Actors Fund ☙ Children's Defense Fund-New York Community Service Society of New York
Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority
Young Invincibles

Testimony on CVS Health's Acquisition of Aetna Inc.
June 4, 2018

Health Care for All New York (HCFANY) would like to thank the chairs of the Assembly Committees on Insurance and Health for this opportunity to comment on CVS Health's proposed acquisition of Aetna Inc. and the potential impact this could have on New Yorkers. Health Care For All New York is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We do this in part by bringing consumer voices to policy discussions and ensuring that the issues important to consumers are reflected in policy decisions.

CVS Health (CVS/Caremark) is a retail chain of drug stores, a pharmacy benefit manager (PBM) through its Caremark line of business, and a direct care provider. It is the second largest pharmacy chain in the United States, with over 10,000 stores.[1] Its PBM is the largest in the United States and controls 25 percent of that market. Its MinuteClinic division runs over 1,000 walk-in clinics at which consumers can get physicals, vaccinations, and treatment for minor illnesses with no appointment.

Aetna is the third largest insurance company in the United States. In 2014 (the most recent year for which complete data is available) Aetna had 476,000 members in New York, mainly in the large group market but also with substantial numbers of enrollees in the individual, small group, and Medicare markets.[2] In 2017 it had about 66,000 members in its small group

[1] Statement of George Slover Senior Policy Counsel Consumers Union Before the Subcommittee on Regulatory Reform, Commercial and Antitrust Law House Committee on the Judiciary on Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna, February 27, 2018, https://judiciary.house.gov/wp-content/uploads/2018/02/Slover-Testimony.pdf.

[2] United Hospital Fund, "The Big Picture VI: New York's Private and Public Insurance Markets, 2014," October 2014, pages 11-12, https://uhfnyc.org/publications/881161.

plans in New York, most in the New York City area and Long Island.[3] In 2016 it had about five percent of New York's Medicare Advantage enrollees (about 69,000 members) including large shares of enrollees in the following counties: Putnam (34 percent), Westchester (19 percent), Richmond (18 percent), Tioga (17 percent), Oswego (14 percent), and Rockland (14 percent).[4]

The proposed acquisition would be the largest health insurance transaction ever.[5] It is a type of merger for which there is little precedent because it is across business lines (a provider, PBM, and an insurance company) rather than a merger between two direct competitors (such as two insurance companies). Our comments focus on the potentially anticompetitive effects of the acquisition and the power a combined CVS/Caremark-Aetna could have to reduce access to care for its customers and avoid regulations meant to protect consumers.

I. The merged company's insurance division will potentially have access to data on millions of consumers and the prices its rivals pay for prescription drugs.

CVS has data on millions of consumers who use many types of insurance and the prices those insurers pay for drugs. As a pharmacy chain and as a PBM, this presents no problems for the market. However, if CVS is allowed to absorb and run an insurance plan, unless safeguards are put in place, it will potentially have an unfair market advantage by gaining access to information about its competitors' pricing strategies. This information is something that all insurers closely guard as a trade secret. Other insurers may be driven by competitive disadvantage to seek their own similar mergers, with unclear repercussions.

One way to counteract any adverse effects from making one player in the market privy to its competitors' trade secrets is to make all the information regarding drug prices considerably less secretive. Health Care for All New York sees the lack of price transparency as a major issue that hurts consumers and has argued that all players in the health care system should provide more information to the public about prices. The information that the public and the government needs to appropriately regulate the health care system is locked within private systems. The CVS/Caremark-Aetna merger does not make this situation worse or better – but it is another instance in which private actors will have far superior knowledge about matters of vital importance to the public than the public or regulators. Health Care for All New York encourages

[3] Aetna Life Insurance Company, Rate Application Submitted to the New York State Department of Financial Services, 2017, Exhibit 13b: Narrative Summary and Exhibit 13c: Average Premium Details,https://myportal.dfs.ny.gov/documents/538523/11838371/Aetna%20Life_SG_OFFX_AETN-131017525_Narrative.pdf.

