1 STATE OF CALIFORNIA
2 DEPARTMENT OF INSURANCE
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10 PUBLIC HEARING
11 REGARDING THE PROPOSED MERGER OF
12 AETNA INC. INTO CVS HEALTH CORPORATION
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STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

PUBLIC HEARING
REGARDING THE PROPOSED MERGER OF
AETNA INC. INTO CVS HEALTH CORPORATION

Transcript of proceedings, taken at California Department of Insurance, Hearing Room, 22nd Floor, 43 Fremont Street, San Francisco, California 94105, commencing at 10:24 a.m., Tuesday, June 19, 2018, before Andrea F. Dance, CSR No. 12865.

A P P E A R A N C E S:

INSURANCE COMMISSIONER DAVE JONES
DEPUTY INSURANCE COMMISSIONER JANICE ROCCO
SENIOR COUNSEL BRUCE HINZE

WITH CVS HEALTH:
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ELIZABETH FERGUSON, Deputy General Counsel CVS Health

WITH AETNA INC.
KRISTEN MIRANDA, President of California, Head of Western Territory

PAUL WINGLE, Vice President of Operations, Product and Technology

ACADEMIC WITNESSES:

THOMAS GREANEY, JD, UC Hastings
RICHARD SCHEFFLER, PhD, UC Berkeley
NEERAJ SOOD, PhD, Sol Price School of Public Policy, USC
DIANA MOSS (Telephonically) PhD, American Antitrust Institute
LAWTON BURNS, PhD, Wharton

PROVIDER WITNESSES:

BARBARA MCANENY, MD, President of the American Medical Association
LONG DO, Legal Counsel, California Medical Association

CONSUMER WITNESSES:
DENA MENDLESON, Senior Attorney, Consumers Union

YASMIN PELED, Health Access California
BEN POWELL, Litigation Attorney, Consumer Watchdog

PUBLIC COMMENTS:
TANYA STEVENSON, MD, CEO of Breathe California
JULIAN CANETTI, President California Hispanic Chamber
BOB GORDON, American Cancer Society Cancer Action Network
ANTHONY GALACE, Bridges to Health Director, Greenlining

SAN FRANCISCO, CA; TUESDAY, JUNE 19, 2018; 10:24 A.M.

COMMISSIONER JONES: Good morning, and welcome to the California Department of Insurance. My name is Dave Jones, and I have the privilege of serving as California's Insurance Commissioner, where the Department and I regulate the largest insurance market in the United States, where insurers collect over $300 billion dollars a year in premium, have about $5.5 trillion dollars assets under management, provide all sorts of necessary and critically important insurance products to Californians, California's families, and California's businesses.

We have a court reporter present who will be transcribing today's proceedings. I'm going to try to talk clearly and deliberately, although I do have a tendency to go really super fast, and so I encourage the court reporter to throw a flag if I'm going too quickly or if any of you are going too quickly.

And of course I'm sure we'll very quickly in to insurance speak, and that more uniquely arcane language health insurance speak, with lots of great acronyms and buzzwords which will challenge our court reporter to no end, and so I encourage her to throw a flag and stop us if we use some acronym or buzzword that

1 requires further elaboration.
2 I want to welcome all of you here today.
3 We're also live streaming this as well, so that those
4 that were not able to join us in our very crowded
5 hearing room could participate, too.
6 With me is Janice Rocco, the Deputy
7 Commissioner for health reform and health policy at the
8 Department of Insurance, and Mr. Bruce Hinze, our Senior
9 Counsel on all health insurance matters.
10 So I want to begin by welcoming as well, the
11 representatives from Aetna and CVS Health, as well as
12 all of the members of the public from whom we're going
13 to have a chance to hear in a moment.
14 This public hearing is being held pursuant to
15 Insurance Code Section 12924, to examine the proposed
16 acquisition of Aetna Incorporated -- which I'll refer to
17 as "Aetna" -- by CVS Pharmacy Incorporated, a direct
18 wholly owned subsidiary of CVS Health Corporation, which
19 we'll be referring to as "CVS" throughout the
20 proceeding, in a reverse subsidiary merger.
21 And the purpose of the hearing is to look at
22 the effect of the merger on competition in the
23 California health insurance market, and its effect on
24 California consumers, their access to healthcare, access
25 to health insurance, quality of healthcare, and

1 processing of healthcare.
2 One of the things that I'm concerned about as
3 California's insurance regulator is whether or not this
4 merger will have any impacts on competition in
5 California, whether it might impair competition in any
6 way, shape, or form in California's health insurance
7 market.
8 Again, this hearing is held pursuant to
9 Insurance Code Section 12924, which provides authority
10 for such hearings, quote, "on any subject touching
11 insurance business."
12 Aetna Incorporation is a Connecticut
13 corporation, and under the holding company "at," which
14 is at Insurance Code Section 1215, etcetera. The
15 Department of Insurance does not have direct approval
16 authority over this acquisition because the transaction
17 does not involve a California domestic or commercially
18 domiciled California insurance company.
19 However, the transaction does involve an Aetna
20 subsidiary, which is licensed here in California, Aetna
21 Life Insurance Company, which provides coverage to more
22 than 1 million Californians. So certainly this merger
23 has impacts in California potentially, and is something
24 that we ought to be taking a look at and look at
25 closely.

1 As a holder of a California Insurance
2 Certificate of Authority, Aetna is obliged to comply
3 with the requirements of the Insurance Code and related
4 California laws.
5 This hearing will develop facts relevant to an
6 evaluation of the ongoing compliance with these legal
7 obligations and the potential effect of the proposed
8 merger on this compliance, its impact on consumers, and
9 its impact on healthcare and health insurance markets in
10 California.
11 As a holder of a California Insurance
12 Certificate of Authority, Aetna must adhere to the
13 licensing requirements of Insurance Code Section 717,
14 which require, among other things, that the insurance
15 commissioner must consider, first, the financial
16 condition of the company in terms of its capitol and
17 surplus, second, the claims handling practices of the
18 company, third, and I quote, "the fairness of methods of
19 doing business," and fourth, any hazards to policy
20 holders.
21 In addition, the Insurance Code prohibits
22 unfair methods of competition, that's contained in
23 section 790.03, and includes specified acts resulting in
24 unreasonable restraint of or monopoly in the business of
25 insurance.

1 So the hearing is being held pursuant to the
2 Departments of Escrutory Authority regarding these and
3 other statutes, and also so that the Department of
4 Insurance, and I as Commissioner, may provide findings
5 to other state and federal agencies regarding the
6 proposed transaction.
7 However, and I want to reiterate this,
8 regrettably the Department of Insurance does not have
9 direct approval authority over these mergers because
10 California law provides that we only have authority when
11 an acquired company is a domiciled subsidiary or
12 domiciled company that's being acquired, or whether the
13 threshold for a commercially domiciled insurer is met,
14 and it's not met in this instance.
15 In 2016 I held hearings on three other
16 mergers, the Health Net-Centene merger, the Aetna-Humana
17 merger, and Anthem-Cigna mergers. However, only with
18 the merger of Health Net with Centene did I, as of
19 Commissioner, have direct approval authority, which in
20 that case enabled the Department to require that Centene
21 agreed to a number of strict undertakings as a condition
22 of approval of the merger.
23 I do want to note that there's a bill pending
24 in the State senate, Assembly Bill 595 authored by
25 assembly Jim Wood, which would give the Department of

1 Managed Healthcare, but not the Department of Insurance,
2 expanded approval authority over mergers like the one
3 today.
4 Again, I want to reiterate to the legislature
5 that that expansion ought to apply to both of
6 California's regulatory agencies.
7 Now the three mergers of health insurers in
8 2016 involve what are called horizontal mergers; mergers
9 involving competitors in the same industry and markets.
10 The proposed Aetna-CVS merger, in contrast, is described
11 largely as a vertical merger, involving entities at
12 different levels of supply or service within the same
13 chain.
14 Vertical mergers raise competition concerns,
15 however, because if a seller owns their supplier,
16 barriers may be erected to make it difficult for other
17 sellers to use that supplier, especially if that
18 supplier has dominant market power.
19 The proposed Aetna-CVS merger raises potential
20 concerns for California health insureds markets,
21 healthcare markets, and consumers. CVS has a dominant
22 footprint, not only in the retail pharmacy market but
23 also in the pharmacy benefit manager services market,
24 through its subsidiary CVS Caremark.
25 As a PBM, CVS Caremark acts as an intermediary

1 in the drug distribution chain by negotiating prices
2 with drug companies and receiving rebates from them
3 while also establishing networks and formularies for
4 health insurers.
5 Consolidating the retail and PBM services of
6 CVS with a major health insurer may have an adverse
7 effect on the ability of other health insurers to
8 compete in or enter the California health insurance
9 market. Such anticompetitive impacts could hurt
10 California consumers. So this hearing will investigate
11 those potential effects.
12 Now before we begin discussion of those
13 effects and hear directly from the two companies
14 involved and all the other witnesses that have asked to
15 testify, I would like to mention that in February the
16 Department initiated investigation into Aetna Life
17 Insurance Company's processes for prior authorization,
18 utilization management, and medical director review.
19 Information gained through that initial
20 investigation indicated the need for a targeted market
21 conduct examination of these areas, which commenced in
22 March.
23 Our final reports of examination of any unfair
24 or deceptive practices in insurance are public documents
25 pursuant to Insurance Code Section 12938(b).

1 However, that market conduct examination is
2 still ongoing, and while it is ongoing the information
3 related to it remains confidential at this time and will
4 not be discussed as a part of this proceeding. So I
5 thought it important to be very explicit about that
6 particular matter.
7 With that, I would like to invite the
8 representatives of Aetna and CVS please to come forward,
9 and I understand that we'll have a slight change in
10 order of presentation from that indicated in our agenda,
11 and we're happy to accommodate that.
12 It's my understanding that the representatives
13 of CVS would like to speak first, to be followed by the
14 representatives of Aetna. So welcome.
15 there's also a very nice pot of tea that has
16 been brewed by our special counsel Bruce Hinze, and I
17 can vouch for its quality and magical elixir effects, so
18 you're welcome to have some of that. And then I see you
19 also brought other beverages as well, so that's good.
20 Nonalcoholic, of course.
21 So welcome. Please do introduce yourselves,
22 and then we'll hear first from CVS and then from Aetna.
23 MR. MORIARTY: My name is Elizabeth Ferguson.
24 I'm the deputy general counsel at CVS Health --
25 COMMISSIONER JONES: Make sure to push the

1 little button on the front of the microphone. It should
2 be green to indicate it's on.
3 MR. MORIARTY: Hi. My name's Elizabeth
4 Ferguson. I'm the deputy general counsel of CVS Health.
5 Thank you.
6 COMMISSIONER JONES: Welcome.
7 MS. MIRANDA: Good morning. I'm Kristin
8 Miranda. I'm the California market president and the
9 west territory head for Aetna.
10 COMMISSIONER JONES: Welcome.
11 MS. MIRANDA: Thank you.
12 MR. WINGLE: My name is Paul Wingle, and I'm
13 vice president for Operations, Product and Technology
14 for Aetna.
15 COMMISSIONER JONES: Welcome.
16 MR. MORIARTY: Commissioner, my name is Tom
17 Moriarty. I'm executive vice president, chief policy
18 and external affairs officer, and general counsel for
19 CVS Health.
20 COMMISSIONER JONES: Excellent. Well thank
21 you all for attending the hearing, and we look forward
22 to your testimony after which I'll have some questions,
23 Ms. Rocco will have some questions, and then from there
24 we'll proceed accordingly through the agenda.
25 But whoever would like to start, could please

1 do so.
2 MR. MORIARTY: I'll start. Thank you, sir,
3 for your consideration of letting us go first.
4 But first I would like to thank you,
5 Commissioner Jones, and your staff for having me here
6 today to discuss CVS Health's proposed combination with
7 Aetna. And I also want to thank you, sir, for your
8 leadership to this state.
9 Most of you know us as the local pharmacy in
10 your community, but we really are more than that. We
11 are a front door to a path to better health. We have
12 long been at the forefront of putting our patients'
13 health first and improving the public health of our
14 communities.
15 Over the past few years we have taken bold
16 steps that define us as a company. We have removed
17 tobacco from our stores, we are promoting healthier food
18 options, and we have been waging a multi-front fight
19 against the opioid epidemic.
20 CVS Caremark, our PBM, was the first to
21 implement a program to ensure that opioids are being
22 prescribed and used appropriately, consistent with
23 centers for disease control and prevention guidelines.
24 Our Pharmacist Teach Program brings local
25 pharmacists to schools to talk to students about their

1 choices and the dangers of opioid abuse.
2 We have done more than 8000 presentations
3 nationally, touching almost 400,000 students including
4 over 1000 presentations here in California touching over
5 62,000 students, and our pharmacists are eager to help
6 for more.
7 CVS Health has donated more than 900
8 medication disposal units to police stations in 43
9 states, over 159 metric tons -- that's over 350,000
10 pounds -- of unwanted medications that could otherwise
11 have been diverted, misused or abused, have been
12 collected and safely disposed of through this program in
13 just the last two years.
14 We have now expanded our program to bring 756
15 disposal units into our retail pharmacies nationally as
16 well, bringing our total to date to 83 disposal units
17 here in the state of California.
18 Nationwide the high cost of prescription drugs
19 is one of the nation's most pressing problems and a
20 major source of financial worry for consumers here in
21 California, and across the nation.
22 To address the high cost of prescription
23 drugs, CVS Health is giving expanded tools to patients,
24 prescribers, and pharmacists so they can evaluate
25 prescription drug coverage in real time and identify

1 lower cost alternatives.
2 We are offering more pricing transparency for
3 prescribers, pharmacists, and patients as part of our
4 commitment to helping consumers find the lowest cost
5 prescription drugs. This includes the new CVS
6 pharmacies, RX Savings Finder, which will enable the
7 company's retail pharmacist, for the first time, to
8 quickly and seamlessly evaluate individual prescription
9 saving opportunities right at the pharmacy counter.
10 But we have gone even further, by giving
11 physicians actual transparency that they can use with
12 their patients to help find lower cost drugs by
13 providing real time member specific information through
14 their electronic health records system at the point of
15 prescribing.
16 Early results show that prescribers accessing
17 the real time benefits information through their EHR
18 switch their patient's drug from a non covered to a
19 formulary covered drug 85 percent of the time with an
20 average savings of $80 per prescription.
21 Our proposed combination with Aetna is a
22 natural extension of these community commitments and
23 innovations. Our healthcare system in many ways is a
24 work in progress. It was built for a different time,
25 for a different consumer with different needs. It is

1 fragmented, complex, and burdensome for consumers and
2 providers, and it is unsustainably expensive. It faces
3 huge demographic and chronic care challenges, and too
4 often the tug of war between entities with conflicting
5 incentives means that the patient is not always being
6 looked at holistically with the goal of preventing
7 disease and improving their health.
8 Our vision is to create a new, open healthcare
9 model that will help consumers improve their health and
10 simplify their healthcare experience.
11 I would like to highlight three ways this
12 transaction will help facilitate this vision to benefit
13 the California consumers.
14 First, we will put consumers at the center of
15 their care. Consumers are looking for more value,
16 greater convenience, and help in making healthier
17 choices in their everyday lives. This new model will
18 provide consumers the information and resources they
19 need to better manage their own health and access care
20 in more convenient community settings at an affordable
21 price. The combined company will be able to better
22 understand patients' health goals, guide them through
23 the healthcare system, and help them achieve their best
24 health.
25 It will also mean expanded opportunities to

1 bring appropriate healthcare services to consumers every
2 day, where and when it is convenient for them and to
3 complement the care provided by their physician and
4 medical teams so they have the support they need to stay
5 healthy between physician office visits.
6 Second, we will focus on prevention, primary
7 care, and chronic conditions. The combination of our
8 companies will giving physicians, and us, a more
9 holistic view of a patient's health. On average
10 patients see their pharmacists much more often then they
11 see their doctor, and many patients see multiple
12 physicians, but only see one pharmacist.
13 We hope to build on that point of continuity
14 by having pharmacists engage patients early and often,
15 to help prevent and manage illness much more
16 effectively. Programs including one-on-one counseling
17 between a patient and a pharmacist are two-to-three
18 times more effective at improving medication adherence
19 than other interventions and result in a cost savings of
20 $6 for every $1 invested.
21 Pharmacists want to practice at the top of
22 their license and help patients on their path to better
23 health. By combining pharmacy and medical information,
24 pharmacists will be better able to help coordinate
25 population health, provide information from the doctor

1 to the patient at the pharmacy counter, and give
2 patients tools to more effectively manage their health,
3 which will patients on track with their physician care
4 plans in between physician office visits.
5 Because of Aetna's broad healthcare provider
6 networks, the combination with Aetna will provide the
7 framework for us to build better communication
8 technology between doctor, pharmacy, and patient, which
9 we will then make available more broadly through other
10 health plan providers nationally.
11 And third, we will find ways to address the
12 rising cost of healthcare. Aging populations and the
13 rise of chronic conditions such as diabetes and heart
14 disease are two of the biggest trends threatening to
15 bankrupt our current system.
16 Diabetes is one key area where we have an
17 opportunity to reshape the delivery of care. An
18 estimated 10.7 million California residents, or
19 38 percent of the population, have prediabetes. As a
20 combined company, we will be able to achieve the highest
21 potential in proactively helping our patients avoid the
22 complication of diabetes.
23 For example, with our combined assets we will
24 be able to deliver preventative counseling for
25 prediabetics, provide more frequent interactions and

1 counseling once a diabetic is diagnosed, and be able to
2 more effectively deploy digital tools that make it more
3 convenient for patients to manage their care.
4 For patients this will mean enhanced care in
5 between physician visits. For example, through
6 face-to-face counseling with their pharmacists who sees
7 them more regularly. Expanded use of digital tools such
8 as remote monitoring of key indicators such as blood
9 glucose levels. When needed, patients would receive
10 text messages to let them know when their glucose levels
11 deviate from normal ranges. Follow-up care such as
12 personalized counseling on how to manage medications
13 safely and effectively. Information on where to pick up
14 diabetes related supplies, and counseling on weight loss
15 and programs designed to address diabetes through
16 nutrition.
17 Today these types of interventions are often
18 offered in an ad hoc or fragmented way that aren't
19 convenient or seamless for consumers. As a combined
20 entity, we will seek to better coordinate and support
21 the care that consumers are seeking across all
22 healthcare settings.
23 Put simply, to make real progress on behalf of
24 consumers and the healthcare system, we have to break
25 the current logjam. We know health can only improve if

1 consumers are connected to support from their providers
2 and pharmacists who live in their communities and
3 understand their personal experiences. That is also why
4 current Aetna members will continue to have access to a
5 broad range of pharmacy options, both chains and
6 independents.
7 Healthcare, like politics, is very local. In
8 the state of California we have over 1100 pharmacies,
9 27,000 employees, and last year filled over 103 million
10 prescriptions, and handled over 96 million claims. Our
11 3,674 pharmacists work with Californians every day to
12 help them on their path to better health.
13 At 57 doctor owned MinuteClinics in
14 California, the nurse practitioners diagnose and treat a
15 variety of lower acuity health conditions, perform
16 health screenings, monitor chronic conditions, provide
17 wellness services, and deliver vaccinations.
18 MinuteClinic is proud to be the first retail
19 clinic provider to earn accreditation from the Joint
20 Commission. MinuteClinics play an important role in
21 filling gaps in care. About half of the patients who
22 come in to a MinuteClinic, do not currently have a
23 primary care provider. Our first step is to provide the
24 patient with a list of physicians in their area who are
25 accepting referrals. In the past year alone we have

1 made three-and-a-half million physician referrals for
2 the MinuteClinic patients who did not have a primary
3 care physician when they visited.
4 About half also come to MinuteClinic on
5 evenings and weekends when primary care is less
6 accessible. As a recent Consumers Report article on the
7 use of urgent care and walk-in clinics states, quote,
8 "When used properly, these newer options can make it
9 easier for to get the care you need, when you need it,
10 and save you time and money, too." End quote.
11 A patient with the flu who does not have a
12 physician can get convenient, inexpensive care at a
13 retail clinic even on the weekend before their condition
14 worsens. This can prevent a costly emergency room visit
15 or costly hospitalization, improving health and saving
16 resources for both consumers and the entire healthcare
17 system.
18 One peer reviewed study of CVS Health's own
19 employees show that those who use MinuteClinic had
20 8 percent lower overall healthcare costs compared to
21 matched nonusers.
22 Before I answer the six specific questions the
23 Commissioner has asked us to address during this
24 hearing, I would note that later today you are going to
25 hear testimony from Consumer Watchdog. As you are

