSION

For all the reasons expressed by the health economists and other experts both at the June 19 hearing and in their reports accompanying this statement, it is the AMA's opinion that this merger would likely substantially lessen competition in many markets. The AMA therefore respectfully requests that the Department urge the DOJ to block the merger.