[4] Kaiser Family Foundation, 2016 Market Share Data by County, https://www.kff.org/medicare/issue-brief/data-note-medicare-advantage-enrollment-by-firm-2015/.

[5] Emily Stewart, "What the CVS-Aetna merger could mean for health care deals, drug prices, and Amazon," December 4, 2017, https://www.vox.com/business-and-finance/2017/12/4/16731310/cvs-aetna-merger.

our political leaders to take this opportunity to closely question CVS/Caremark and Aetna about transparency in the health care industry and its plans for using this information.

II. The merger could create new incentives for Aetna to limit the providers its members may use.

In their announcement, CVS/Caremark and Aetna talk about empowering customers, integrating care, and improving health outcomes while lowering costs.[6] Examples include using home devices to monitor vital signs after hospitalizations and receiving medication evaluations at community "health hubs."

However, there is no reason that CVS/Caremark and Aetna have to merge to provide the straightforward health services described in their public comments on the acquisition. In fact, the services they describe are already offered by various players in the health care sector. Aetna members can already use MinuteClinics if they wish; however they can also use other urgent care or walk-in clinics if they prefer. The benefits that will accrue to shareholders from the acquisition likely depend on getting Aetna members to use CVS clinics and pharmacies over other choices. The way that insurance companies do this is by imposing financial penalties for members who use other sources of care – creating a new network problem for consumers to navigate.

Further, Aetna provides no evidence that increasing its members' use of walk-in clinics will mean better integration or coordination. New York State has worked for many years to create health "homes" for consumers in an effort to make sure they receive appropriate, coordinated medical care. There are times when consumers may prefer walk-in clinics to their primary care doctors, and certainly walk-in clinics are preferable to emergency room visits – this is why Aetna and other insurers already have provider agreements with walk-in clinics owned by CVS/Caremark and many other entities. However, increasing the incentives that consumers have for using those clinics is not a strategy for integration or coordinated care. New York should be watchful about reducing effectiveness of health home efforts.

III. The acquisition could reduce an avenue for competition between pharmacy benefit managers, which would have unpredictable effects on consumers.

[6]"CVS Health to Acquire Aetna; Combination to Provide Consumers with a Better Experience, Reduced Costs and Improved Access to Health Care Experts in Homes and Communities Across the County," December 3, 2017, https://news.aetna.com/news-releases/cvs-to-acquire-aetna/; Thomas M. Moriarty, 'Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna,' Testimony to the United States House of Representatives Committee on the Judiciary, Subcommittee on Regulatory Reform, Commerical and Antitrust Law, February 27, 2018, https://judiciary.house.gov/wp-content/uploads/2018/02/Moriarty-REVISED-Testimony.pdf.

Insurers hire PBMs in part to negotiate with drug manufacturers. The PBMs negotiate with manufacturers for rebates, which are then shared with the insurer. The PBM marketplace is already highly concentrated amongst three companies: Caremark is the largest with 25 percent of the market. Aetna currently uses Caremark as its PBM.

The alternative to PBMs is that insurers manage pharmacy benefits in-house. The argument for using a PBM is that it will have more negotiating power with manufacturers than plans will. However, it is unclear whether the existence of independent PBMs adds value for consumers or insurers.[7] Their revenue structure is based on the size of the rebates they extract from manufacturers – which means that they benefit when drug prices go up because higher prices means larger rebates. Their perverse incentive to accept higher drug prices is likely exacerbated by a lack of transparency about the size of the rebates they earn from manufacturers.[8] There is an almost complete black box over the prices of drugs and the rebates paid back out as funds flow from the manufacturer through the PBMs to the insurer . In fact, Aetna has accused CVS/Caremark of keeping all of the discounts it negotiates with manufacturers while charging Aetna full price.[9]

Real competition between PBMs would give them a greater incentive to demonstrate value to the insurance companies that have hired them, because those insurance companies would have other PBMs to turn to. Aetna has hired CVS/Caremark as its PBM; for now, it could decide to fire CVS/Caremark if it does not receive good service in favor of managing its own pharmacy benefits or using a CVS/Caremark competitor. That could change if Aetna is purchased by CVS/Caremark. If competition is the best strategy for getting full value out of PBMs, then the CVS/Caremark-Aetna deal could be negative for consumers.