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1 aware, we are in active litigation with this group, and
2 this is not the appropriate forum to discuss that
3 litigation.
4 However, I need to point out that Caremark
5 offers a range of network options to its clients,
6 including networks that allow patients to access HIV
7 drugs at local independent pharmacies.
8 Our highest priority is assuring patient
9 access to clinically appropriate drugs while managing
10 overall healthcare costs for our clients, and we offer
11 our clients multiple clinical tools and pharmacy network
12 options targeted at achieving both of these goals. This
13 includes an option for clients to allow their members
14 with HIV to fill their HIV-related medications at
15 in-network local independent pharmacies and other
16 national chain retail pharmacies.
17 Turning to the six specific questions. The
18 first question asked is, quote, "What will be the effect
19 of the proposed merger on competition in the California
20 health coverage market?" End quote.
21 Competition within each of these segments in
22 which we operate, which are PBMs, pharmacies, and
23 insurers, is fierce and will remain so. The healthcare
24 sector will continue to attract significant investment
25 from companies entering and expanding. We believe

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1 competition in California will remain robust to the
2 benefit of patients and payers.
3 There is a track record of successful PBM and
4 health insurer combinations today. That track records
5 collides United Healthcare and Optum RX, which is a
6 leading health insurer and fast growing top three PBM.
7 Humana, which is a leading health insurer and
8 top five PBM.
9 Prime Therapeutics, which is a top five PBM
10 owned by over a dozen Blue Cross Blue Shield plans.
11 And Anthem, the second largest health insurer
12 in this country, which recently announced its plans to
13 launch a new PBM business called IngenioRX.
14 This is a complementary transaction with
15 minimal overlap in Medicare Part D. Our businesses and
16 areas of expertise differ. Our acquisition of Aetna
17 does not further concentrate the healthcare sector.
18 Instead, it reconfigures it to bring together disparate
19 parts of the healthcare system that today lead to
20 inefficient, ineffective, and more costly care.
21 The healthcare sector will not be losing a
22 pharmacy, it will not be losing a health plan, and it
23 will not be losing a PBM. No player leaves the field.
24 With respect to CVS and Aetna, since 2011 we
25 have been a party to a seven year agreement under which

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1 CVS provides PBM services to Aetna.
2 The second question asked is, quote, "What
3 will be the effect of the proposed merger on consumer
4 premiums and out-of-pocket healthcare costs."
5 Integrative pharmacy and medical information
6 will allow us to engage with the patient early and more
7 often and provide preventive care that can help avoid
8 the need for more serious and costly interventions.
9 The combination of our pharmacy services with
10 Aetna's expertise and medical benefits will
11 significantly improve our ability to help patients
12 manage their chronic illnesses. Failures of care
13 coordination cost the healthcare system 35 billion
14 dollars per year.
15 Similarly, there are some 60 billion in
16 savings in hyperlipidemia if patients were 95 percent
17 adherent to their medications. There are over 20
18 billion in avoidable healthcare costs in severe asthma.
19 If we can even address a small portion of
20 failure of care in these populations, we will be able to
21 reduce healthcare costs for payers and consumers
22 significantly. Further, the combination will also allow
23 us to explore new benefits designs with zero copays or
24 reduced cost sharing. Cost savings from this
25 transaction will allow us to be even more competitive

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1 with our peers, ultimately passing on additional savings
2 to consumers, including employers.
3 We will pass along cost savings to our
4 consumers in two ways. First, as our costs go down,
5 consumers will see the benefits in terms of premiums
6 that will be lower than they would be otherwise.
7 Second, we intend to invest these savings into
8 improving the quality of services we offer to consumers,
9 thus these cost savings will improve our consumers
10 experiences in ways beyond merely the cost of their
11 premiums.
12 The third question asked is, quote, "What will
13 be the effect of the proposed merger on provider and
14 facility network, contracting, and on consumer choice of
15 and access to providers?" End quote.
16 Importantly, Aetna plan members will continue
17 to be able to see their primary care physicians and fill
18 prescriptions at non CVS pharmacies as they do today.
19 Our customers expect Aetna to provide access
20 to a diverse network of healthcare professionals and
21 pharmacies. Closing or severely restricting our network
22 would be bad for our business. We will ensure that our
23 incentives are aligned to provide the highest quality
24 plans, highest access, and greatest cost savings for our
25 beneficiaries. We do not plan to change to this.

1 The fourth question asked is, quote, "What
2 will be the effect of the proposed merger on network
3 design, including on the ability of consumers to
4 continue to receive care from their current providers on
5 an in-network basis?" End quote.
6 At present we have no intention to make
7 changes in the plans provider network after the closing
8 date other than changes in the normal course of
9 business. Consumers are protected as any changes that
10 are contemplated in the future must comply with
11 California regulations and requirements.
12 Post transaction, we will strengthen
13 relationships with providers. We want to fortify the
14 provider-patient relationship while making outcomes
15 better and more affordable.
16 Aetna requires our Medicare members, and
17 encourages all members, to have a primary care
18 physician. We will continue to do that. About half of
19 the patients who come to MinuteClinic, as I mentioned,
20 do not currently have a primary care provider.
21 MinuteClinic providers counsel patients about
22 the importance of having a primary care provider and
23 provides patients with a list of physicians in their
24 area. Connecting physicians and patients is an
25 important role MinuteClinic and CVS Health play today

1 and will continue to play in the future.
2 Additionally, MinuteClinic currently has
3 affiliations with 70 health systems nationally, a
4 further indication of our commitment to the importance
5 of supporting the care management system prescribed by
6 the treating information.
7 The fifth question is, quote, "What
8 efficiencies, if any, are expected from the proposed
9 merger and what are their implications for the cost and
10 quality of care delivered to consumers?" End quote.
11 CVS Health projects that it will achieve
12 approximately $750 million in annual recurring savings
13 shortly after closing this transaction. These near-term
14 benefits will include substantial savings in the form of
15 medical cost reductions from improved care management.
16 Over the longer term, or within three-to-five
17 years, the transaction is expected to result in further
18 reduction in medical costs. One of the most significant
19 opportunities for obtaining those savings is through the
20 improved coordinated chronic care management that CVS
21 Health will be better able to integrate as a result of
22 the proposed transaction.
23 Patients with at least one chronic condition,
24 such as diabetes, heart disease, or cancer, account for
25 more than 80 percent of all hospital admissions and more

1 than 90 percent of all prescriptions filled.
2 The combined company will be able to better
3 manage medical costs for chronic patients by providing
4 them, first, better coordination of care across
5 providers, including physicians, and, two, post
6 discharge support to increase medication adherence and
7 reduce hospital readmissions. Three, increase patient
8 engagement at the pharmacy, at a walk-in clinic, or in
9 their home, to supplement physician office visits. And,
10 four, greater access to care through convenient, lower
11 cost sites of care.
12 The expected improvement in health outcomes
13 and reduction in spending will benefit members and the
14 healthcare system overall.
15 The shorter terms savings will also include
16 lower costs resulting from the combining of the
17 companies operations in the PBM and Medicare areas and
18 the streamlining of redundant corporate functions.
19 There will be no changes, however, to Aetna's licensed
20 insurance company operations at closing.
21 The sixth and last question asked is, quote,
22 "What will be the competitive effects of a vertical
23 merger in the health insurance retail pharmacy and
24 pharmacy benefit manager PBM markets, including barriers
25 to entry by competitors, elimination of Aetna as a

1 potential PBM competitor, and effects on network and PBM
2 service contracting by competitors, on competitor PBM
3 data utilization, and on pharmaceutical costs borne by
4 insurance consumers.
5 This is a complementary transaction, sir. Our
6 businesses and areas of expertise differ. Our
7 acquisition of Aetna does not further concentrate the
8 healthcare sector. Instead, it reconfigures it to bring
9 together disparate parts of the healthcare system that
10 today lead to ineffective and more costly care.
11 The healthcare sector will not be losing a
12 pharmacy, health plan, or PBM, as I noted earlier.
13 CVS Health services will continue to be fully
14 available to other health plans here in California, and
15 nationally. This includes PBM services and pharmacy
16 services. In fact 88-to-89 percent of CVS Health
17 revenue come from the services we provide to health
18 plans other than Aetna across this country.
19 These continued revenues are critical for us
20 to maintain and a fundamental guiding principal for our
21 business going forward. We will continue to provide
22 services to other health plans, employers and unions,
23 and we will work with pharmacies across the country,
24 independents and chain, to build networks across
25 California and across the country. This has been CVS

1 Health's commitment in the past, and it will continue
2 going forward.
3 For example, even those CVS Caremark health
4 plan clients offer Part D services that compete with
5 Silver Script, CVS Caremark has provided the highest
6 level of PBM services to those health plans. In fact,
7 we know from our experience with Silver Script, our
8 standalone Part D prescription drug plan, that we can
9 take innovations learned there, and offer them to our
10 other clients.
11 That is why, for example, 83 percent of CVS
12 Caremark's Medicare Part D clients have star ratings of
13 four and five, and have seen significant improvements in
14 these ratings.
15 That is the exact model we envision for the
16 combined company, and we will be offering our
17 innovations on an open platform.
18 With respect to the effects on competitor PBM
19 data utilization, CVS Health currently operates with a
20 number of firewalls in place to ensure the proper use of
21 its customers' information. For example, Caremark has
22 long provided PBM services to Medicare Part D Plan
23 sponsors that compete with Silver Script, as I noted,
24 and we have sufficient and affective firewalls without
25 incident or complaint in the operation of those

1 businesses.
2 In addition, health plans, including Aetna,
3 impose similar restrictions on Caremark as a condition
4 of doing business. Beyond our firewalls and (inaudible)
5 limitations, we also have a commercial imperative to
6 protect our consumers and suppliers' confidential
7 information. Failing to do so would risk loss of an
8 enormous amount of business for us.
9 With respect to the effects of pharmaceutical
10 costs borne by insurance consumers, let me start by
11 saying first that drug prices are set by the
12 pharmaceutical manufacturers. We believe combining drug
13 and medical benefits in the same place will allow payers
14 to determine whether expensive new drugs are actually
15 making people better and saving money by keeping them
16 out of the hospital.
17 This information will help reduce the use of
18 expensive drugs that are not resulting in better
19 outcomes, and contributing to lower overall healthcare
20 costs.
21 At CVS Health, we work every day to lower the
22 price consumers pay for their medicines. For example,
23 we offer point of sale rebates to our clients, and
24 currently have 10 million lives that are enrolled in
25 these plans, which gives consumers the direct benefit of

1 the negotiated drug price.
2 We also offer our clients plans, as we do to
3 our CVS Health employees, where maintenance medications,
4 including insulin and generic drugs, are provided at no
5 copay. Importantly, as I noted earlier, we are bringing
6 actual transparency to the physician's office and to the
7 pharmacy counter to help consumers choose lower cost
8 medications.
9 That completes our answers to the six
10 questions and we look forward to answering questions
11 during the Q and A.
12 But before I turn and close, we are pleased
13 that our proposed transaction is also supported by a
14 wide range of California providers including the
15 National Hispanic Medical Association, Memorial Care,
16 Cedar Sinai, and Venice Family Clinic, and community
17 leaders such as the mayor of Fresno and the California
18 Hispanic Chambers of Commerce.
19 These organizations and many others have
20 provided testimony on our behalf at a prior hearing, and
21 several of them will be here sharing their views with
22 the Department. We are grateful for their support.
23 In closing, we are confidential that our
24 acquisition of Aetna will enhance competition in the
25 healthcare marketplace by creating significant consumer

1 benefits and spurring innovation in an industry that
2 disparately needs it. By integrating medical and
3 pharmacy information and enhancing local services, the
4 merger will deliver significant value to California
5 consumers.
6 Competition in the PBM industry is robust, and
7 will continue to be so after this merger. The merger
8 does not eliminate a competitor. Competition in the
9 pharmacy industry also continues to thrive. This is
10 especially true for independent pharmacies. Recognizing
11 the important role that these independent pharmacies
12 play in providing affordable pharmacy access to patients
13 here in California, independents comprise some
14 41 percent of our networks.
15 Finally, competition in the Part D business
16 will continue to be healthy as well, with several
17 Fortune 500 competitors, including Anthem, Cigna,
18 Express Scripts, Humana, Rite Aid, United Health, and
19 Wealthcare.
20 In the face of this competition, the
21 transaction will enable our companies to combine our
22 complementary expertise and lower our costs in order to
23 offer even more competitive Part D plans and Medicare
24 Advantage plans to seniors.
25 We believe that integration in healthcare

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1 communities is one key aspect of solving rising
2 healthcare costs and reducing the complexity consumers
3 face in the current system. Adding a full range of
4 pharmacy, pharmacy benefit management, and MinuteClinic
5 services to an integrated health plan, goes beyond the
6 existing business models and will further transform
7 delivery of care.
8 This transaction is about bringing two
9 complementary businesses to create an innovative, new
10 healthcare platform that is easy to use, less expensive
11 for consumers, and that partners with local healthcare
12 providers to deliver superior coordinated care. It's
13 about fulfilling an evolution of our vision and our
14 commitment to better health and healthcare.
15 Thank you for the opportunity to speak with
16 you this morning, and you will hear next from Kristen
17 Miranda, who will share Aetna's perspective on the
18 benefits of the proposed transaction.
19 Thank you again.
20 COMMISSIONER JONES: Thank you, Mr. Moriarty.
21 MS. MIRANDA: Great. Thank you, and good
22 morning.
23 Just to reiterate, my name is Kristen Miranda,
24 I'm the California market president for Aetna. And I'd
25 like to echo Tom's appreciation to you, Commissioner,

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1 for having us here this morning to talk about a proposed
2 transaction that Aetna is incredibly excited about.
3 We see this as really the next and most
4 important step in Aetna's journey to put consumers at
5 the center of their own healthcare. On a somewhat
6 personal note, as someone who has spent her entire
7 career trying very hard to make improvements in a
8 healthcare system that is largely broken, much of that
9 work done right here in California, I see the proposed
10 coming together of CVS and Aetna as one of the most
11 promising developments in healthcare in a while.
12 Aetna's a national company as you know, but
13 our roots here in California go deep. We have been here
14 for over a century, and as just one example, in the 1906
15 San Francisco earthquake, Aetna was there, we paid out
16 about 3 million in claims. Since that time we've
17 evolved from a life and accident coverage into a
18 healthcare company with a focus on medical coverage.
19 Today in California we serve approximately
20 1.4 million medical members through various product and
21 funding arrangements. Or workforce here in California
22 is about 2600 associates, 1400 of whom work across nine
23 offices in the state, the other 1200 work from home. We
24 span the geography here in California with offices in
25 San Francisco, Sacramento, Walnut Creek. In southern

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1 California we go from San Diego go up to Orange County
2 to Los Angeles and Woodland Hills.
3 In the central valley, I'm especially proud to
4 call out that we have a facility there that has about
5 1100 employees in the city of Fresno, which makes us one
6 of the largest private employers in that community.
7 Fresno, as you probably know, is a city with an
8 unemployment rate of approximately 7.6 percent, almost
9 double the national average. It means something to us
10 at Aetna that we are embedded in that community and able
11 to give something back in terms of jobs and opportunity.
12 I'm going to touch briefly on Aetna's products
13 both nationally and here in California. We currently
14 serve approximately 38 million people nationally, with
15 information and resources that help them make better
16 informed decisions about their healthcare. We offer a
17 broad range of traditional, voluntary, and consumer
18 directed health insurance products including medical,
19 pharmacy, dental, behavioral health, Medicaid, and
20 workers' comp options.
21 Here in California, Aetna serves multiple
22 employer segments ranging from large multisite national
23 customers to 100-and-below small group employers. We're
24 fortunate to serve beneficiaries in the Medicare
25 Advantage market, and most recently, effective the

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1 beginning of this year, Aetna entered both San Diego and
2 Sacramento counties for MediCal. We are thrilled to be
3 able to serve that vitally important market.
4 As of March of this year, approximately
5 20 percent of Aetna's 1.4 million enrollees here in
6 California are in PPO fully insured commercial products,
7 which are, of course, regulated by the Department of
8 Insurance. About 18 percent are in HMO products that
9 are, of course, regulated by the DMHC, and the remaining
10 62 percent are in self-funded PPO products regulated by
11 the federal government.
12 As Tom indicated, the status quo in healthcare
13 is not working. We have an incredibly fragmented,
14 siloed system that is much too expensive and much too
15 complicated to navigate through. This is true not just
16 across the country, but here in California as well.
17 Today's healthcare system is largely designed
18 to fix people when they are broken, not keep them
19 healthy and active throughout their lives. It's focused
20 on delivering new clinical capabilities, but research
21 clearly now shows that a full 60 percent of the factors
22 leading to premature death have nothing to do with the
23 care that a patient receives in a physician's office, in
24 a hospital, or even related to their genetics.
25 The 60 percent of factors that we can no

1 longer ignore are the social and environmental factors
2 that are critical to overall wellbeing. The unfortunate
3 realty today is that your zip code has a direct and
4 often profound impact on your wellbeing and you health
5 status.
6 The US News and World Report recently, in
7 partnership with Aetna's foundation, conducted a study
8 ranking the 500 healthiest communities in America. Many
9 communities here in California made the list, Marin
10 County, Placer, Santa Clara, just to name a couple.
11 Unfortunately, these communities stand in
12 sharp contrast to other California counties that are
13 struggling with variable issues related to the social
14 determents of health. So for us, the coming together of
15 CVS and Aetna represents a meaningful opportunity for
16 this combined company to make a significant difference
17 in this landscape, to improve the healthcare delivery
18 system at the most local level.
19 Together CVS and Aetna will work to create an
20 improved healthcare experience for consumers, with
21 expanded access that meets consumers where and when they
22 need to be met. We plan to combine CVS' broad retail
23 footprint with Aetna's analytical capabilities,
24 predictive modeling tools, our extensive network of
25 physicians, hospitals, and other medical professionals.

1 Our goal is to create a consumer centric
2 model. One that is embedded in the local community,
3 those that we jointly serve, and one that enables us to
4 learn more about the health needs and ambitions of the
5 individuals that we serve.
6 This is not something that Aetna can do on its
7 own, but this transaction gives us the opportunity to
8 become a new front door to the healthcare system,
9 meeting patients where they are and engaging them. This
10 is why, from Aetna's perspective, the combination of our
11 two companies is so compelling.
12 I want to spend a minute talking about the
13 incredibly important physician-patient relationship. As
14 a healthcare company, Aetna understands and deeply
15 respects the important primacy of that relationship.
16 Our new company certainly won't seek in any way to
17 diminish that, in fact quite the opposite. We actually
18 believe that the physician-patient connection will be
19 strengthened as our enrollees will have additional
20 resources to support their healthcare needs in their
21 local communities.
22 As Tom noted, there are no proposed changes in
23 our provider contracts at this time, other than those
24 that would come up as just the normal course of
25 business. We would certainly discuss any proposed

1 future changes, as appropriate, with state regulators.
2 Our provider partners are, in fact, central to
3 the work that we do at Aetna and to the value that we
4 bring our customers. This transactions will not affect
5 Aetna's networks or our network designs. We believe at
6 Aetna that strong collaborative relationships with
7 hospitals and physicians coupled with member engagement
8 capabilities are our keys to driving value to consumers
9 in California.
10 Our national goal is to have 75 percent of our
11 provider reimbursements in value-based models by 2020,
12 and I'm proud that Aetna has played a significant
13 leadership role across the country and here in
14 California, in not only supporting but in driving that
15 important transformation.
16 In California our ACO partnerships range from
17 Memorial Care, who serves customers of ours in Los
18 Angeles and Orange counties, to Providence Health, to
19 Prime Care in the Inland Empire, to Sharp Health in San
20 Diego.
21 As you're aware, in northern California we
22 recently launched a joint venture with Sutter Health to
23 serve our PPO members. By bringing together the
24 clinical and medical management capabilities of these
25 sophisticated provider organizations, and coupling those

1 with what Aetna brings to the table in terms of robust
2 claims data, predictive modeling tools, and member
3 engagement capabilities, we are actively improving, we
4 believe, the health of California.
5 We also remain focused on quality. As just
6 one example, Aetna contracts today in California with 81
7 highly regarded centers of excellence. These are
8 publically recognized provider organizations that
9 deliver highly complex and specialized services to Aetna
10 customers and of course will continue to do so.
11 As important as quality and access are, cost,
12 and specifically the effect of this transaction on
13 consumer costs, is of critical importance. I'd like to
14 be very clear on this: As Tom noted, costs associated
15 with this merger will not be passed on to Aetna's
16 customers. They will not result in increased premiums,
17 increased co-pays, or increased deductibles.
18 Just as important to Aetna, is our commitment
19 to diversity and corporate social responsibility. Those
20 are core business values of ours and an important
21 element of our culture. As just one example of this
22 commitment, Aetna has been for 10 years in a row ranked
23 by Diversity Inc. as one of the top 50 companies in the
24 country.
25 We've taken specific actions to ensure that

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1 diversity is integrated in to all aspects of how we do
2 business, including diversifying our supplier base to
3 strengthen our ability to do business with suppliers who
4 represent the cultures and the geographies that we
5 serve.
6 Aetna has had a long commitment to our LGBT
7 employees and to the LGBT community at large, from being
8 one of the first companies implementing policies for
9 domestic partners to being the first major health
10 benefits company to often transgender inclusive benefits
11 to our own employees.
12 Lastly, Aetna has made a significant
13 commitment to improving the health and wellbeing of
14 Californians through our foundation, through corporate
15 giving, and through employee volunteerism. Since 2010,
16 Aetna has contributed over 7.4 million in California to
17 make improvements in health through community grants and
18 partnerships. In addition, in just the last two years,
19 Aetna employees here in California have volunteered over
20 60,000 hours to causes that are important to them and to
21 us.
22 I'd like to end by noting that Commissioner,
23 as you mentioned in the beginning, this is a vertical
24 transaction with no significant overlap in the two
25 existing businesses. The vast majority of CVS' revenues

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1 come from retail pharmacy and pharmacy benefits
2 management. Aetna is focused on health insurance and
3 does not have a retail footprint in any of the
4 communities that we severe.
5 Thus the Aetna and CVS transaction brings
6 together two innovative businesses in a sector that is
7 very much in need of change. The new company will offer
8 a local experience that is simpler to use and built
9 around consumers.
10 And with that I would just like to say, again,
11 thank you very much for having us with you today. We
12 look forward to questions.
13 COMMISSIONER JONES: Thank you very much, and
14 I appreciate your testimony as well as Mr. Moriarty's
15 testimony.
16 I want to go back to something Mr. Moriarty
17 said, which was that, I believe, CVS and Aetna have
18 quantified the potential savings of the merger at an
19 annual figure. I think the figure was, if I had it
20 correct, $750 million a year?
21 MR. MORIARTY: That's correct sir, yes.
22 COMMISSIONER JONES: And did I understand your
23 testimony to be also that that is what CVS and Aetna
24 anticipate, by way of savings, annually for a five-year
25 period?

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1 MR. MORIARTY: We view the 750 that I
2 specified as recurring, so that's both through reduced
3 medical costs and enhanced operational efficiencies as
4 part of the transaction.
5 COMMISSIONER JONES: What's the duration of
6 time that you anticipate that annual savings to accrue
7 to the merged entity?
8 MR. MORIARTY: We stated publically, sir, that
9 we anticipate that those synergies will be achieved over
10 the first two years after closing.
11 COMMISSIONER JONES: And how long will they
12 continue?
13 MR. MORIARTY: They, again, will be recurring,
14 so they will be part of the business as we move forward.
15 And our goal is to continue to look to improve, and as
16 we talked about, look at where some of the key costs are
17 in medical costs, some of the key conditions, diabetes,
18 asthma etcetera, and look for greater ways to manage
19 those and lead to even more cost savings.
20 COMMISSIONER JONES: So there's no endpoint in
21 your respective company's analysis with regard to the
22 $750 million in annual savings?
23 MR. MORIARTY: Well, it is -- once achieved,
24 it becomes recurring in the sense that it's been
25 achieved and it's represented as you go forward.

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1 It's not a new 750 each year, if that's, I
2 think, what you may be asking.
3 COMMISSIONER JONES: Well, I guess I'm trying
4 to understand. So the notion is within the first two
5 years you'll have $750 million in savings, and then each
6 year thereafter those savings will continue to accrue.
7 It's not an additional 750 on top of every 750 every
8 year, but rather that $750 million in annual savings
9 will be the savings that the merged companies anticipate
10 they will be benefiting from on an ongoing basis from
11 year two forward?
12 MR. MORIARTY: That's correct.
13 COMMISSIONER JONES: Then I think you also
14 testified, as you did just a moment ago in response to
15 my question, that there are some other potentials for
16 savings beyond that associated with integrated care
17 management, I think you said, better coordination of
18 care, decreased hospital admissions, increased patient
19 engagement, increased access to care. There were a
20 variety of things you listed.
21 So do I understand your testimony to be that
22 on top of the $750 million a year in savings, the merged
23 entities anticipate additional savings?
24 MR. MORIARTY: That's correct, sir. As we
25 bring these organizations together and, again, we look

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1 at where the higher cost areas are in terms of some of
2 the key chronic and complex conditions, we think that by
3 bringing the companies together, the better use of the
4 care coordination and management tools that Aetna
5 brings, as well as our local presence, our ability to
6 integrate and work with patients much more directly and
7 on an continual basis, that we can start solving for
8 that.
9 And again, any just small increase in
10 adherence in some of these key chronic and complex
11 conditions, lead to significant reduction in costs that
12 will inure to the benefit of the citizens of California
13 as well as nationally.
14 COMMISSIONER JONES: Do either of you have a
15 start date for those additional savings on top of the
16 $750 million a year?
17 MR. MORIARTY: It's part of our integration
18 planning as we start, and then obviously as soon as we
19 close the transaction, it will be a very key focus for
20 us as we go forward to drive innovative, new solutions
21 in some of these areas.
22 COMMISSIONER JONES: What does your plan say
23 with regard to when you anticipate those savings might
24 accrue?
25 MR. MORIARTY: As I think I indicated in my

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1 opening remarks, roughly in a three-to-five year
2 timeframe.
3 COMMISSIONER JONES: And then has there been
4 any quantification with regard to this additional
5 increment of savings that the companies or the merged
6 entity anticipates?
7 MR. MORIARTY: We have -- "we" being CVS
8 Health -- do not have any quantification for that.
9 Aetna has identified, I believe in their S4, a
10 figure that they feel is potentially achievable, just as
11 a way of demonstrating the value that the transaction
12 can bring.
13 COMMISSIONER JONES: So let me turn to Aetna,
14 then, and see if you can share with me the figure that
15 Aetna believes might accrue as a result of these
16 additional savings in the out years.
17 MR. WINGLE: We can up supply that figure to
18 you, Commissioner, after the hearing.
19 COMMISSIONER JONES: Is it known to you now?
20 MR. WINGLE: Not off the top of my head. I
21 need to refer to the file.
22 COMMISSIONER JONES: That would be great if
23 you could.
24 Is there anything else that Aetna could share
25 with us to elaborate on that particular additional

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1 dollar figure of savings? Is there any analysis or
2 indication with regard to how long that might accrue?
3 Is it an annual savings? Anything else that you could
4 elaborate on that?
5 MR. WINGLE: I think we're aligned around the
6 timeframe. Obviously we're focused on
7 condition-specific interventions that would provide the
8 best value both to our consumers but also in terms of
9 achieving the targets.
10 COMMISSIONER JONES: Okay. But you'll provide
11 us with the figure and any -- do you have any
12 information with regard to the duration of time that
13 that additional savings will accrue?
14 MR. WINGLE: Well, we hope that the
15 improvements are ongoing and become foundational,
16 obviously. So, you know, obviously each new initiative
17 would be additive, so we would hope that continuous
18 improvement would be an ongoing focus of the company.
19 COMMISSIONER JONES: Okay. Then let me ask
20 both companies: With regard to the $750 million a year
21 in savings, where will that savings go?
22 Let's start with CVS.
23 MR. MORIARTY: I can start, and then obviously
24 I'd ask my colleagues from Aetna.
25 We don't have a specific in terms of where it

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1 will flow directly to beneficiaries. Obviously, as we
2 can reduce medical costs and reduction in medical
3 costs -- and condition-specific cost is a key component
4 of that 750 -- that should enure to the benefit of the
5 consumers here in California as well as nationally, as I
6 stated earlier.
7 COMMISSIONER JONES: Do you want to add
8 anything?
9 MS. MIRANDA: Yeah, I think that really
10 captures it. I think the intent certainly is that the
11 efficiencies that will be driving will go to, you know,
12 invest in programs that improve health.
13 COMMISSIONER JONES: So back to Mr. Moriarty,
14 nothing specific, but a general statement of where the
15 savings go.
16 Let me ask specifically, will the entirety of
17 the $750 million be allocated to reductions in premium
18 or decreases in the rate of increase of premium for the
19 merged entity?
20 MR. MORIARTY: I can't say, Commissioner, what
21 percentage will. There certainly will be some. There
22 obviously are investments that need to be made in
23 systems and other programs to drive these longer term,
24 and so you'll see a component of that reinvested in to
25 the business as well to improve the services and develop

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1 better programs as we go forward.
2 COMMISSIONER JONES: Aetna, can you give me a
3 specific answer to the question of whether or what
4 amount of the $750 million will result in a reduction in
5 premium?
6 MR. WINGLE: Not on an allocated basis. I'd
7 say that we are interested in reducing premium pressure.
8 Obviously there are larger factors driving medical costs
9 in the system, but we would like to, you know, put this
10 against any of those costs and those cost pressures.
11 But we also want to improve the quality of our services
12 as well. So we believe that under both circumstances
13 the consumer will benefit.
14 COMMISSIONER JONES: Can Aetna give me any
15 estimate of the portion of the $750 million a year that
16 will be allocated to premium reductions or decreases in
17 the increase in premium?
18 MR. WINGLE: I don't have that information
19 available at this time.
20 COMMISSIONER JONES: Has there been an
21 estimate made by the company?
22 MR. WINGLE: Not that I'm aware of, but we can
23 get back to you on that.
24 COMMISSIONER JONES: I appreciate that.
25 CVS, do you have any estimate of the

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1 allocation of $750 million to either reduce premium or
2 to decrease the increase in premium over time?
3 MR. MORIARTY: I don't as I sit here today,
4 Commissioner, but if we have done that, we will provide
5 it.
6 COMMISSIONER JONES: I appreciate that.
7 Let me go now to some of the specifics that
8 you testified about with regard to the merger.
9 Both companies have testified that there will
10 be no competitive impacts on any of the various markets
11 in which you variously operate, whether it's retail
12 pharmacy, PBM, insurance, Part D Medicare drug plans.
13 So is that correct, it's your, CVS' view that
14 there will be no negative competitive effects in any of
15 those markets?
16 MR. MORIARTY: That's correct.
17 COMMISSIONER JONES: Is that Aetna's view as
18 well?
19 MS. MIRANDA: It is.
20 COMMISSIONER JONES: So one of the things you
21 have also testified to, if I understand correctly, is
22 that CVS, in particular CareMark, its PBM entity, will
23 continue to contract with a variety of different
24 entities including those that might be competitors of
25 Aetna.

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1 Is that correct?
2 MR. MORIARTY: As we do today sir, yes.
3 COMMISSIONER JONES: Okay. And you are doing
4 that today, but you're not, you're not merged today. So
5 I'm wondering how it is that the merger won't result in
6 incentives for CVS to give preferential treatment to
7 Aetna or providers in the Aetna network versus other
8 competitors of Aetna?
9 MR. MORIARTY: Well, we have seven-plus years
10 or so of experience as being a service provider to Aetna
11 today in terms of how we have operated our business,
12 ensuring that we offer what we can to all of our clients
13 to ensure that we're lower in cost and improving the
14 service to them.
15 So we have that market experience, as well as,
16 as I indicated, if you look at where the lion's share of
17 our revenues come today at CVS Health, 88 to 89 percent
18 come from other health plans. And it's our fundamental
19 goal that we continue that and we drive improvements
20 more broadly beyond simply Aetna, but in to the
21 healthcare system overall.
22 COMMISSIONER JONES: Will there be any
23 differences in CareMark's business practices with non
24 Aetna insurers?
25 MR. MORIARTY: Coming from the merger?

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1 Absolutely not, no.
2 COMMISSIONER JONES: Do you want to add
3 something, Counsel?
4 MS. FERGUSON: I did want to add something.
5 What I wanted to add is today we do provide services to
6 competitors, Silver Script, which is our Part D plan, is
7 serviced by CareMark. CareMark also services other Part
8 D plans. So today we are actually are providing
9 services to direct competitors.
10 COMMISSIONER JONES: So I heard that point in
11 the testimony, and I heard the point that you have just
12 reiterated, that there won't be any differences in
13 CareMark's business practices with non Aetna insurers as
14 a result of the merger.
15 I just want to explore that a little bit. I
16 understand the point you made in the testimony, which
17 was that CareMark will continue to have and seek
18 contracts with competitors of Aetna.
19 What I'm wondering is whether there will be
20 any pricing difference associated with the PBM services
21 that CareMark provides to Aetna versus to other
22 entities.
23 MR. MORIARTY: Right. And what I can say,
24 Commissioner, is that the PBM marketplace is highly
25 competitive. If you look at the bids and the bid

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1 structures and how they are done and how competitive
2 those are, there will not be an ability to have a price
3 difference between them. So our fundamental guiding
4 principle, again, is to be as competitive as possible
5 across our entire book of business.
6 COMMISSIONER JONES: So you would rely on the
7 market to discipline CareMark to make sure that it does
8 not offer preferential pricing treatment to Aetna versus
9 Aetna's competitors?
10 MR. MORIARTY: It is an incredibly efficient
11 marketplace in doing that, sir.
12 COMMISSIONER JONES: Are there any other
13 guarantees you can offer or commitments or is
14 assurances, beyond the market, with regard to making
15 sure that there aren't price differentials associated
16 with your offering of PBM services to Aetna versus
17 Aetna's competitors?
18 MS. FERGUSON: We would have contractual
19 commitments with our clients today that would prevent us
20 from increasing prices.
21 COMMISSIONER JONES: But those contracts are
22 for a duration, a period of time, correct?
23 MS. FERGUSON: They are, but we are always
24 seeking to extend those. I'm just saying it's not just
25 market pressures, we have client commitments as well.

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1 COMMISSIONER JONES: Existing contracts. But
2 those contracts aren't infinite in duration. They come
3 to an end at some point, right?
4 MR. MORIARTY: Some of them are very long in
5 term.
6 COMMISSIONER JONES: They seem like they're
7 infinite to you.
8 MR. MORIARTY: I want the record to be clear,
9 I did not say that.
10 COMMISSIONER JONES: I know. I know.
11 MS. FERGUSON: He thought it, but he didn't
12 say.
13 COMMISSIONER JONES: You haven't tried the
14 tea, either, but I'm trying. I'm trying.
15 I understand. But just to be clear for the
16 purpose of the record, the contracts have a finite
17 period of time in which they are in operation, correct?
18 MS. FERGUSON: Yes, they do.
19 COMMISSIONER JONES: And then after that, that
20 contract might being extended or it might not be
21 extended. It might be renegotiated at different price
22 term potentially, yes?
23 MR. MORIARTY: Yes. But, again, as you look
24 at the marketplace, those pricing trends have been very
25 negative in terms of lowering costs in the sense of

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1 driving further efficiencies into the system.
2 COMMISSIONER JONES: The concern that I have,
3 though, is that arguably the market for PBM services is
4 getting smaller, not larger, and so I don't know -- I
5 guess we'll here some testimony on this as well as to
6 how competitive that market true is -- but if your
7 answer is that the market will discipline CareMark, I
8 think that's possible, but I'm trying to see if there's
9 any other assurance or commitment that you're making as
10 a part of this transaction that if the market doesn't
11 discipline CareMark, there's some other form of
12 commitment that CareMark won't engage in price
13 differentials or price differentiation between Aetna and
14 its competitors.
15 MR. MORIARTY: I think there's several things
16 to note and point out particularly in regard to what may
17 be testimony later here, is how competitive the PBM
18 marketplace is and how the barriers to entry are
19 incredibly low. So I think the announcement by Anthem
20 in terms of it wanting to bring in and bringing its own
21 new PBM solutions marketplace is a great example of new
22 competition coming in.
23 There are any number of players here in
24 California as well who remain. I noted five or six of
25 them in my testimony, there are many more than that.

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1 We obviously have our ongoing contractual
2 commitments that we've talked about here in terms of
3 providing the best price to the clients.
4 I would also point out just simply the
5 economic reality of our business and the need for
6 CareMark to remain competitive to win and continue to
7 grow as a very key factor in driving efficiency further
8 into the system.
9 COMMISSIONER JONES: So can you elaborate a
10 little bit on CVS CareMark's business model? How does
11 it make its money?
12 MR. MORIARTY: At a very high level, the
13 pharmacy benefit management model aggregates lives,
14 aggregates shares, and drives discounting through
15 negotiating to get to the deepest discounts across the
16 board to lower costs.
17 And if you look -- at we publish a drug trend
18 report each year for CareMark, that looks at the price
19 discounting and our ability to drive lowest costs for
20 our clients. And while you'll see list pricing going up
21 historically at double-digit levels, over the last
22 several years we have seen low CIGLE (phonetic,) and in
23 fact this year, almost less than 1 percent increase in
24 the annual cost for our clients, and roughly a little
25 more than a third actually had what's called negative

1 drug trends, where the cost from 2016 to 2017 was less.
2 So those efficiencies, I think, are
3 demonstrated by the data.
4 COMMISSIONER JONES: So CVS CareMark
5 negotiates with the drug manufacturers for a price, and
6 uses its bargaining position as an aggregator of
7 purchase, if you will, with all of the entities with
8 whom you have contracts behind you.
9 Does CVS CareMark pass through any rebates
10 that it obtains one for one, any rebates it obtains from
11 the drug manufacturer, do you pass 100 percent of that
12 through to the payer or the consumer?
13 MR. MORIARTY: Let me answer, first, by
14 starting with what a rebate is.
15 A rebate is essentially a price discount
16 that's negotiated in terms of what the list price is
17 versus what the net price will be associated with that.
18 We pass more than 95 percent of rebates back.
19 We actually have a number of clients where we pass
20 100 percent back and they pay us an administrative fee.
21 There are clients who actually do not want to do it that
22 way, so we retain a certain portion of rebates in lieu
23 of an administrative fee to pay for our services.
24 And so what you have seen over the years is
25 the rebating value, the discounting value increasing,

1 our ability to control costs for our clients increasing.
2 COMMISSIONER JONES: On an annualized basis,
3 what is the value of that rebate that is retained by CVS
4 CareMark?
5 MR. MORIARTY: I don't have that figure as I
6 sit here today, sir.
7 COMMISSIONER JONES: Do you have you it,
8 Counsel?
9 MS. FERGUSON: I don't.
10 COMMISSIONER JONES: Could you provide it to
11 us?
12 MR. MORIARTY: I could review it and give you
13 the information that we can give you, yes, sir.
14 COMMISSIONER JONES: Okay. Thank you.
15 Does CVS CareMark or CVS more broadly have any
16 involvement with Anthem's new -- is IngenioRX PBM?
17 MR. MORIARTY: Yes, sir. There was a
18 competitive bid process to be the initial service
19 provider to Anthem, and we were successful in that
20 competitive process to win that. So we by and large
21 will provide administrative services as Anthem launches
22 their new PBM model.
23 Importantly though, as Anthem has announced,
24 they retain all the significant levels of controls
25 associated with some of the key elements of the pharmacy

1 benefit management services that are part of that in
2 conjunction with what we can offer.
3 COMMISSIONER JONES: What happens to that
4 relationship with Anthem and IngenioRX PBM post merger
5 with Aetna?
6 MR. MORIARTY: That will continue.
7 COMMISSIONER JONES: Okay.
8 Question for Aetna. So Aetna is obviously
9 concerned, as you testified, about the rising cost of
10 drugs, and Aetna has an economic interest in trying to
11 obtain lower drug costs. We have heard from CVS that a
12 portion of their business model is retaining a portion
13 of the discount, if you will.
14 So if Aetna is successful in driving drug
15 costs down, that has an economic consequence for
16 CareMark potentially. How exactly is that going to
17 work? I mean isn't Aetna, in fact, no longer going to
18 be as incentivized to reduce drug costs because the
19 parent company's business model relies in part on
20 retention of a portion of discounts that it's obtaining?
21 So to the extent that the overall price goes
22 down, less money to CareMark, not good for CareMark, may
23 be good for Aetna.
24 So how exactly is that going to work?
25 MR. WINGLE: Well, what it does is it