On the other hand, the PBM market is already so consolidated that this effect would be small. It is not clear that there is any benefit to the existence of external PBMs even if the government protects what little competition currently exists. The CVS/Caremark-Aetna merger could be a sign that the model of external PBMs is being replaced by one where insurers use in-house PBMs.[10] That evolution could benefit consumers, if it meant that insurers were paying less for drugs and then passing on their savings to consumers.

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[7] Austin Frakt, "Why the CVS-Aetna Merger Could Benefit Consumers," New York Times, December 3, 2017, https://www.nytimes.com/2017/12/03/upshot/why-the-giant-cvs-aetna-merger-could-benefit-consumers.html?_r=0.

[8] Frakt.

[9] Susan Morse, Aetna whistleblower accuses CVS Health's Caremark of fraud in Medicare Part D drug prices, Healthcaer Finance, April 10, 2018, http://www.healthcarefinancenews.com/news/aetna-whistleblower-accuses-cvs-healths-caremark-fraud-medicare-part-d-drug-prices.

[10] Frakt.

In addition, to the extent that PBMs become in-house operations for insurers, it may subject them to more of the rules applicable to insurers, which could benefit consumers. For example, right now it is not standard practice of many PBMs to issue Explanation of Benefit forms when consumers fill prescriptions. Consumers are deprived of a record of what they have spent, how their copayment is computed, and what cost the PBM has attributed to the drug they have purchased. Integrating PBMs more closely into insurers should subject PBMs to greater consumer protections.

IV. Merging an insurance company with a provider undermines medical loss ratio requirements, an important strategy for keeping costs down for consumers.

The medical loss ratio is a limit on how much of its revenue an insurer can spend on anything other than medical care. It is a way of ensuring that premium increases are tied to actual costs of care instead of insurance company profits.

The structure of the medical loss ratio already creates some incentives for insurers to accept higher prices. Insurers are allowed to keep a percentage of their total premium revenue for administrative costs and profits. If they are allowed to raise premiums to cover increased medical costs, the amount they can keep for administrative costs, including profits, goes up as well. In other words, they can make more money by paying higher prices to providers for services and goods like drugs, and in turn charge customers more.

A merger between a provider (such as MinuteClinic) and an insurer adds yet another incentive to raise prices. If Aetna and CVS/Caremark merge, Aetna can pay higher prices for services provided to members through CVS/Caremark, thus increasing profits on the care providing side. It can use those higher prices to help meet its minimum medical loss ratio requirement. And since those higher prices will register as an increased cost of medical care, even though no additional care was provided to Aetna members, it can then say that costs for medical services have gone up and raise its premiums.

When there is a separation between providers and insurance companies, insurance companies play an important role in keeping prices down despite some shortfalls of the medical loss ratio rule. They negotiate with providers to add them to their networks for the lowest prices, ultimately benefiting consumers. When there is no separation, the insurer has an overwhelming conflict of interest. Its incentive is to raise the prices it pays to providers – because the rates ultimately profit the same corporate entity.

Conclusion

Many of the effects of the contemplated merger are difficult to predict, with potential benefits to consumers we have identified above as well as potential detriments. However, it is difficult to see an upside to the conflict of interest introduced when the insurer charged with controlling costs will benefit in another part of its operations from increasing those costs.

Nevertheless, it is possible that federal regulators will approve the merger. If the merger is permitted to take place, it must be accompanied by conditions that address the potential harm, including new, stronger consumer protections. New York should prepare to scrutinize the merger carefully and impose those conditions if federal actions are insufficient.

Thank you again for conducting this hearing and seeking to increase the public's knowledge on such an important matter. The public is depending on government leaders to ask these questions and we commend you for taking this step to protect consumers.