1 completely aligns or interests together around the best
2 solution for the customer. So right now if it's an
3 over-the-fence transaction, one side's cost is another
4 side's revenue, we don't get that whole patient view.
5 If we can, together, figure out the best care
6 plan, the medical side and the pharmacy side, we hope
7 those efficiencies for the benefit of the entire
8 combined company, and more importantly to our members by
9 reducing some of their episodes of care and keeping them
10 adherent and compliant.
11 As you know, drug costs are a significant
12 concern in the healthcare system. They currently
13 represent about 20 percent of our healthcare spend, and
14 you know, specialty drugs, which are only 1.3 percent of
15 our scripts, represent 40 percent of our pharmacy costs.
16 So we are interested in addressing the
17 challenge of drug costs, and believe that when we marry
18 the medical and the pharmacy view together, we'll get
19 that stronger alignment that we need to address the
20 problem.
21 MS. MIRANDA: You know, I think Paul's point
22 is an important one. It might also be worth just noting
23 that in California, Aetna today has 5000 retail pharmacy
24 options for our members that are non CVS. We have about
25 1100 pharmacies in our network in California that are

1 CVS, right? Our members will absolutely continue to
2 have access to those non CVS pharmacies, right? It's
3 important for access, to ensure that we have coverage
4 across what is a very broad state, as you know.
5 It's also important because our customers
6 expect a reasonable degree of choice when they are
7 coming to us and purchasing products.
8 So I guess I'm just raising that as a bit of a
9 corollary. Certainly we do think that the integration
10 of pharmacy and medical will offer up some opportunities
11 that we really don't have today to better manage care
12 and cost, but in California we certainly will continue
13 to have a significant number of non CVS pharmacies
14 available to our customers.
15 COMMISSIONER JONES: Will the cost sharing be
16 the same for the non CVS pharmacies as for the CVS
17 pharmacies post merger?
18 MS. MIRANDA: I can tell you we certainly
19 don't have any plans to modify cost sharing for CVS
20 versus non CVS retail pharmacies.
21 Again, I think what is important to our
22 customers in California is that they continue to have a
23 degree of choice.
24 COMMISSIONER JONES: What about the potential
25 for having the independent pharmacies be out of network

1 while the CVS pharmacies, the MinuteClinics are in
2 network?
3 MS. MIRANDA: Yeah, no plans like that all,
4 Commissioner.
5 COMMISSIONER JONES: So there won't be any
6 steering of Aetna patients towards the one-minute
7 clinics?
8 MS. MIRANDA: Well, again, we have
9 significant -- now we're talking about the
10 MinuteClinics -- we have a significant number of other
11 kinds of retail settings and urgent care clinics and
12 things like that. So we have no plans to change the
13 composition of that network, and no plans today to
14 change benefit designs to result in steerage into CVS.
15 COMMISSIONER JONES: Is there anything that
16 would prohibit you from doing that though?
17 MS. MIRANDA: Well, I think one thing --
18 COMMISSIONER JONES: Other than network
19 adequacy, which we'll stipulate is always an issue.
20 It's out there, both regulators -- but assuming you
21 could meet network adequacy requirements under
22 California law and California regulation, whether it's
23 CDI or DMHC, and still at some point in the future put
24 the MinuteClinics or other CVS pharmacies in network and
25 the independents out of network, is there any commitment

1 as a part of this merger that would prohibit you from
2 doing that?
3 MS. MIRANDA: Well, I think again, in addition
4 to access, it would be that we have customers who expect
5 to have that degree of coverage in California.
6 Were you going to add something, Paul?
7 MR. WINGLE: No -- we'd be saying goodbye to a
8 significant chunk of our core business, which is part of
9 our value in this acquisition.
10 COMMISSIONER JONES: So let me go back to the
11 pricing question though, again. And that is: I'm still
12 not convinced that there isn't misalignment here of
13 incentives, if you will.
14 I understand your point about all of the
15 things you hope to do in terms of overall cost
16 reduction -- which I guess add in to this $750 million a
17 year figure, and then some other figure in later out
18 years -- but on the issue of drug prices, which is what
19 I'm asking about now specifically, it seems to me that
20 Aetna's economic interest is trying to get those drug
21 prices down. CareMark's interest is somewhat mixed,
22 yes, getting it down, but they retain a portion of
23 whatever discount that they are able to negotiate.
24 So it just seems like those two interests
25 might be at odds with one another.

1 MR. WINGLE: I think I differ in that we are,
2 as a medical insurance company, very concerned about
3 drug adherence and making sure that the patients are
4 following the care plan.
5 One of the exciting things about this
6 opportunity is that we would be able to leverage the
7 significant network of pharmacists and retail sites to
8 reinforce the doctor's instructions around drug
9 adherence and keeping those prescriptions filled where
10 appropriate.
11 The point is to get to efficiency in the
12 system by looking at the efficacy. So if we see data
13 and we see results on the medical side that we can share
14 with the pharmacy side and say we're seeing some
15 inefficiencies here, how do we get to the patient and
16 get them the right solution? The drugs that are
17 prescribed, how do we work together to talk to the
18 provider community, to talk to that person's PCP or
19 their primary care provider, you know, how do we work to
20 get that patient from presenting in an urgent or
21 emergent condition, keep them healthy, whether that's
22 medical care or drug adherence.
23 COMMISSIONER JONES: So another question I
24 have is the issue of making sure people have access to
25 their primary care physician, and I think both of your

1 companies testimonies are that the MinuteClinics are
2 actually a channel, have been a channel for acquainting
3 people with a primary care physician who don't currently
4 have one.
5 If I understand correctly, tell me if I'm
6 wrong, that you believe that this merger will increase
7 access to primary care physicians as opposed to today
8 decrease it?
9 MR. MORIARTY: That's correct.
10 COMMISSIONER JONES: Is that Aetna's view as
11 well?
12 MS. MIRANDA: Yes, absolutely.
13 COMMISSIONER JONES: So I think there's a
14 little bit of a conflict here, though, between the
15 testimony about the savings, which in part, if I
16 understand the testimony correctly, involves the
17 utilization of the pharmacies and within the pharmacies
18 they have MinuteClinics, the MinuteClinics has a more
19 robust provider of primary care services, and this
20 testimony about not reducing access to a primary care
21 physician.
22 So which is it?
23 MR. MORIARTY: I'll start and the colleagues
24 can add to it.
25 The most significant part of the savings

1 opportunity here is an increased adherence. And the
2 categories that I mentioned in my testimony of diabetes,
3 hyperlipidemia, cardiovascular, other areas where you
4 have lack of compliance today with the care plan and the
5 pharmacy plan the physician has prescribed for the
6 patient.
7 Those are your most significant opportunities
8 because each one-point increase in adherence to those
9 key chronic medications has a significant cost savings
10 for the health system and obviously has a huge impact on
11 the member health and quality of life for that.
12 So while there will be savings associated with
13 emergency room visits that can be taken care of at
14 MinuteClinic -- and we've seen that, frankly, in our own
15 CVS employee population, the study that I mentioned --
16 the lion's share, and the most significant is chronic
17 care management, and better adherence to the physician
18 care management plan.
19 COMMISSIONER JONES: Does Aetna want to add
20 anything on that?
21 MS. MIRANDA: Yeah, you know, I think really
22 all that I would add is this is certainly not about
23 supplanting that critical primary care physician
24 relationship with his or her patient. We actually, even
25 in products that we have today that don't require that

1 assignment, we really do try to encourage it where we
2 can.
3 The other thing that I would note is that in
4 addition to 50 percent of the folks who access
5 MinuteClinics not even having an established primary
6 care physician today, the opportunity that we have to
7 connect them with a primary care in their community
8 who's accepting patients, 50 percent of those who visit
9 a MinuteClinic are doing so after hours where their
10 primary care physician is not accessible.
11 COMMISSIONER JONES: So why can't these
12 benefits associated with greater adherence to drug
13 regimes or courses of treatment or greater access to the
14 MinuteClinics to primary care physicians, why can't that
15 be accomplished through a contract between Aetna and
16 CVS? Why is it necessary to merge the entities to
17 accomplish this?
18 I'll ask Aetna.
19 MR. WINGLE: The exciting thing for us is we
20 are trying to move away from the model of being the
21 warranty card that you pull out of your wallet when you
22 have a problem. I'm broken, I'm sick, I present my card
23 to get that fixed. The presentation at an emergency
24 room, the presentation at a doctor's office, is often
25 the lagging indicator of an issue or a problem.

1 We want to help and we want to join members to
2 keep them healthy and maintain their health aspirations
3 so they use the system as appropriate when they need to,
4 but we're taking all the steps with them to make sure
5 they're staying healthy.
6 We cannot replicate on our own what CVS has.
7 82 percent of the American public lives within ten miles
8 of a CVS. 71 percent lives within five miles of a CVS.
9 We're starting to pilot community based models of care
10 in a couple of markets, and we're seeing great early
11 success with that.
12 We're partnering with social workers. We're
13 partnering with visiting nurses. We're partnering with
14 in-home meal delivery. We need a health hub in the
15 community to expand that model. That's the model we
16 want to use to address the social determinants, because
17 as Kristen said, most of what drives health problems
18 that we see are based on broader needs that you can only
19 know by being local and getting to know folks in the
20 community and being a hub for coordination in the
21 community.
22 And that's what the CVS presence gives us that
23 we can't do on our own.
24 COMMISSIONER JONES: But why can't you
25 contract for that presence?

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1 MR. WINGLE: We're talking about a big
2 investment as a joint company together to build a
3 different model in the communities, and, you know, that
4 means I think a long-term commitment that's more than a
5 contract.
6 COMMISSIONER JONES: But there's no legal
7 prohibition against your contracting for exactly what
8 you have just described, is there?
9 MR. GREANEY: Right. But if we were to make a
10 commitment to transform along the lines that I'm talking
11 about and we're contract limited, it's not like we could
12 build 11,000 retail clinics around the country on our
13 own if that relationship were to end.
14 We're looking for a permanent arrangement so
15 that we can make those investments and confidently
16 rebuild the health care system together.
17 COMMISSIONER JONES: Does CVS want to add
18 anything on that point?
19 MR. MORIARTY: I guess on some levels,
20 Commissioner, you're asking the core question as to why
21 the current system has not been able to solve for the
22 lack of coordination, the lack of integration in the
23 system. And it's a great question and it's exactly what
24 this transaction, this combination, is going to seek to
25 solve for.

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1 Align incentives, align organizations in a way
2 where it's not a binary determination, but investments
3 can be made more holistically and information systems
4 can connect and we can drive better coordination between
5 the physician, the pharmacy, and the caregivers in each
6 community in which that patient is sitting.
7 That's ultimately what we're go to be seeking
8 to solve.
9 COMMISSIONER JONES: I think it's your
10 testimony that Aetna is not going to have any special
11 deal with the PBM, it's not going to -- the information
12 that the PBM collects from other payers is not going to
13 be shared with Aetna, and the PBM is not going to use
14 its relationship with Aetna in some way adverse to the
15 other health insurers that it has a relationship with.
16 So it's essentially an arm's length relationship at some
17 level.
18 If that's true, if all of things you have said
19 are true and I take them at face value, what is the
20 point of the merger?
21 MR. MORIARTY: The merger is not a PBM centric
22 merger, Commissioner. It is literally looking at how we
23 can bring new models into healthcare to lower costs and
24 get better patient benefits. So that can partially be
25 accomplished through the PBM, but largely it has to be

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1 accomplished by developing new programs, new plans, that
2 can lead to those outcomes.
3 And the benefit, then, that will enure to CVS
4 Health after Aetna and we work together to develop
5 these, is that we can offer those to our existing client
6 base, either through the pharmacy networks or through
7 the PBM CareMark, to it's broader client set through the
8 health plans that we serve today.
9 So it's not a PBM centric merger, it is much
10 more a health plan and health plan innovation centric
11 merger.
12 COMMISSIONER JONES: Aetna want to add
13 anything?
14 MR. WINGLE: We're also a diversified company
15 and we offer a multitude of services and provide that
16 same wall of protection.
17 So, for example, we have a company within,
18 within our walls that provides services analytics to
19 state and regional plans to help them manage their
20 administrative services-only arrangements with large or
21 medium sized employers. So as a diversified company
22 we're pretty well rehearsed and understand how you
23 protect the integrity of each line of business.
24 Again, I think the focus is moving away from
25 thinking about the old divisions and silos to thinking

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about knew capabilities we can bring together as we
bring our analytical tools and our networks of providers
together with that local presence to improve the health
model.

COMMISSIONER JONES: Let me see if Ms. Rocco
has any questions.

DEPUTY COMMISSIONER ROCCO: I just have a
follow-up question in the area having to do with the
$750 million in potential annual savings.

The testimony was that the most significant
portion of that savings would be due to increased
adherence, and I'm trying to figure out if you have a
company that has a lot of pharmacies, is a PBM, has a
lot of MinuteClinics, you're acquiring a health insurer,
not medical provider groups, but a health insurer.

So how does the merger of those companies lead
to increased adherence specifically?

MR. MORIARTY: It's a great question and I'll
answer it by way of an example.

You know, we referenced just the overall
national impact here in California of diabetes and
prediabetics and what that means to the cost curve going
forward. And I think the best way to answer that
question is if you look, a patient with diabetes will
see their primary care physician four to maybe six times

a year. That's what the data says.

We know, though, that that same patient sees
their pharmacist and is in the pharmacy anywhere from 18
to 24 times a year.

How do we then take better advantage of those
points of engagement at the pharmacy counter where we
can look at the care plan the physician has prescribed
for that patient and ensure, at least work more closely
on ensuring that they are adhering to that care plan.

And as I mentioned, any increase in both the
testing for the blood sugar levels, blood glucose
levels, as well as adherence to medication therapy has
significant impacts not only the quality of health for
that patient but also, obviously, in the cost to the
system.

So better using information, better using
data, and better leveraging the points of contact when
the patient wants to interact with the healthcare
system, that's where we think significant impact can be
made.

DEPUTY COMMISSIONER ROCCO: Are you able to be
any more specific in terms of the acquisition of the
health insurer, how does that improve the patient's
experience when they are at the point of contact at
pharmacy? What changes?

MS. MIRANDA: Yeah, so think about going into
your pharmacy today. Today you go into your pharmacy
and if you, if your pharmacist as a question, they call
the doctor on the phone, right, and the doctor is seeing
patients and calls the pharmacist back at the end of the
day, and then you may have to go back to your pharmacy
tomorrow.

Now imagine where, much like, think about the
electronic medical record, if the pharmacy system could
talk to the doctor system, if the pharmacy could have
almost a skinny EHR where it was part of that record and
it could send messages back to the doctor, "patient in
today" -- because if you go to a good pharmacy and you
talk to a good pharmacist, what you see when they stand
in line is they know about your dog, they know about
spouse, they know about your kids, right? They really
are embedded and have a great relationship with the
patient.

And sometimes patients are, are shy about
talking about things with the doctor, they may feel a
little intimidated, that they might talk to with their
pharmacist.

Now the pharmacist, instead of having to pick
up the phone and call and leave a message, maybe talk to
a nurse, maybe the doctor gets back to them the next

day, we have a type of message that goes directly into
the EMR so the doctor, when they pull up the patient's
file, can see, oh, the patient didn't pick up their
medication for three months. Oh, the patient this
happened, that happened, and send a message back to the
pharmacist. All done electronically.

That's a vision for a new way of communication
between a pharmacist and a doctor, where the doctor is
the hub, the doctor is in charge of the care, but the
pharmacist is able to supply information in a way that
doesn't happen today. It would be great if this
happened, but it doesn't.

MR. WINGLE: I would like to embellish if I
could, because I think we have some examples of how are
analytics could really help that local approach.

You know, Kristen mentioned in her testimony
about how US News and World Report, which has fantastic
datasets, worked with us through our foundation to rank
communities, to find the healthiest communities.

Well, that same dataset we've used to look at
anomalies around the country and develop targeted
programs, culturally appropriate programs in communities
where there are issues, so we all understand the
disparities that exist around maternal health and
pregnancy and delivery and addressing those disparities,

1 that allowed us, that data allowed us to develop
2 targeted programs to ensure better maternal health in
3 minority communities where that presented as an issue in
4 our data. Same thing on an asthma intervention that
5 we've piloted. Same thing on a diabetes intervention.
6 So if we can take that data and develop with a
7 brick and mortar location and the resources around it,
8 more community based programs that address the dynamics,
9 the social determents within the community, I think it
10 will be a very powerful effect for the healthcare
11 system.
12 DEPUTY COMMISSIONER ROCCO: I have a question
13 on a separate issue having to do with PBMs. One of the
14 criticisms of the model that we use in this country
15 today is that there's not enough transparency.
16 There are, my understanding at least, is that
17 there are some PBM contracts that prohibit pharmacists
18 from disclosing to the patient that there are lower cost
19 drugs available or that if they didn't use their
20 insurance they could get the drug at a lower cost with
21 the CVS CareMark PBM.
22 Is that a practice that is used in any of your
23 contracts?
24 MR. MORIARTY: It is not, and there is
25 actually federal legislation prohibiting the use of so

1 called gag clauses that we fully support and have
2 indicated our support for that.
3 And then just on the transparency question,
4 because I do think it's important. The PBM model is
5 absolutely transparent to our clients. Our clients know
6 down to the drug level the cost associated with each
7 medication. They know fundamentally what our retained
8 rebates are, the administrative fee that they are paying
9 us.
10 So there's absolute transparency at the client
11 level, and we are now bringing that transparency and
12 drug cost transparency to consumers, both at our
13 pharmacy counters, as I indicated in my testimony, but
14 also now to the physician office through the use of the
15 electronic health record. So.
16 COMMISSIONER JONES: Just to be clear about
17 the client consumer distinction, when you say "clients,"
18 you mean entities that the CareMark PBM are in a
19 contractual relationship with. So that's various payers
20 self insured, employers, health plans, health insurers,
21 those are the clients that have this transparency
22 currently. It's not the actual end user of the drug,
23 yet, that has that transparency?
24 MR. MORIARTY: Well, it is, actually, in the
25 new system that we launched about two months ago where

1 you can see based off your formulary, where you are in
2 your deductible cycle, what your cost is for that drug,
3 and then as I indicated we also provide point of sale
4 rebate capabilities to some 10 million lives that the
5 plan sponsors have chosen to provide that to their
6 members.
7 So we have a number of programs to bring that
8 transparency to the consumer level.
9 COMMISSIONER JONES: Is it your intention to
10 provide those approaches to all of Aetna's
11 policyholders?
12 MR. MORIARTY: We offer these today, and
13 obviously the plan sponsor makes their determination in
14 terms of how they manage the benefit and the value they
15 deliver to the beneficiary for that plan.
16 But, yes, we have brought a number of
17 capabilities to other health plans as well in terms of
18 these capabilities.
19 COMMISSIONER JONES: Will Aetna as a result of
20 the merger automatically get access to that or will they
21 have to negotiate for it like every other plan has to
22 negotiate for it?
23 MR. MORIARTY: Like all the other plans today,
24 they have access to it and can make decisions as to how
25 they choose to put the benefits together.

1 COMMISSIONER JONES: But what about after the
2 merger?
3 MR. MORIARTY: Absolutely, same -- nothing
4 changes today versus after the merger in terms of how we
5 will operate the CareMark business with health plans.
6 COMMISSIONER JONES: So that benefit, if you
7 will, of transparency will only be available if Aetna
8 decides to pay for it?
9 MR. MORIARTY: Actually there's no cost
10 associated with this.
11 I think Aetna may have some --
12 MR. WINGLE: Right. We are already developing
13 the same transparency tools, so we are all moving in the
14 same direction.
15 COMMISSIONER JONES: Maybe I misunderstood,
16 though. I thought you were saying that CareMark offered
17 to some millions of consumers this transparency already
18 for those plans that have elected to have that.
19 I assumed that that meant they are paying
20 something for it. They're not?
21 MR. MORIARTY: It's part of the broader
22 offering we give them.
23 COMMISSIONER JONES: But there's no price
24 consequence associated with that as opposed to not
25 offering that?

1 MR. MORIARTY: No.
2 COMMISSIONER JONES: Okay.
3 Then we're going to hear some testimony I
4 think in a little bit about a horizontal competitive
5 aspect of this merger, if you will, and that is the
6 implications of this merger on the availability of Part
7 D prescription drug plans.
8 Both of your companies in various ways,
9 shapes, or forms offer Part D. There's some evidence
10 that's been provided that we're going to hear about a
11 little bit later on that indicates that under the metric
12 that one uses to measure market consolidation, that this
13 merger will result in some number of geographic areas
14 being impacted in terms of decreased competition as it
15 relates to the Part D prescription drug benefit.
16 I want to give you a chance to respond to that
17 now, and of course we'll give you a chance after you've
18 had a chance to hear everybody else's testimony, to
19 respond later.
20 But it is an important issue to me, so I
21 wanted to give you a chance to respond to it now.
22 MR. MORIARTY: Okay. And again I'll start and
23 others can add to it.
24 But I think first and foremost the Medicare
25 Part D and MAPD markets are highly competitive. The

1 statistics will be there for California. We can provide
2 that level of analysis for you as well.
3 I think what's really important as you look at
4 the markets is that it is Part D as well as MAPD. When
5 you look at those data and share numbers, I think the
6 combined shares were in the 15 to 17 percent range,
7 which clearly does not implicate any real competitive
8 concerns.
9 I think you see a highly competitive market,
10 not only with the number of competitors and the large
11 Fortune 5000 companies that compete, but also because of
12 the annual bidding cycle that is part of the Part D
13 program that is leading to lower and lower premiums each
14 year and more efficient programs, and that has
15 fundamentally been very efficient in actual lower costs
16 than anticipated by the government accounting office.
17 And I think what is really important as you
18 look at this is, is that annual bidding cycle and what
19 it means -- and actually I'll ask Ms. Ferguson to
20 comment on it -- because those details are important as
21 you look at this marked.
22 MS. FERGUSON: Yeah, so the first thing I'd
23 note is in California there are 25 different plans that
24 are offered by ten companies currently, and it's
25 important to remember that both Aetna and CVS have large

1 LIS -- low income subsidy populations.
2 For those that don't select, those are
3 auto-enrolled by the government into plans on a yearly
4 basis, and they are enrolled into plans that are below
5 the benchmark. What the benchmark is varies each year
6 depends on the bids, and you don't know whether you're
7 above or below the benchmark when you bid.
8 So what can see from year to year through the
9 cycle, is shifts in share as though auto-enrollees are
10 automatically put into plans by CMS that are below the
11 benchmark. So you can see shifts in share.
12 COMMISSIONER JONES: Let me be very specific.
13 Professor Scheffler, who we're going to have a chance to
14 hear from a little later on, has found in his study that
15 30 Part D regions would experience an HHI increase of
16 over 200 points as a result of CVS' acquisition of
17 Aetna, and that's typically used as a threshold by
18 federal DOJ and FTC as an indicator of a negative impact
19 on competition, and that 10 of those 30 would have a
20 post-merger HHI of greater than 2500.
21 I'm sure he's going to explain in greater
22 detail the nomenclature, but you're familiar with it,
23 and so I'm wondering if you can speak specifically to
24 that impact in particular regions across the United
25 States associated with this merger.

1 MS. FERGUSON: So I'm sorry, I have not seen
2 his study so I don't know what regions he's talking
3 about. We don't believe there is a certain in
4 California. And to the extent the Department of Justice
5 found a concern, divestiture would be an appropriate
6 remedy for that.
7 COMMISSIONER JONES: I'll give you a chance
8 after you've had a chance to hear his testimony and look
9 at his study to respond to it.
10 Let me just ask this, then. In the interest
11 of time I'm going to stop asking questions, and also to
12 give our very able court reporter a break, and all of
13 you a break, I think we're going to take a little
14 ten-minute recess.
15 I want to ask, if I have additional questions
16 that I wasn't able to get to, can I present those to CVS
17 in writing and within a reasonable time expect some sort
18 of answer?
19 MR. MORIARTY: Absolutely.
20 COMMISSIONER JONES: And Aetna the same?
21 MR. WINGLE: Of course.
22 MS. MIRANDA: Of course.
23 COMMISSIONER JONES: I appreciate that. And
24 there were a couple of items during the course of the
25 testimony you both very kindly consented to provide us

1 as well.
2 So if there are additional questions that we
3 have that we're not raising during this hearing, we'll
4 provide you with something in writing and, you know,
5 whatever reasonable amount of time you need to try to
6 answer those would be appreciated.
7 So we're going to take a ten-minute recess.
8 We will reconvene at -- what's the pleasure of the court
9 reporter?
10 COURT REPORTER: It's 12:15, how about 12:25?
11 COMMISSIONER JONES: 12:25 it is. Always pay
12 attention to the court reporter. Very important.
13 We'll reconvene at 12:25.
14 (Off the record.)
15 COMMISSIONER JONES: Okay. Why don't we
16 resume our hearing, and we have got another panel of
17 witnesses who are invited to come to the front. One of
18 whom, Diana Moss, we're going to call in at that moment
19 by phone, but I think everyone else is going to be here
20 in person.
21 First before we do that, those that wish to
22 have a copy of the transcript, we encourage you to take
23 the reporter's business card, which is up here on the
24 counter in front of her, and then that will tell you how
25 to get ahold of her in order to arrange to get a

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1 transcript.
2 We'll also post something on our website with
3 regard to how to get a transcript as well -- oh, I stand
4 corrected. We actually will post the transcript itself,
5 too.
6 It's my pleasure to ask the next set of
7 witnesses to come forward, and I'd like to ask if they
8 might introduce themselves, and then we'll jump right
9 into this next panel.
10 MR. GREANEY: I'm Tim Greaney, Professor of
11 Law at UC Hastings College of Law and a fellow at the
12 UCS Hastings Consortium on Healthcare Law.
13 COMMISSIONER JONES: Excellent. And then the
14 second witness is Professor Scheffler.
15 MR. SCHEFFLER: I'm Richard Scheffler. I'm a
16 professor of Health Economics at the Goldman School of
17 Public Policy and the School of Public Health at
18 Berkeley.
19 COMMISSIONER JONES: Wonderful. And I think
20 Professor Greaney will start.
21 MR. GREANEY: Commissioner, thank you for the
22 opportunity to participate in this proceeding, and thank
23 you for conducting this proceeding. I think it's a very
24 important issue that merits close attention.
25 Let me just mention at the outset, that, as I

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1 do with all my public participation, including
2 congressional testimony and filing Amicus briefs, I do
3 so pro bono. I don't receive support from anyone either
4 interested in this merger pro of con.
5 So in my remarks today I would like to first
6 offer a brief summary of the role of antitrust
7 enforcement in healthcare and the current state of the
8 law and economic analysis of vertical mergers in
9 particular, and then move on to specifically address the
10 issues presented by the CVS-Aetna merger.
11 And let me just cut to the chase. My bottom
12 line is this: The points I want to make are, first,
13 that market concentration is a leading cause of high
14 costs in healthcare and, second, that antitrust
15 enforcement has really neglected the risks associated
16 with vertical combinations and has concentrated on
17 horizontal combinations, and both are presented in this
18 merger.
19 As a result of that neglect, a lot of the law
20 is really out of date and not very much helpful for
21 guidance.
22 Now as you know, this merger is being
23 carefully reviewed by the Department of Justice in
24 Washington -- my alma mater actually, the antitrust
25 division of the Department of Justice where I began my

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1 career -- and a lot of facts are being gathered, and
2 those facts are essential to understanding the
3 implications of these mergers.
4 But that said, we can learn and we can sort of
5 help steer the conversation by looking at what we know
6 about market structures and incentives of the parties.
7 Based on that, my view is, at least based on
8 what we know right now, I think the CVS-Aetna merger has
9 the potential, and is indeed likely, to lessen
10 competition in the standalone prescription drug plan
11 market.
12 And secondly, that when you look at CVS-Aetna
13 combining along with Express Scripts Cigna, which is
14 also on the horizon, it will enhance incentives by
15 foreclosing competition and raising rivals' costs.
16 So by way of introduction, I just want to
17 mention that I'm currently associated with the
18 University of California. My remarks here represent
19 only my own views, not those of the university, and I'm
20 also a professor emeritus from St. Louis University
21 where I spent 29 years.
22 Most of my career, in fact, has been focused
23 on the area of antitrust in healthcare. I've written
24 numerous articles in that area, and I recently put out a
25 two-part white paper with a colleague at Duke University

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1 on the American Antitrust Institute web page that
2 covers, tries to cover comprehensively the issues
3 presented by healthcare competition and what should be
4 done going forward. And before that I was an assistant
5 chief in the antitrust division of the Department of
6 Justice where I supervised healthcare matters.
7 So let me start with talking about the role of
8 antitrust in healthcare. The American antitrust
9 enforcement agencies, and by that I mean the FTC, the
10 Department of Justice, and the State Attorneys General,
11 have long devoted an extraordinary amount of their
12 resources to the healthcare sector.
13 Examples include challenges to hospital
14 mergers, physician cartels, reverse payments by
15 pharmaceutical companies, insurance company mergers, and
16 anticompetitive practices. And in recent years it's
17 important to note that the agencies have won a series of
18 very important cases challenging horizontal mergers
19 among hospitals, horizontal mergers among physicians,
20 and horizontal mergers among insurance companies.
21 These cases have gone a long way to clarify
22 the law and send a clear message that combining
23 competitors in concentrated local markets is going to
24 face close scrutiny.
25 These cases actually reverse the series of

1 losses in hospital mergers, and I think they have
2 created what will be enduring legal precedents going
3 forward. Among other things they clarify that insurance
4 markets are highly localized, most of them are, there
5 are some national markets.
6 These cases have rejected the arguments that
7 market power will be checked by the countervailing power
8 of large buyers, or vice versa large buyers will
9 counteract the market power of providers. What I refer
10 to in the Health Affairs article as the sumo wrestler
11 fallacy, that the two would get together and the
12 consumer would be better off.
13 They've declined to accept arguments that the
14 uncertainties arising from the changing market structure
15 we see today justifies consolidation. And they have
16 just been quite skeptical, I think appropriately so, of
17 promised efficiencies.
18 But that said, there's considerable evidence
19 that past consolidation, consolidation that in some
20 cases is the product of mergers that went unchallenged,
21 is responsible for the high cost of healthcare today.
22 There's an extensive economic literature that
23 details, and I cite in my written testimony, that
24 details the amount of consolidation and the fact that it
25 has occurred in all of these sectors, hospital,

1 physician, health insurance, PBM markets.
2 And in each sector, it's important to note,
3 that there are high barriers to entry, and proven, at
4 least in part, by the fact market shares have grown or
5 stabilized at high levels and entry has not righted the
6 boat in those cases.
7 And finally, there are lots of studies showing
8 concentration in healthcare is associated with high
9 prices. And fundamentally, when you get down to it, the
10 healthcare markets are characterized by a variety of
11 unusual characteristics. Marketing elasticity, perfect
12 information, agency relationships, and that makes these
13 markets particularly vulnerable to market power and they
14 exacerbate the risks we see going forward with mergers.
15 So let me turn to the issue of how the law
16 deals with vertical mergers.
17 I submitted a draft article that is going to
18 be published soon in the American Journal of Law,
19 Medicine, and Ethics that summarizes my views. I begin
20 the article with a quote from George Orwell's novel
21 Animal Farm, in which one of the animals, Snowball,
22 describes his world view as "four legs good, two legs
23 bad." And I compare that to the Chicago School of
24 mergers, which is vertical good, horizontal sometimes
25 bad.

1 And that pretty much describes how government
2 enforcement has gone forward, and to a degree explains
3 why case law is sparse and really out of date in this
4 area.
5 The important thing I would observe is
6 contemporary economic analyses have really questioned
7 the basis for that laissez-faire approach to vertical
8 combinations.
9 The modern account shows that the
10 preconditions underlying the Chicago School's view,
11 quote, "rarely hold and can obscure how a merger may
12 enable conduct that limits rivalry at the horizontal
13 level."
14 And I would commend for your summer beach
15 reading a really excellent article that just came out in
16 the Yale Law Journal by Steven Salop, one of the most
17 respected economists in this area, called Invigorating
18 Vertical Merger Analysis, where he really takes on the
19 assumptions that led to this laissez-faire approach and
20 suggests a more vigorous approach. Not that all or even
21 most vertical mergers are problematic, but clearly some
22 are.
23 And the problem is that, as Commissioner said
24 earlier, they combine inputs with distribution and they
25 create incentives, they can create incentives, for the

1 merged firm to exclude its rivals downstream or
2 upstream, and they can do it two ways. They can either
3 cut them off or they can raise rivals' costs, that's
4 Professor Salop's term for charging discriminatory or
5 high or detrimental prices to a rival that gives the
6 integrated firm, the merged firm, the cushion to charge
7 higher prices. It gives them protection. And anyway,
8 there is extensive literature on that.
9 So another faulty premise of the vertical
10 world view is the assumption that savings inevitably
11 flow from these kind of hierarchal vertical
12 arrangements. Economic evidence for this is lacking,
13 and you're going to hear from Professor Burns shortly,
14 economic integrations often fail to generate the
15 benefits that were promised.
16 Not unlike horizontal mergers, vertical
17 mergers are subject to inherent problems when two
18 companies get together. Culture clashes, inadequate
19 information pre merger, challenges that are just
20 inherent in merging two entities.
21 Another well known economist, Martin Gaynor,
22 put it concisely. He said "consolidation is not
23 coordination." And I think it's noteworthy to note that
24 antitrust law appropriately places a high bar on these
25 efficiencies justification.

1 Under the law in order to assuage competitive
2 concerns, an efficiency benefit must be achievable, one,
3 only through merger, two, it must offset potential
4 competitive harms, it must be pretty sizeable, and most
5 importantly, it must be passed on to consumers.
6 For that reason there's never been a merger
7 decided by a federal court in which efficiency
8 justifications alone were sufficient to excuse a merger.
9 And also important is mergers occur --
10 benefits occurring outside the market in which
11 competition is harmed, are not considered. So the case
12 law has been pretty clear since the old Philadelphia
13 National Bank case, that you don't go looking for
14 benefits in side markets to justify an anticompetitive
15 merger.
16 And a further reason for concern over vertical
17 integration that goes too far, is the experience that we
18 have seen in which market dominance by merger, that's
19 achieved by merger, can give rise to anticompetitive
20 conduct. So the history of antitrust law is littered
21 with examples of hospitals, physicians organizations and
22 insurers that have taken advantage of their dominant
23 position once they've gotten it through a merger, and
24 restrained competition going forward.
25 An example I'm sure the Commissioner is

1 familiar with was a case that was ultimately challenged
2 in Michigan involving insurers, an insurer with market
3 power, Blue Cross Blue Shield, insisting on most favored
4 nation's treatment in order to reduce rivalry from rival
5 insurers.
6 So the antitrust law has actually been
7 relatively lenient, however, on conduct that's
8 exclusionary. It's more concerned with collusion
9 activity. And that explains why merger law is all the
10 more important. Because merger law is prophylactic.
11 It's designed to nip concentration in the bud before
12 firms get too big so they can exercise this. And
13 Professor Hovenkamp and others have argued where merger
14 is likely to lead to conduct that's both anticompetitive
15 but difficult or impossible for antitrust law to reach
16 once the merger has occurred, it's especially important
17 to pay attention to those.
18 I'll be happy to talk a little more about the
19 recent AT&T-Time Warner decision. Those of you who
20 haven't had the opportunity to read all 172 pages of it,
21 I have, and it certainly is an important case, but it
22 does not do what some of the press has tried to paint
23 it, as creating clear path for vertical mergers. In
24 fact it's very fact specific, and it doesn't even deal
25 with foreclosure.

1 And the thing to remember about foreclosure
2 issues is that foreclosure has horizontal impact.
3 Foreclosure really says the merging firm has the
4 opportunity and the incentive to disadvantage rivals by
5 raising their costs or depriving them of customers. And
6 Time Warner doesn't do that, but just word of caution
7 because the press sometimes goes a little far on that.
8 Let me now turn to the risks specific to
9 CVS-Aetna, and I'm just going to sort of introduce some
10 of the ideas that some of the other speakers are going
11 it talk about.
12 We have seen in healthcare that provider
13 concentration, where a lot of the antitrust work has
14 been done, is not the only source of high costs. There
15 is really a legion of middlemen, many with market power
16 that can also extract costs. These risks were really
17 nicely summarized very recently in speech by the new FDA
18 Commissioner, Scott Gottlieb, and I'll just quote what
19 he said. He said "The top three PBMs control more than
20 two-thirds of the market, the top three wholesalers 80
21 percent, the top five pharmacies 50 percent. Market
22 concentration may prevent optimal competition, and so
23 the savings may not always be passed along to employers
24 or consumers."
25 And he went on to say, "Too often we see

1 situations where consolidated firms, the PBMs, the
2 distributors and the drugstores, team up with payers.
3 They use their individual market power to effectively
4 split some of the monopoly rents with the large
5 manufacturers and other intermediaries rather than
6 passing along the savings garnered from competition to
7 patients and employers." And that sort of captures the
8 risks of vertical issues.
9 And I think that observation, you're going to
10 hear, is echoed to some extent by Professor Sood's
11 empirical study, which finds out of every $100 spending
12 by insured customers on pharmaceuticals, $42 goes to
13 middlemen: PBMs, pharmacies, wholesalers, and insurance
14 companies.
15 So antitrust analyses, as I mentioned, are
16 notoriously fact intense. There's a lot to be learned
17 here. And courts are asked to perform a predictive
18 exercise, predict future conduct and the effect on
19 competition. And to quote another famous economic
20 expert, Yogi Berra, "Predictions are very difficult,
21 especially about the future." And that's what we've
22 saddled the courts with doing here. But it necessarily
23 involves a close examination of facts, and the
24 Department of Justice is hard at work on this.
25 But based upon what we know about structure

1 and the things you're going to hear today, there
2 certainly are ample grounds for concern. Let me first
3 talk about what your earlier dialogue touched on, the
4 horizontal effects of this merger.
5 First of all, as to horizontal competition, as
6 most of you probably know the case law appropriately
7 places a presumption of competitive harm where market
8 shares and concentration is high and entry is not likely
9 to be timely or sufficient.
10 There are good reasons for this. Not the
11 least of which is that mergers are permanent. Unlike
12 exclusive dealing contracts where there is competition
13 for the contract every year, two years, five years
14 there's competition, mergers don't have that character.
15 And the horizontal concerns here, which we're
16 going to hear in a moment from Professor Scheffler, are
17 typical; two firms competing head-to-head in the
18 standalone prescription drug plan market, PDP market.
19 And, by the way, contrary to what I think was
20 suggested earlier, I think there are good reasons to
21 treat the standalone PDP market separate and distinct
22 from the PDP options in Medicare Advantage plans. And
23 that certainly was a lesson we learned, and Commissioner
24 knows well, from the discussions of the Aetna merger,
25 attempted merger, that was dealt with with the courts

1 where they found they were separate and distinct
2 markets.
3 They are different in the services provided,
4 consumer preferences, and regulation, and I'll leave it
5 to Professor Scheffler to talk about the increase in the
6 market shares that appear to be present in California
7 and at least 10 or 20 other states -- and he'll also
8 talk about the economic studies which show a correlation
9 between high concentration and higher prices.
10 There are other aspects to this merger that
11 merit scrutiny. One is, another one you mentioned
12 earlier, which is the loss of potential competition.
13 Aetna acknowledged that it was contemplating entering
14 the PBM market at one time or another de novo, and that
15 would add to deconcentrating what is a concentrated PBM
16 market.
17 That clearly has been a possible issue in
18 health law antitrust cases, and as you also mentioned,
19 CVS has a contract with the second largest insurer,
20 Anthem, to assist in its development of a PBM service,
21 and the inherent conflict in having CVS serve its new
22 insurance division -- Aetna -- and it's rival --
23 Anthem -- presents serious concerns about coordination,
24 price fixing, market division, or resulting from the
25 information they have access to.

1 Now whether firewalls share that, solve that
2 problem is an open question. Some firms have been
3 satisfied with firewalls. But remember, firewalls will
4 only be as vigorous and as rigorous as the market makes
5 them be. And if we have a diluted competition with
6 these integrated entities, there's no reason to believe
7 that the firewalls will be airtight.
8 The final aspect of horizontality here, if I
9 can use that word, is that if CVS-Aetna goes forward and
10 Express Scripts Cigna go forward, the consumer will only
11 be faced with three entities that actually serve
12 independent insurers, the smaller insurers that are out
13 there.
14 And the important thing to note about that, is
15 these three integrated insurance PBM entities will have
16 aligned incentives. None will have incentives to offer
17 competitive terms to small insurers that are rivals of
18 their own insurance division. And there are widely
19 recognized barriers to entry. I think you addressed
20 that briefly with your dialogue earlier, Commissioner,
21 but there is some considerable writing, and I'll submit
22 an article by my colleague at Hastings, Robin Feldman,
23 that volume is what drives these rebates. They have to
24 offer significant volume to the pharmaceutical companies
25 to get a significant rebate. And that is an important

1 barrier to entry in this case.
2 A new firm contemplating entry will also have
3 to enter two markets. It will have to enter the PBM and
4 insurance market, and at the same time some of the
5 largest potential customers of that PBM service are
6 already taken, as Aetna will be taken up as a customer
7 of another PBM. So the emergence of a tight oligopoly
8 of this magnitude with aligned incentives creates
9 another risk.
10 Finally, let me just turn briefly to the
11 vertical aspects of this merger. The law is sparse
12 here, as I mentioned, but a few things are clear about
13 harm under Section 7 of the Clayton Act. Concerns are
14 raised when a merger creates or strengthens incentives
15 of firms to foreclose rivals or raise their costs for
16 inputs necessary to compete.
17 And I think you'll hear from Diana Moss, who
18 put out a very comprehensive letter to the Assistant
19 Attorney General of the Antitrust Division describing
20 the risks that arise from structure and incentives, that
21 it could change the incentives that CVS has as a
22 standalone PBM right now to one in which it has a
23 different and distinct interest when it acquires Aetna.
24 And post merger, the argument goes, it will
25 take into account the benefits its insurance subsidiary

1 may achieve by providing less favorable terms to its
2 insurance rivals.
3 No how do we know which will prevail, the
4 incentives to keep your PBM healthy or to benefit your
5 insurance subsidiary? And I think you'll hear from
6 Professor Sood some very interesting analysis of the
7 relative margins of insurance versus PBMs that suggests
8 that there's a very real possibility that this effect
9 will be realized and it will harm competition.
10 There's also a discussion present of whether
11 CVS-Aetna will have incentive to disadvantage retail
12 pharmacies, the independent pharmacies. The risk here
13 is what economists like to call "customer foreclosure."
14 CVS will have strong incentives, in some markets at
15 least, to deprive rival pharmacies of competitive access
16 to Aetna's insured -- "steering" as you put it
17 earlier -- where it has a sizeable presence, raising
18 rival costs. Tactics of this kind can be destructive of
19 price and service competition.
20 So let me close with sort of a cautionary tale
21 about overlooking market concentration. The nation has
22 really learned the hard way about overlooking
23 consolidation in healthcare. It's learned the hard way
24 that that oversight, in the bad sense of the word
25 oversight, is costly.

1 There was a seven-year period when no hospital
2 mergers were challenged by federal or state governments,
3 and they did so because there was unfortunate precedent
4 that came out of the courts. Precedent that we now
5 recognize was wrongly decided. But those mergers, that
6 wave of mergers produced excessive concentration that,
7 in turn, resulted in higher prices for consumer
8 services. And the FTC did some marvelous studies about
9 the cases that it lost, showing that they were right,
10 that prices did go up. In fact one is right here in our
11 own backyard, Sutter, where the post-merger analysis
12 showed the price went up even though the court allowed
13 the merger to go forward.
14 So I think, likewise, the benign neglect of
15 vertical mergers between hospitals and physicians have
16 resulted in higher prices. The government has never
17 challenged a vertical merger between hospitals and
18 physicians, and now economic studies are showing that
19 those combinations, where they are sizeable, produce
20 higher costs in the physician market. Again, this is
21 the product of oversight.
22 So with most healthcare sectors highly
23 concentrated and competition anemic in many of them, I
24 think vertical mergers have to be closely monitored.
25 COMMISSIONER JONES: Thank you very much,

1 Professor Greaney.
2 Now we'll have a chance to here from Professor
3 Scheffler.
4 MR. SCHEFFLER: Thank you, Commissioner Jones.
5 So a little bit more about a background just
6 briefly. I have already told you I'm a distinguished
7 professor of health, economics, and public policy at the
8 School of Public Health in the Goldman School of Public
9 Policy at the University of California Berkeley.
10 I also hold the chair in the Healthcare
11 Markets and Consumer Welfare endowed by the Office of
12 the Attorney General for the State of California, and
13 the founding director of Nicholas C. Petra Center on
14 Healthcare Markets and Consumer Welfare.
15 My longer CV is attached.
16 I have testified for the Commissioner before.
17 I testified at the California Department of Insurance
18 January 22, 2016 hearing of the Centene Corporation's
19 proposed acquisition of Health Net, and the California
20 Department of Insurance March 29th, 2016 hearing on
21 Anthem's proposed acquisition of Cigna Corporation.
22 I've also testified at the Federal Trade
23 Commission and the Department of Justice meeting
24 examining healthcare competition in Washington D.C.,
25 February 25th, 2015.

1 I want to thank the American Medical
2 Association for supporting my work and research in this
3 area and also for the help in preparing and support for
4 preparing this testimony.
5 Let me make it clear that my testimony
6 reflects my views and opinions, not necessarily the
7 views of the American Medical Association.
8 Little background. In 2018, 43 million of
9 60 million people with Medicare had prescription drug
10 coverage on the Medicare Drug D plan.
11 Of the 43 million, 25 million are covered
12 under a standalone prescription drug plan -- which I'll
13 call PDP -- while the remaining 18 million, or
14 42 percent, are enrolled in Medicare's Advantage
15 prescription drug plans.
16 In California, 2.3 million people are enrolled
17 in a PDP plan, while 2.5 million are enrolled in a
18 Medicare Advantage plan.
19 My professional opinion is similar to Tim
20 Greaney that you have heard, that the PDP and the
21 Medicare Advantage markets are separate markets due to
22 the lack of plan switching across the markets after the
23 initial enrollment the choice.
24 There is also an excellent study that I have
25 recently reviewed by the Kaiser Family Foundation

1 entitled "To Switch or Not to Switch: Are Medicare
2 Beneficiaries Switching Drug Plans to Save Money," and
3 the answer is they are not switching between these two
4 markets.
5 The total drug costs of the Medicare Plan D
6 claims have increased rapidly since 2013. Nationwide,
7 total Medicare Part D drug costs increased from 103.7
8 billion to 146.1 billion, a 41 percent increase between
9 2013 and 2016.
10 In California the increase was slightly higher
11 in percentage term. The total Medicare Plan D drug
12 increasing from 10.5 billion in 2013 to 15.1 billion in
13 2016, a 44 percent increase.
14 Additionally, monthly Part D consumer premiums
15 have increased by 58 percent since the start of the
16 Medicare Part D program in 2006. During the same time
17 period, the consumer price index, the CPI, increased
18 only 24 percent.
19 In 2006 average monthly consumer premiums were
20 $26 across the United States -- see Figure 1 where it's
21 up on the board there.
22 Average monthly consumer premiums leveled out
23 from 2010 to 2015, hovering around $38 -- as you can see
24 from Figure 1.
25 Since 2015 average monthly consumer premiums

1 rose 11 percent from $37 to $41 per month.
2 In Figure 1, I also show how average monthly
3 premiums for PDPs have changed in California since 2006.
4 The California line you see is the red line.
5 In 2006 the average monthly premium in
6 California was $20, which was 23 percent below the 26
7 national average. By 2011, however, the average monthly
8 premiums in California had caught up to the national
9 average of $38.
10 Similar to national premiums, California
11 premiums were stable from 2011 to 2015. However, since
12 2015 California premiums have increased by 18 percent,
13 from $38 to $45, and today California premiums are ten
14 percent above the national average. Overall, California
15 premiums have increased 125 percent since 2006.
16 My testimony here focuses on the horizontal
17 overlap between CVS and Aetna in California's PDP
18 market. I specifically measure market concentration
19 before and after the proposed merger and the potential
20 impact on PDP market in California.
21 How Part D Premiums Are Determined. Part D
22 plan's sponsors compete on premiums to attract
23 enrollees, but do not set premiums directly. Plan
24 sponsors submit bids to the Center for Medicare and
25 Medicaid Services -- CMS -- and represents the revenue

1 requirements including administrative costs and profits
2 for delivering basic benefits to an enrollee of average
3 health.
4 CVS then calculates a nationwide enrollment
5 weighted average among all bid submissions. The monthly
6 premium on an enrollee for a plan is a subsidized base
7 premium -- $35 in 2018 -- plus or minus any difference
8 between his or her plan bid and the national average.
9 If an enrollee picks a plan that contain supplemental
10 coverage, the enrollee pays the full price of the
11 additional coverage.
12 Part D bidding process also determines the
13 maximum premium that Medicare will pay on behalf of the
14 low-end subsidized enrollee. The amount is calculated
15 separately for each of the Part D geographic regions as
16 an average premium among the plans with basic benefits
17 weighted by each plan's LIS enrollment in the previous
18 year.
19 Twenty-five of the 34 national Part D
20 geographic regions, excluding territories -- including
21 California -- are a single state, as you can see from
22 the map. The remaining nine regions are comprised of
23 multiple states. The formula used for LIS programs
24 ensures that at least one standalone PDP in each region
25 is available to LIS enrollees at no premium.

1 The importance of the 35 Part D regions in the
2 determination of the maximum premium amount Medicare
3 will pay on behalf of the LIS enrollees, plus the fact
4 that the plan's sponsors must offer a plan in at least
5 one entire region -- they cannot pick and choose among
6 the geographics within a region that offers plans --
7 makes Part D regions the geographic level which
8 antitrust authorities are likely to examine in the CVS
9 and Aetna overlap in the PD market. Hence Part D
10 regional level PDP market concentration is analyzed in
11 what follows.
12 Measuring Market Concentration. I use the
13 Herfindahl Hirschman Index -- which is called HHI -- to
14 measure PDP in market concentration. The HHI has been
15 used frequently as a measure of market concentration in
16 merger cases brought by the antitrust division of the
17 U.S. Department of Justice and the Federal Trade
18 Commission, and is used in horizontal merger
19 guidelines -- hereafter called "guidelines" -- authored
20 by these agencies.
21 HHI is calculated by taking the market share
22 of each firm, squaring it, and summing the results. The
23 HHI values range from zero to 10,000.
24 Guidelines consider markets where the HHI is
25 between 1500 and 2500 points to be moderately

1 concentrated, and markets with HHIs in excess of 2500 to
2 be highly concentrated. Market shares in each of the 24
3 Medicare Part D regions were calculated based on plan
4 sponsored PDP enrollment.
5 To address the impact of CVS-Aetna merger on
6 PDP market concentration, 2018 marked concentration was
7 calculated in two ways. One, assuming CVS and Aetna
8 were separate firms -- that's the pre merger HHI. Two,
9 assuming CVS and Aetna were a single firm -- post merger
10 HHIs.
11 Market concentration measured from 2009 to
12 2017 were also calculated to show the trend in the PBP
13 market.
14 In the context of the guidelines assigned
15 highest certain and scrutiny to mergers which would
16 increase HHIs by over 200 points and lead the market
17 with an HHI of 2500 -- you can see that from Table 1
18 that I have indicated with yellow marking.
19 Other HHI changes and levels trigger different
20 degrees of concern and scrutiny -- see Table 1 for
21 details.
22 Markets that would experience HHI increases of
23 over 200 points and result in HHIs at or above 1500 --
24 again see the yellow cells -- will be discussed in the
25 analysis that follows.

1 Market Concentration Trends and Post Merger
2 HHIs. Table 2 shows in 2018 the USPDP enrollment and
3 market shares by parent organization. Currently, three
4 parent organizations, CVS, United Health and Humana,
5 account for 65 percent of the US PDP enrollment. A
6 combined CVS-Aetna would lead to three parent
7 organizations accounting for 73 percent of the USPDP
8 enrollment.
9 Table 3 shows in 2018, California's PDP
10 enrollment and market share by parent organization.
11 Currently there are three parent organizations, United
12 Health, CVS, and Humana, account for 74 percent of
13 California's PDP enrollment. A combined CVS-Aetna would
14 lead to three parent organizations, accounting for
15 83 percent of California's PDP enrollment.
16 Table 3 lists all the other competitor's
17 parent organizations in California.
18 Figure 3 shows the PDP market HHI weighted by
19 PDP enrollment from 2009 to 2018 across the United
20 States. In 2009 the U.S. HHI was 1109, just above the
21 guideline's 1500 threshold for moderately concentrated
22 markets. By 2018 the U.S. HHI had increased to 1861, an
23 increase of 342 HHIs or a 23 percent increase.
24 The triangle in Figure 3 represents the U.S.
25 HHI in 2018 if CVS and Aetna are treated as a single

1 firm in HHI calculations. If CVS and Aetna were a
2 single firm, the U.S. HHI would increase 410 points
3 higher by 2018 than it is currently.
4 Mergers that lead to an HHI change of over 200
5 points and resulting in an HHI between 1500 and 2500,
6 quote, "Potentially raise significant competitive
7 concerns and often warrant scrutiny" according to the
8 guidelines.
9 Figure 3 also shows California's HHI from 2009
10 to 2018. From 2009 to 2013, California's HHI lied below
11 the national average indicated by the red line.
12 Between 2013 and 2015, California was almost
13 completely on line with the national average -- the
14 national average being the dotted line.
15 Since 2015, California's HHI has moved above
16 the national average. This mirrors the pattern I
17 discussed earlier between the U.S. and California's PD
18 premium market in Figure 1. That is, the observed HHI
19 increase is similar to the increase in premiums over the
20 same time period. Today California's HHI is 2,007, 136
21 points above the national average.
22 The diamond in Figure 3 represents
23 California's HHI in 2018 if CVS and Aetna are treated as
24 a single firm in HHI calculations. If CVS and Aetna
25 were a single firm, California's PDP market would be 434

1 points higher in 2018 than it is currently, a 22 percent
2 increase.
3 Mergers that lead to an HHI change of over 200
4 points resulting in an HHI between 1500 and 2500 are,
5 quote, "potentially raise significant competitive
6 concerns and often not warrant scrutiny" according to
7 the guidelines.
8 Table 4 shows how pre and post merger HHIs for
9 each of the 34 Part D markets -- I hope you can see
10 that, it's a little small -- overall, 30 of the Part D
11 regions would experience an HHI increase of over 200
12 points as a result of the CVS acquisition of Aetna. Of
13 these 30 regions, 10 would have a post merger HHI of
14 greater than 2500.
15 Mergers that increase HHIs by over 200 points
16 and result in a post merger HHI of over 2500 are, quote,
17 "presumed to be likely to enhance market power"
18 according to the guidelines.
19 The post-merger HHIs of the other 20 regions
20 would experience increases of 200 points, would all be
21 in the 1500 to 2500 range, and thus the merger would
22 trigger moderate concerns in these regions, according to
23 Table 1.
24 A merger in California with a post-merger HHI
25 of 2,441 -- an increase of 434 points -- is one of the

1 20 regions that fall just below being, quote, "presumed
2 to be likely to enhance market power" according to the
3 guidelines. And I guess Table 4 lists all of the
4 markets.
5 Impact of Proposed CVS-Aetna merger on
6 Medicare Part D Premiums.
7 I have reviewed a large number of studies that
8 are cited in my testimony, and provide evidence that
9 increases in market power raise Medicare Part D
10 premiums.
11 Based on these studies and my own analysis,
12 the proposed merger of CVS and Aetna will have important
13 and significant impacts on the concentration of the
14 Medicare Part D standalone prescription drug plan, PDP,
15 market.
16 In 10 of the 34 PDP regional markets, the
17 merger should be, quote, "presumed to be likely to
18 enhance market power" according to the guidelines. An
19 additional 20 of the 34 PDP regional markets, the merger
20 would potentially, quote, "potentially raise significant
21 competitive concerns and often warrant scrutiny"
22 according to the guidelines.
23 This later competitive concern was found in
24 California, and it is my opinion that the merger would
25 raise PDP premiums in markets across the country

1 including California.
2 Thank you, Commissioner.
3 COMMISSIONER JONES: Thank you, Professor
4 Scheffler. It's a privilege to see you again and to
5 have you testify again before the California Department
6 of Insurance.
7 Our next witness is Professor Neeraj Sood.
8 Please, welcome. Why don't you take a seat to the right
9 of Professor Greaney. And after we hear from you -- do
10 you want to call -- what we're going to do is we're
11 going to call Diana Moss so she can hear Professor
12 Sood's testimony as well.
13 Just a minute. We're trying bring in
14 Professor Moss.
15 Hi, Professor Moss. Can you hear me?
16 MS. MOSS: I can, yes.
17 COMMISSIONER JONES: This is Commissioner Dave
18 Jones, and you are now live before an audience of 50
19 people here and live streaming on various social media
20 as well. I appreciate you joining us.
21 I think we're now at the point in our hearing
22 where we're going to hear from Professor Sood, and then
23 after Professor Sood, then we'll go to you, with your
24 permission.
25 MS. MOSS: Very good. That works great.

1 COMMISSIONER JONES: And if you want to mute
2 your phone while we're hearing from Professor Sood, if
3 they're any intervening variables in your life like
4 children and cats and dogs, we might not hear those as
5 well -- if you're at home.
6 All right. Professor Sood.
7 MR. SOOD: So thank you very much for giving
8 me the opportunity to present today.
9 I want to start with a couple of disclosures.
10 The first is that the support for some of the research
11 cited in the presentation today, as well as my
12 appearance at this hearing, was supported by the
13 American Medical Association.
14 What I'm going to talk about today is my views
15 and opinions and not necessarily those of the AMA or of
16 my employer, the University of Southern California.
17 I will start by talking a little bit about
18 myself. So I'm Professor of Health Policy and the Vice
19 Dean for Research at the Sol Price School for Public
20 Policy, and a professor at the Schaeffer Center at the
21 University of Southern California.
22 My past research has focused on health
23 insurance markets, pharmaceutical markets, and global
24 health. I have published more than 100 papers, reports
25 in top peer reviewed journals in economics, medicine,

1 and health services research.
2 I'm also the associate editor of two leading
3 journals in my field, the Journal of Health Economics
4 and Health Services Research.
5 This next accomplishment I'm particularly
6 proud of, that both the Council of Economic Advisors of
7 President Obama, as well as President Trump, have cited
8 my work on the pharmaceutical supply chain and my other
9 work on healthcare costs.
10 I have also been -- but I have not been
11 treated by President Trump so far.
12 I have also --
13 COMMISSIONER JONES: Hope springs eternal for
14 you that you forever avoid that distinction.
15 MR. SOOD: I have been a scientific advisor
16 for several organizations in the healthcare industry.
17 So what I'm going to do today is first give
18 you, or, you know, give the audience, an overview of how
19 drugs reach from manufacturers s to consumers. This is
20 a fairly complex supply chain, and I'm a professor, I
21 love to lecture, so I'm going to start by just kind of
22 setting the stage, and then I'll move to kind of the
23 question today, which is how will the proposed merger
24 between CVS and Aetna affect competition in the
25 insurance market, PBM market, and pharmacy market, and

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1 then finally I'll offer some concluding thoughts.
2 So if you look at how manufacturers are the
3 ones who come up with a drug or do R&D for the drug and
4 produce the drug, so from manufacturers the drugs are
5 sold to wholesalers, wholesalers in turn sell drugs to
6 pharmacies, and then, you know, we as consumers go and
7 buy our drugs from pharmacies. So the flow of drugs is
8 from the manufacturer to the wholesaler to the pharmacy
9 to the beneficiary.
10 And this seems like a fairly simple or easy
11 flow. But when you start looking at how money changes
12 hands, there are two new entities that many come in to
13 play. One is the PBM, and the other is a health plan.
14 So I as a consumer pay some copay or cost sharing to the
15 pharmacy when I purchase a drug, but I also pay a
16 premium to my health insurance plan who helps cover some
17 of my drug costs. Some of my premiums are paid by me
18 out-of-pocket and some of them are paid by my employer,
19 in this case USC.
20 The pharmacy, in turn, buys drugs or pays
21 money to a wholesaler to buy drugs from them. So there
22 is a price or drug acquisition cost for the pharmacy
23 that is received by the wholesaler. The wholesaler when
24 they are done, buys the drug from the manufacturer. So
25 there is a wholesale acquisition cost for the

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1 wholesaler.
2 The manufacturer sometimes offers consumers
3 copay assistance, which is they will help defray some of
4 the out-of-pocket cost for the consumer. I'll get a
5 coupon which I can take to a pharmacy and cover some of
6 my cost.
7 The manufacturer also makes payment to a PBM,
8 which is commonly referred to as a rebate. The PBM also
9 receives payment from a health plan, and it collects
10 some of this money and passes. So every time I as an
11 insured consumer buy a drug from a pharmacy, the PBM
12 reimburses the pharmacy for my drugs. The PBM also
13 shares some, or a lot, of these rebates back with the
14 health plan with which it has contracted.
15 So if you look at what services are offered by
16 different entities then, so the manufacturer is doing
17 the R&D for the drug; the wholesaler is kind of managing
18 the drug inventory, has large warehouses to store the
19 drugs; the pharmacy in some sense is the retail store
20 front, so they have costs related to operating all these
21 stores.
22 The PBM is, in some sense, truly a middleman
23 in that they really don't touch the drugs, but they are
24 kind of the middleman that helps the health plan
25 negotiate with the pharmaceutical firm, and it also

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1 helps the health plan negotiate with pharmacies. So
2 they help negotiate pharmacy reimbursement as well as
3 the level of rebates or discounts they are going to get
4 from the manufacturer.
5 And the health plan plays an important role in
6 terms of providing financial risk protection to
7 consumers. So we as consumers, once we have insurance,
8 are shielded from very high medical care costs or
9 prescription drug costs.
10 So what we did was we kind of took this
11 conceptual framework and then looked at publicly
12 reported statements to the Securities and Exchange
13 Commission of top pharmaceutical firms, wholesalers,
14 retailers, pharmacy benefit managers and health plans,
15 and then we try to estimate this question which is if I
16 as a consumer spent $100 on a drug, how much of that
17 money eventually reaches the manufacturer and how much
18 of that accrues to different bodies in the
19 pharmaceutical supply chain.
20 So what we find from this data is that if I
21 have $100 in spending on drugs, about $42 goes to
22 middleman, and $58 reaches the pharmaceutical firm. And
23 the way it is divided among the middlemen is insurers
24 receive about 19 out of those $100, PBMs receive about
25 five, wholesalers receive about two, and the remaining

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1 amount goes to pharmacies.
2 So you can also look at what is the true or
3 net profits of each of the players in the pharmaceutical
4 supply chain, and what we find is of every $100 in
5 spending, $23 goes toward profits, and of these profits
6 about $3 accrue to insurers, $2 to PBMs, about $3 to
7 pharmacies, and about .30 to wholesalers and $15 to
8 manufacturers.
9 So some of these net profit numbers are
10 important because they highlight the incentives in
11 different parts of the market, and I'm going to come
12 back to that later in the presentation.
13 So one question we might ask is, you know,
14 given that these players are making $23 in profit out of
15 every $100 in consumer spending or middlemen are keeping
16 $42 out of $100 in consumer spending, are there some
17 entities in the supply chain that are making too much
18 money or are they making excess profit?
19 And what our study did is, we could not answer
20 that question directly. Our study in some sense is a
21 descriptive study where we're just saying they are
22 making $42 or they're making $23. So one way economists
23 try to answer this question, whether a certain industry
24 segment is making more money or not, is by looking at
25 market power or looking at how concentrated these

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1 industries are.
2 So if you look at market power, what you will
3 see is a lot of the pharmaceutical supply chain is
4 characterized by tremendous market power or being highly
5 concentrated industry. So the top three PBMs account
6 for 70 percent of the market. The top three pharmacies
7 account for 50 percent. The top three wholesalers
8 account for 90 percent of the market and so on.
9 And what happens is -- there's a lot of both
10 reports in the scientific literature as well as media
11 reports -- showing how this market power manifests in
12 practices that might potentially be hurting consumers.
13 So what we find, what the reports say is -- so
14 I did a study where we showed that within the same
15 geographic markets, so within a small, like within the
16 same zip code around USC, if an uninsured consumer goes
17 to buy a drug at different pharmacies, there is a
18 tremendous amount of price variations across pharmacies
19 within the same zip code.
20 So this is, again, this kind of price
21 discrimination where some pharmacies have brand power
22 and are selling drugs at a much higher price compared to
23 other pharmacies, is a classic symptom of market power.
24 Sometimes what we found was even within the
25 same pharmacy, depending upon how sophisticated a

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1 consumer is, the price could vary. So if you go in and
2 you say "I want drug X," you might get a certain price.
3 But if you say, "Oh, by the way, I have an online
4 coupon" you get another price, and if you ask for
5 another discount you might get some other price. So
6 there is a lot of price discrimination in the pharmacy
7 market, especially for the uninsured consumers.
8 Some of my colleagues at the Schaeffer Center
9 did a study where they showed that a lot of times
10 consumers what they pay out of pocket, insured consumers
11 what they pay out of pocket as co-insurance or copay,
12 could exceed the drug acquisition cost for the insurer.
13 So from a consumer's perspective, not only are they
14 paying premiums to the insurer, but even their
15 out-of-pocket cost is higher than the drug acquisition
16 cost for the insurer.
17 So in substance if they didn't have insurance,
18 they could actually have gotten the drugs at a cheaper
19 price and at the same time saved premiums.
20 The third thing related to this practice, is
21 that because this happens, PBMs sometimes have gag
22 clauses, which basically forbid a pharmacy from telling
23 a consumer that if they didn't use their insurance card,
24 they would have actually got the drug for cheaper.
25 There is a lot of report from policymakers as

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1 well as, you know, in the media saying that PBMs often
2 do not disclose the amount of rebates they get, so
3 therefore it's unclear how much of the rebates are being
4 kept by PBMs and how much of them are eventually being
5 passed on to health plans and then from health plans
6 eventually to consumers.
7 There is also this narrative that PBMs,
8 because of their market power, demand higher and higher
9 rebates. Pharmaceutical firms in response to that
10 increase their list prices so as not to affect their
11 revenues. But what happens with higher list prices is
12 that if you are a consumer in a high deductible health
13 plan, you are responsible for paying the list price of
14 the drug, not the actual drug acquisition cost for the
15 insurer.
16 So now basically, again, the system is
17 creating incentives where, especially consumers in high
18 deductible plans, are left footing the bill for the high
19 prices.
20 So now I'm going to talk about the merger and
21 what potential affect it might have on the health
22 insurance market.
23 So the first thing about health insurance
24 markets is that they are highly concentrated. So if you
25 look at the AMA study on health insurance markets, they

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1 find that they are highly concentrated, that the
2 Herfindahl Index exceeds 2500 in several markets.
3 Similarly, if you look at data from the Kaiser Family
4 Foundation, which splits the market into individual,
5 small, and large groups, they also find highly
6 concentrated markets.
7 And Aetna is, you know, the third largest
8 insurer. It's a dominant firm in several of these
9 markets. So Aetna is the number one or number two
10 insurer, according to the AMA study, in roughly 70 HMO
11 markets and about 100 PPO markets.
12 So my opinion is that what this merger will do
13 is it will exacerbate the lack of competition in health
14 insurance markets. So we are already highly
15 concentrated. The merger might make these markets even
16 more concentrated.
17 The reason why I think that might happen is
18 because CVS-Aetna, or the entity after the merger, is
19 going to control two key inputs for providing health
20 insurance, which are PBMs and pharmacies. So if you
21 have control over two key inputs, you have an incentive
22 to use these inputs to disadvantage health plans
23 competing with Aetna.
24 And so if you increase the cost of these
25 inputs for these competing health plans, then these

1 completing health plans will experience an increase in
2 prescription drug costs. They might also experience an
3 increase in total healthcare costs because prescription
4 drug spending, or how well you manage your prescription
5 drug benefit, has a consequence for your total medical
6 cost.
7 So if you design a formulary that is not
8 optimized, what will happen is that people might not
9 take their medications for chronic conditions and they
10 might end up in the hospital, increasing your medical
11 care costs.
12 So the control of these two key inputs is not
13 only going to affect prescription drug costs, but might
14 also have spillovers on total healthcare costs. And if
15 total healthcare costs rise, it will probably lead to
16 increased premiums faced by consumers.
17 And maybe some health plans or health plans
18 that are competing with Aetna recognize CVS-Aetna's
19 control over these two key inputs, and maybe they don't
20 enter the market or it reduces the level of competition,
21 they're disadvantaged in this market, so overall it
22 might lead to reduced competition in health insurance
23 markets.
24 So to give you some examples of how, say, the
25 PBM arm or the pharmacy arm of CVS-Aetna might

1 disadvantage competing health plans. So maybe one the
2 things you can do, you know, the incentive would be
3 there that the PBM arm of CVS-Aetna might reduce the
4 pass through of rebate dollars to competing health
5 plans. So this will essentially increase the
6 prescription drug costs of competing health plans.
7 The PBM arm of CVS-Aetna might not optimize
8 formulary design, and this might lead to changes in use
9 of prescription drugs and also changes in overall
10 healthcare costs. They might slow down claims
11 processing, or create, you know, other hurdles to
12 increase operating costs for competing health plans.
13 They might not negotiate, so as I mentioned
14 earlier, one of the roles of the PBM is to negotiate
15 with pharmacies. So now if CVS-Aetna is negotiating
16 with its own pharmacy, CVS, they have an incentive to
17 not negotiate very hard, which would basically mean that
18 competing health plans will be paying higher in pharmacy
19 costs, and then the pharmacy arm of CVS-Aetna might
20 charge higher prices to competing health plans to
21 disadvantage them.
22 So one of the issues is that suppose they do
23 this, maybe the competing health plans say we don't want
24 CVS-Aetna to be our PBM or our pharmacy provider and we
25 want to chose someone else.

1 And I feel the extent of if that would happen
2 is reduced by the fact that there isn't a lot of
3 competition in the PBM market. There are not a lot of
4 options available for competing health plans to go to
5 other large PBMs who might offer comparable services.
6 And the other problem is the other large PBMs
7 also are owned by health plans, so then you're kind of
8 stuck with the same problem, that you are always stuck
9 with a PBM that is owned by a competitor.
10 And finally, you know, CVS pharmacies, as we
11 heard today, are present everywhere. They have a
12 dominant position in the market. So even if you are not
13 happy with CVS pharmacies, a competing health plan might
14 not be able to exclude CVS pharmacies from their network
15 because patients would value having these pharmacies in
16 the network. So that gives CVS pharmacies, in some
17 sense, the market power to Advantage Aetna at the cost
18 of competing health plans.
19 So one question you could ask is that suppose
20 they do this and they risk losing some PBM or pharmacy
21 customers, how strong are those incentives so that
22 potential loss and revenue from losing a PBM or pharmacy
23 customer, versus disadvantaging a competing health plan
24 and taking their customer as an insurance customer,
25 right?

1 So if I as a PBM or CVS-Aetna as a PBM doesn't
2 provide high quality service to competing health plans,
3 those competing health plans might drop CVS-Aetna as a
4 PBM, but CVS-Aetna might end up getting a customer from
5 that competing health plan to Aetna. So what would
6 those incentives look like?
7 So if you just consider a hypothetical
8 customer who spends, say, on average $10,000 a year --
9 this is roughly what U.S. per capita spending on
10 healthcare is -- and let's say they spend about 10
11 percent of that on prescription drugs, so about $1000 on
12 prescription drugs.
13 So if you remember my numbers earlier, the PBM
14 net margin or net profit margin is about 22.3 percent.
15 So on the $1000 of drug costs, the PBM is going to earn
16 roughly $23 in profit. So if I lose this customer as a
17 PBM customer, I'm looking to lose about $23 in profit.
18 But if I gain this same customer as a health
19 insurance customer, then basically I'm going to make
20 about three percent on the total healthcare spending,
21 which is $10,000. So three percent of $10,000 is
22 roughly $300, and I'm still going to be providing PBM
23 services to this customer because now they're a combined
24 entity, so I'm going to make another $23 in PBM profits.
25 So getting one insurance customer is valued at roughly

1 $323. Losing one PBM customer is valued at $23.
2 So in some sense the incentives are there to
3 disadvantage competing health plans, even if it means
4 losing these $23, because the gain on the other side is
5 pretty big, that if you get one insurance customer in to
6 your firm, that's going to be valued at $323.
7 So in other words, in this hypothetical
8 example one insurance customer is as valuable as 14 PBM
9 customers. So even if I lose 14 PBM customers and gain
10 one insurance customer, my profits remain unchanged.
11 You can do the same calculation for the
12 pharmacy side of the market, and the numbers are fairly
13 similar that, you know, one insurance customer is as
14 valuable as nine pharmacy customers.
15 And the reason this works is your net profit
16 margins are roughly similar in the insurance and the PBM
17 market, but as an insurance customer, you own that net
18 margin on the entire healthcare cost. But PBM and
19 pharmacy customers, you only earn the net margin on the
20 prescription drug cost and not the entire drug cost.
21 So another argument here could be that, fine,
22 you know, maybe this merger might lead to some
23 anticompetitive effects, but maybe lack of competition
24 or higher concentration in the insurance market is good
25 for consumers. So one theory for that is that a big

1 insurer can exercise their market power to reduce
2 provider reimbursement. So to make sure that they clamp
3 down on hospital costs and physician costs and so on.
4 But if you look at the evidence, the evidence
5 is that what the literature finds is, yes, there is some
6 evidence that larger insurers pay, you know, lower
7 prices to providers, but in net, higher market power in
8 the insurance industry means higher premiums for
9 consumers. So those savings from paying lower prices to
10 hospitals or physicians are not being passed on to
11 consumers in the form of lower premiums.
12 Finally, we can kind of look at the potential
13 efficiencies in the health insurance market. So I think
14 one efficiency would be that now CVS becomes part of
15 Aetna, and therefore CVS has the incentive to be a
16 better PBM for Aetna. So right now they are separate
17 entities, CVS, the PBM, is more bothered about its
18 bottom line than, you know, what Aetna's bottom line
19 would be. But now when they become a combined entity
20 their incentives align, and therefore CVS might become a
21 better PBM for Aetna. It might optimize their formulary
22 design in a way as to lower total healthcare costs and
23 not just focus on the prescription drug costs.
24 But the extent to which this happens and the
25 magnitude of the efficiencies or the savings will depend

1 upon whether CVS is performing kind of the key strategic
2 decisions for Aetna. Which is, are they in charge of
3 formulary design, are they the ones negotiating rebates
4 on behalf of Aetna and so on. So to the extent that
5 they are doing this, the savings would be big.
6 But if you look at the 10K statement for
7 Aetna, which was filed with the Securities and Exchange
8 Commission, what that statement says is "We also perform
9 various pharmacy benefit management services for Aetna
10 pharmacy customers consisting of product development,
11 commercial formulary management, pharmacy rebate
12 contracting and administration, sales and the account
13 management, and precertification programs." And then
14 they go on to say that CVS performs certain
15 administrative functions related to PBM or related to
16 prescription drugs.
17 So the key question is, you know, if Aetna is
18 already its own PBM, which is what they claim in their
19 SEC or their 10K filings, then this efficiency isn't
20 there. But to the extent that CVS is truly Aetna's PBM
21 right now and they are performing the core PBM
22 functions, then I think those efficiencies do exist.
23 So based on the review of the prior
24 literature, what I conclude is that, in my opinion, the
25 potential costs of the merger, due to foreclosure in the

1 insurance market, outweighed the potential efficiencies
2 in the insurance market.
3 And here are some factors that led to this
4 opinion. So the first was that CVS and Aetna, you know,
5 will control two key inputs, PBMs and pharmacies, so
6 they have an opportunity to disadvantage rival health
7 plans.
8 CVS and Aetna have a dominant position in each
9 one of these input markets, which means it's not going
10 to be easy for competing health insurers to find other
11 entities to provide these functions.
12 Third, the number of consumers who stand to
13 lose from the mergers, so CVS has on its website, it
14 claims that they serve about 94 million customers.
15 Aetna on its website claims that they have about
16 22 million subscribers. Which means maybe 22 million
17 subscribers might benefit from this merger, but
18 72 million subscribers who are basically CVS customers
19 with competing health plans, might experience higher
20 costs as a result of this merger.
21 Finally, the incentives are such that the gain
22 from getting one insurance customer far exceeds the loss
23 from losing a PBM and pharmacy customer, so their
24 incentives are to kind of disadvantage competing health
25 plans.

1 And as I said, to the extent that Aetna, as
2 its SECs filings say is its on PBM, the potential
3 efficiencies are minimal.
4 So now lets switch to the potential effect of
5 competition in the pharmacy market.
6 So just like insurance markets, pharmacy
7 markets are also highly concentrated. So CVS and
8 Walgreens control about between 50 and 75 percent of the
9 drugstore market in each of the countries 14 largest
10 metro areas.
11 CVS has a dominant position in several
12 markets. So according to, again their own SEC
13 statements or 10K statement, they state that "We
14 currently operate in 98 of the top 100 United States
15 drugstore markets and hold the number one or number two
16 market share in 93 of these markets." This is from
17 their own filings with the Securities and Exchange
18 Commission.
19 So now the argument here is similar, which is
20 that the health insurance arm or the PBM arm of
21 CVS-Aetna could disadvantage pharmacies competing with
22 CVS by either excluding them from the pharmacy network
23 or through other business practices, and this might hurt
24 these competing pharmacies and therefore reduce the
25 level of competition in the pharmacy market.

1 So how might this, you know -- and if this
2 happens, this will further strengthen the already
3 dominant position CVS has, which is that they are the
4 number one or number two pharmacy chain in 93 of the top
5 100 markets in the U.S.
6 So how might this happen or what might some of
7 these business practices look like? So CVS-Aetna
8 pharmacies -- they could basically promote CVS-Aetna
9 pharmacies or exclude competing pharmacies in outreach
10 communication with CVS-Aetna insurance subscribers.
11 So as an insurance company you sometimes
12 communicate about your pharmacy network with your
13 beneficiaries or your subscribers, and maybe one thing
14 you could do is highlight CVS pharmacies in bold font or
15 give them more prominence in that communication while
16 other competing pharmacies are hidden somewhere in the
17 communication, and that might drive market share towards
18 CVS pharmacies.
19 They could reduce reimbursement to competing
20 pharmacies, and then maybe once they are under financial
21 stress, subsequently buy them.
22 They could exclude competing pharmacies from
23 the CVS-Aetna pharmacy network, so basically just say we
24 won't send any of our subscribers to your pharmacies.
25 Or they could have preferred status for

1 CVS-Aetna pharmacies -- which was a question,
2 Commissioner, you asked earlier -- which might be that
3 consumer based lower cost sharing, if they go to
4 CVS-Aetna pharmacies relative to other pharmacies.
5 So these are not just hypothetical examples.
6 In my expert report I cite a variety of lawsuits between
7 pharmacies and PBMs where such conduct has been alleged.
8 So these were all pulled from media reports where there
9 were lawsuits where such conduct was alleged.
10 So one question might be that CVS is already
11 the PBM for Aetna, so in some sense CVS CareMark, or the
12 PBM, already has an incentive to favor CVS pharmacies,
13 and then maybe this merger where CVS buys Aetna doesn't
14 really affect that incentive.
15 And the counter argument to that would be that
16 Aetna currently does not have the incentive to favor CVS
17 pharmacies, but post merger that check disappears.
18 Because right now if CVS CareMark tries to favor CVS
19 pharmacies and that increases costs for Aetna, Aetna is
20 going to object to it. But post merger, Aetna is part
21 of the same entity, and that incentive disappears.
22 The other thing is that the vertical merger is
23 more permanent than a contract, and therefore it
24 eliminates competition that occurs when a contract needs
25 to be renewed.

1 So right now there might be a contract with
2 CVS pharmacies, but if they don't like the terms or if
3 they feel CVS pharmacies are not providing value for
4 money, good quality care at low costs, they don't have
5 to renew the contract with CVS. But if there is a
6 merger, than that contract is no longer needed and it
7 becomes a more permanent deal.
8 So this anticompetitive effect is going to be
9 larger in markets where Aetna has a dominant position.
10 So if Aetna controls, say, 50 percent of the market,
11 which it does in Anchorage Alaska, now independent
12 pharmacies in those markets are going to be really
13 worried because they might feel that 50 percent of the
14 market, or a large fraction of that 50 percent, might go
15 to CVS instead of to them.
16 So the higher is Aetna's market share in a
17 market, the more worried would competing pharmacies be
18 about Aetna steering patients toward CVS pharmacies and
19 them losing business as a result.
20 So now let's consider the potential
21 efficiencies in the pharmacy market. So in the
22 testimony today, as well as in other written testimony,
23 CVS argues that the merger will lead to lower healthcare
24 costs through integration of pharmacy and medical data.
25 So one protocol efficiency they talked about

1 is providing data to pharmacists will allow them to
2 better counsel patients. But my understanding is that
3 Aetna, or typically a health insurer doesn't -- and this
4 kind of relates to your question earlier -- a health
5 insurer doesn't have access to electronic health
6 records. Typically what a health insurer has access to
7 is claims or billing data.
8 I feel that data is not enough to, even if
9 that data is provided to pharmacists, that's not enough
10 information for them to better counsel patients. What
11 the pharmacist would need is the electronic health
12 records from the medical providers, and for that what
13 you need is some sort of data use or data sharing
14 agreement with the electronic health, you know, with the
15 medical providers to share their electronic health
16 records with CVS, and I don't see how this merger helps
17 with that. So given that I feel the potential for
18 efficiencies is reduced.
19 Another efficiency is that the integration of
20 pharmacy and health plan data might lead to better
21 benefit design. So ultimately as a health plan what you
22 care about is your total healthcare cost, and now if you
23 have access to pharmacy data and you use some fancy
24 analysis, you might be able to tweak, you know, which
25 drugs to cover as to reduce your overall healthcare

1 costs.
2 But I feel that Aetna can get this data
3 without a merger. So I think that would be the
4 exercise, to kind of analyze your pharmacy and medical
5 data together to optimize your medical benefit. So I
6 think they can get it without a merger, or maybe they
7 already have access to it through their existing
8 arrangement with CVS as their PBM.
9 So again, based on this analysis, my opinion
10 is that the potential cost of the merger due to
11 foreclosure in the pharmacy market outweighs the
12 potential efficiencies in the pharmacy market.
13 So the last market I consider is the PBM
14 market. So we have already covered that PBM markets are
15 also highly concentrated. Currently Aetna contracts
16 with CVS for some PBM services, it's unclear what the
17 exact nature of the contract is.
18 So what will happen is if the merger happens,
19 this contract becomes more permanent or it about becomes
20 permanent, which basically means Aetna is not in the
21 market to contract for PBM services from other PBMs. So
22 this basically essentially contracts the size of the PBM
23 market that the third largest insurer in the U.S. is no
24 longer going to shop for PBM services because they have
25 their own in-house PBM. And this contraction in the

1 size of the market could, you know, reduce incentives to
2 enter the PBM market for potential entrants.
3 The potential entrants might also be worried
4 that most of the PBMs they will not competing with will
5 also be integrated with a health insurer. So Humana has
6 its own PBM. Aetna will have its own PBM. United will
7 have its own PBM. So a new PBM entrant might worry that
8 they not only need no enter the PBM market, but the
9 health insurance market both at the same time, and that
10 might be a big hurdle to cross.
11 So result of this, we might experience less
12 entry in the PBM market, and therefore reduced
13 competition in the PBM market.
14 So now just kind of combining the conclusions
15 from the analysis of the PBM, health insurance, and
16 pharmacy market, what I conclude is that within each of
17 these specific markets, the insurance, pharmacy, and PBM
18 market, in which the merger is likely to have
19 anticompetitive effects, there are no potential benefits
20 of sufficient magnitude or certainty that would outweigh
21 the anticompetitive effects of the merger.
22 Thank you very much.
23 COMMISSIONER JONES: Thank you.
24 So now we'll go to Ms. Ross -- Dr. Diana --
25 Moss, I'm sorry. Ross is the musical artist. Moss is

1 the antitrust expert.
2 Ms. Moss, thank you for joining us
3 telephonically, and we would welcome the chance to hear
4 from you now.
5 MS. MOSS: Very good. Thank you very much,
6 Commissioner Jones. It's an honor to be testifying
7 virtually here today, and unfortunately I do not have a
8 good singing voice, so I'll have to stick to the
9 economics and the antitrust as my contribution.
10 You know, at this point in the lineup, you
11 know, I would be repeating a lot of what you have heard
12 from previous witnesses. So I'm going to do some fancy
13 footwork and sort of retool my presentation to hit on
14 some of the high points that you have already heard, and
15 themes, but also to emphasize what we think are
16 important points.
17 So just by way of introduction, the American
18 Antitrust Institute is an independent nonprofit
19 research, education, and advocacy organization. We've
20 been around for 20 years --
21 COMMISSIONER JONES: Ms. Moss, I should have
22 said this at the front end because you missed it, but
23 we've got a court reporter, and she's trying to capture
24 all of this, so just a little bit slower delivery.
25 Thank you.

1 MS. MOSS: I'll slow it down. Very good.
2 Thank you.
3 So the American Antitrust Institute is an
4 independent nonprofit research, education, and advocacy
5 organization devoted to promoting competition and
6 protecting consumer welfare.
7 My testimony here today is based on a letter
8 that AAI sent to the U.S. Department of Justice
9 Antitrust Division on March 26th, 2018 urging the
10 Division to block the proposed merger of CVS and Aetna.
11 I will explain our reasoning in that letter in
12 summary form today.
13 So, you know, at a high level, let's go up to
14 ten thousand feet and look at what this deal really
15 presents to competition and to the American consumer.
16 It pairs up the number one retail pharmacy
17 chain and one of the two largest PBMs in the nation with
18 the third largest health insurer in the country. So it
19 is a massive, massive, combination of PBM and retail
20 pharmacy services and products with a leading health
21 insurer.
22 It would entail fundamental restructuring of
23 the industry as we know it from largely nonintegrated
24 PBMs and retail pharmacies and nonintegrated insurers to
25 a, where we have more open competition and easier entry

1 at either level, or any of those three levels, and it
2 would transform that industry to a very, very different
3 profile where we have integrated PBMs and health
4 insurers, particularly with Express Scripts and Cigna
5 waiting in guilty the wings. We already have United
6 Healthcare and Optum RX in the market.
7 Together, if all of those three hypothetically
8 were to become vertically integrated or to solidify that
9 landscape, we would have a fundamentally different
10 market structure to deal with. It would raise the bar
11 on entry, it would weaken incentives to compete
12 dramatically, and it would discourage innovative,
13 disruptive business models.
14 So I want to talk about three things. Give
15 some important facts that set the table for how we look
16 at these vertical mergers and why we are concerned about
17 their effects on competition and consumers.
18 I want to just hit the high points again on
19 why the merger raises serious concerns about forecloser
20 or the exclusion of rivals at both the upstream PBM and
21 retail pharmacy levels, but also in health insurance.
22 I want to talk about why the merger would
23 actually facilitate anticompetitive coordination between
24 players in the resulting market, and I want to debunk or
25 discount any claims that this merger would produce

1 efficiencies sufficient to overwhelm the anticompetitive
2 effects.
3 So before that, and certainly in light of what
4 has happened in the last two weeks in the recent
5 district court decision in AT&T-Time Warner -- which is
6 also a vertical merger -- and presents one of the very
7 same issues that is at issue in CVS-Aetna, I want to say
8 that is not a good predictor of an outcome in this
9 particular case.
10 Lest anyone, any sort of pro merger, pro
11 consolidation proponents out there rely on this decision
12 to make their case to the antitrust authorities or to
13 state regulatory agencies, we would really, really
14 discourage that. We have a very different fact pattern
15 here -- and by the way, for those of you not following
16 the case, the district court found in favor of the
17 defendants against the government in attempting to
18 challenge that deal.
19 Very different fact pattern here. Very
20 significant concerns about the role of market
21 concentration and the dominance of the firms involved in
22 this transaction, and the likely anticompetitive and
23 anticonsumer effects.
24 We also have an established record of a lack
25 of transparency in prescription drug pricing and rebates

1 involving the PBMs, and deliberate attempts to shape and
2 control competition in the PBM and retail pharmacy
3 space.
4 So how important is this merger? It is
5 vitally important and should get very serious scrutiny
6 at all levels. Pharmaceutical expenditures account for
7 17 percent of total healthcare outlays in the U.S. PBMs
8 manage prescription drug benefits for 95 percent of
9 Americans with coverage.
10 So we are dealing with a potentially very
11 harmful merger that deserves particularly intense
12 scrutiny for the benefit of promoting competition and
13 protecting consumers.
14 So let's talk about concentration. You've you
15 heard a lot about that from very expert witnesses here.
16 Why is concentration and the market shares of these
17 players so important? The reason why is because it sets
18 the table, it lays out a landscape for why we should be
19 so concerned about the effect of this merger, a vertical
20 merger, in pairing up PBM and retail pharmacy players
21 with health insurers and fundamentally changing their
22 incentives, pre merger to post merger, not to engage in
23 dealing with all comers, but to engage in exclusionary
24 conduct that would make it harder for smaller PBMs to
25 compete and retail pharmacies to compete, particularly

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1 the independents, and also to squelch or to stifle
2 competition in the health insurance market.
3 So insurance markets are very concentrated.
4 The largest four insurers account for 83 percent of the
5 national market. Markets are defined locally in large
6 part for health insurance as Professor Greaney pointed
7 out. 70 percent of locally defined HMO, PPO, POS, and
8 exchange markets are highly concentrated. That means
9 there's not many players down there. There's not many
10 choices for planned sponsors and subscribers.
11 Aetna is the first or second largest insurer
12 in numerous metropolitan statistical areas. The DOJ
13 successfully blocked the mergers of Anthem-Cigna and
14 Aetna-Humana, showing that the merger would result in
15 very highly concentrated markets. Those were both wins
16 by the government in preventing those mergers from
17 moving forward.
18 Turning to PBMs and retail pharmacy, CVS has a
19 25 percent national market share. Express Scripts has a
20 24 percent national market share. Combined they account
21 for 50 percent of the market, the PBM market. The three
22 largest PBMs control 85 percent of the market. That is
23 not a lot of competition. It is not a lot of choice,
24 either at the health insurance level or at the PBM level
25 and retail pharmacy level for consumers, for planned

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1 sponsors, whoever the customer is, to go look around for
2 choice and alternatives to a firm that might be
3 exercising market power.
4 This dominance, particularly in PBM, gives CVS
5 the ability to influence, have a tremendous amount of
6 influence over which drugs are dispensed, what sources
7 they are dispensed from. They have protected positions
8 in serving their clients because once subscribers are
9 in, they are limited to those affiliated pharmacy
10 services.
11 So we should pay great attention to the
12 landscape here and the high levels of concentration and
13 market dominance associated with these two players that
14 are proposing to create a vertically integrated firm.
15 So moving on to how the merger can harm
16 competition and consumers. I'm not going to spend a lot
17 of time on this. It's been explained very, very well.
18 But there are really two ways or two channels through
19 which combining these two companies will fundamentally
20 change incentives pre-to-post merger, that could
21 disadvantage rival insurers in the downstream health
22 insurance markets, and impede competition down there,
23 but also disadvantage smaller PBMs and independent
24 pharmacies in the upstream markets up there.
25 So there's two theories. One is what we call

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1 input foreclosure, which is essentially enhanced
2 incentives, and certainly the ability for the merged
3 company to cut off or frustrate rival health insurers
4 access to CVS products and services.
5 So premerger, CVS has pretty strong incentives
6 to deal with all health insurers. They're not
7 integrated, they're standalone, but post-merger there's
8 a fundamental change. The company now controls an
9 essential, dominant PBM by combining the insurer with
10 the PBM. It's a critical input for rival health
11 insurers.
12 So the combined company now has enhanced
13 incentives through greater bargaining leverage to
14 frustrate rival and insurers access to CVS products and
15 services. They could raise their costs, they could cut
16 them off, and they could do that through any number of
17 conditions.
18 They could develop formularies, for example,
19 that don't include important drugs that are in demand by
20 subscribers. They could refuse to provide transparency
21 about actual costs of drugs or payments or rebates they
22 get from manufacturers. They could offer pharmacy
23 networks that don't provide important options, such as
24 independent specialty pharmacies, or they could force
25 rival insurers into CVS CareMark mail order services --

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1 we have already seen that happen.
2 They could gather information on subscribers
3 and drug spend for rival insurers and target those
4 insurer's customers in ways that would impair their
5 ability to compete. Or they could simply decline to
6 fill prescriptions for rival insurer's enrollees. So
7 there's absolutely any number of mechanisms through
8 which the merged company would act on its greater
9 incentives to make it more difficult for rival insurers
10 to compete.
11 So the key here to understanding why market
12 concentration is so important and is such a fulcrum or a
13 link between concerns over anticompetitive effects is
14 because health insurers have very few options, very few
15 options to switch to other PBMs, right? The two largest
16 PBMs account for 50 percent of the PBM market, right?
17 So if you're a rival health insurer and you've
18 just been cut off by CVS or it's more expensive now for
19 you to deal with CVS, you go searching around for a
20 rival PBM. Well, smaller PBMs don't have the kind of
21 bargaining power, they don't have the sophisticated drug
22 management programs. They are not good options. They
23 are not good substitutes for these health insurers
24 searching around to avoid the discriminatory or the
25 exclusionary conduct.

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1 The bottom line is it risks, this type of
2 strategy risks higher insurance premiums, lower quality
3 services, and less innovation.
4 All right, turning quickly now to the other
5 foreclose theory, which is customer foreclosure, which
6 you just heard about, affects the PDM market. So it
7 could disadvantage rival PBMs and independent
8 pharmacies, right, through what we call customer
9 foreclosure.
10 So pre merger Aetna has great incentives to
11 deal with rival PBMs as a standalone insurer. Post
12 merger, now the company controls an important customer,
13 right, this vertical integrated company controls an
14 important customer.
15 The company therefore has enhanced incentives
16 and greater bargaining leverage to frustrate rival PBMs
17 by making it difficult for them to access Aetna as a
18 potential customer. They, too, can impose any number of
19 conditions. They can drive down dispensing fees and
20 delay reimbursement to smaller rival PBMs. They can
21 cherrypick profitable prescriptions and enforce
22 take-it-or-leave-it contracts with independents, right?
23 Aetna can refuse to grant an affiliation for a rival PBM
24 to serve their insured members -- which is really
25 critical for insuring prescription drug coverage.

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1 These smaller PBMs don't have the scale and
2 the scope that the larger PBMs do to negotiate for
3 rebates, other network services, they are particularly
4 exposed to restrictive conduct, to exclusionary conduct,
5 as are the independent pharmacies, if we're talking
6 about the retail pharmacy market -- which are very
7 important community institutions and provide services,
8 particularly for seniors.
9 The result of customer foreclosure would be
10 higher prescription drug prices, lower quality, and the
11 less innovation.
12 The last concern about anticompetitive effects
13 is that the merger creates incentives not only to
14 exclude rivals, but for the companies to coordinate
15 instead of to compete.
16 So there's two possibilities here. Let's say
17 CVS deals with Aetna, obviously as its integrated
18 affiliate, but it also continues to serve other rival
19 health insurers. So now CVS has lots of information
20 about rival health insurers' subscribers. They can take
21 that information on drug spend and on preferences and
22 all sorts of important customer information and they
23 can -- it circulates within the company, within the
24 integrated CVS-Aetna infrastructure, now they have
25 critical information on arrivals, customers. That can

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1 facilitate price fixing, it can facilitate market
2 allocation, and any number of other ways that would lead
3 to coordination as opposed to hardnosed competition.
4 The other way they can ultimately coordinate,
5 is if these other vertical mergers actually go through
6 and we see a vertically integrated Express Script Cigna,
7 if CVS-Aetna goes through, we have United Healthcare and
8 Optum, we would have three vertically integrated PDM
9 insurer systems transforming the industry away from its
10 current structure to a decidedly, decidedly
11 anticompetitive structure.
12 Having three massive, vertically integrated
13 platforms creates very strong incentives for those firms
14 to align themselves on various policies, to engage in
15 coordination and tacit coordination, tacit conclusion,
16 on any number of issues. And that would prevent the
17 entry of more innovative PBMs, smaller PBMs, more
18 innovative or disruptive business models that would like
19 to come in and enter the market.
20 So in sum, the merger creates significant
21 concerns about exclusionary conduct post merger, both in
22 the PDM and the health insurance market, but it also
23 creates very significant concerns about an
24 anticompetitive coordination as a result.
25 And then finally, I just want to point out

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1 that there has been little evidence that previous
2 mergers in this space has resulted in any substantial
3 benefits. So we have to look skeptically at the record
4 evidence and merger retrospectives that show that.
5 The more anticompetitive a merger is, the
6 higher is the burden to though -- and the burden falls
7 on the companies -- to show any claimed efficiencies
8 from their deal, like elimination of double margins,
9 coordination effects, all the kinds of things you've
10 heard about today, the higher is the burden to show that
11 those efficiencies will countervail anticompetitive
12 effects. That is a very, very tall order.
13 Nor have the companies shown or demonstrated
14 that they need this merger to achieve those benefits,
15 versus contracting, engaging in really creative,
16 innovative contracting at arm's length with a PBM or
17 with a health insurer to achieve those types of
18 benefits.
19 So we're not convinced these efficiencies are
20 merger specific. We are not convinced that they are
21 actually cognizable or verifiable and that they will
22 actually occur.
23 And I would point out that the record evidence
24 on efficiencies is really burgeoning. The management
25 consulting literature shows, a big study by Mackinzie

1 some years ago, shows 70 percent of mergers don't prove
2 up the cost savings. And in a vertical merger -- which
3 is especially difficult and complex given that you're
4 integrating two very different organizations, there are
5 limitations on managerial competence and other
6 factors -- it is a very, very tall order to expect
7 efficiencies to materialize, to be merger specific, and
8 to actually overwhelm these anticompetitive effects.
9 And given the market dominance of these
10 players and the high levels of concentration and the few
11 substitutes that are available out there, I don't think
12 we would ever see any cost savings passed on to
13 consumers, insurers, and ultimately to their
14 subscribers.
15 So AI's position is the most effective remedy
16 here is to block the merger outright.
17 Thank you.
18 COMMISSIONER JONES: Thank you very much,
19 Dr. Moss.
20 Let me check in with the court reporter and
21 see how she's doing.
22 COURT REPORTER: It's been close to two hours.
23 COMMISSIONER JONES: So perhaps we should take
24 ten minutes.
25 COURT REPORTER: Ten minutes is great.

1 COMMISSIONER JONES: So with the indulgence of
2 this panel, I know that we may lose Dr. Scheffler
3 because he has to go, but if the others could remain and
4 give the court reporter a break, and then we'll resume
5 for the last witness in this panel in ten minutes.
6 Thank you.
7 (Off the record.)
8 COMMISSIONER JONES: So we're going to resume
9 the hearing, and ask folks if they can take their seats,
10 and we have one more witness on this panel, and that's
11 Dr. Lawton Burns, and we want to welcome you and thank
12 you for joining us as well.
13 Thanks for letting us take a little recess in
14 advance of your testimony.
15 MR. MORIARTY:
16 MR. BURNS: Thank you, Commissioner, for
17 allowing me to have the opportunity to testify. I come
18 to you today from the temple of capitalism out on the
19 east coast, The Wharton School. It also happens to be
20 the President's alma mater, so hopefully you won't hold
21 that against me.
22 Like our prior speakers, there's some
23 disclosures I need to make. My work was supported by
24 the AMA, but it doesn't reflect their views.
25 Just by way of background, I'm a professor at

1 the Wharton School. Unlike the other speakers, I'm not
2 an economist or an attorney, I'm a behavioral scientist,
3 assist, so I think that I'm probably here for comic
4 relief given everything we've heard about foreclosure
5 and Herfindahl indexes.
6 I'm a professor of healthcare management,
7 study of management strategy in the healthcare system.
8 I've done much of my work over the last 30 years on
9 vertically integrated combinations in the healthcare
10 industry.
11 I teach the core course at the Wharton School
12 on the entire healthcare industry. I have done that for
13 20 years. Prior to that I taught intro to the
14 healthcare system at other universities for 15 years
15 before that. So I've been teaching an intro course on
16 the healthcare system for about 35, 36 years.
17 I have learned two things by having to cover
18 the entire healthcare system. First, as the President
19 himself acknowledged last year, healthcare is pretty
20 complex. The second thing is, and pardon my French, but
21 this industry is full of BS, and so you need to have a
22 good BS detector when you study what goes on in the
23 industry, and I spend a lot of my time confronting a lot
24 of this.
25 The thrust my testimony is that other

1 witnesses have opined on the mergers anticompetitive
2 effects. I'm not an economist, so I will not be talking
3 about anticompetitive effects. Where I come in is when
4 something is found or suspected to be anticompetitive.
5 I will argue here today that the merger fails to deliver
6 any offsetting or compensating benefits that this might
7 nevertheless justify the merger.
8 I'm often asked to testify in antitrust cases
9 about the possible presence of such offsetting benefits.
10 For the last 15 years I have worked for the Department
11 of Justice, the Federal Trade Commission, and several
12 State Attorney Generals on these things, and from what I
13 have been able to glean based on my experience in the
14 healthcare industry, looking at this specific merger, my
15 knowledge of the different sectors that are being
16 combined here, I do not think that there is any evidence
17 for the supposed benefits flowing from this merger.
18 In particular what my comments will focus on
19 is one aspect of the operations of the projected merger,
20 and that's the retail clinics. So that's what the bulk
21 of my remarks will focus on.
22 So just some general observations. First, as
23 Diana Moss recognized, the proposed merger is based on a
24 corporate strategy of vertical integration. Having
25 studied this for 30 years, I can tell you there is no

1 prima face evidence for consumer welfare benefits
2 flowing from a strategy of vertical integration, so the
3 burden is on the people doing it to demonstrate that.
4 In fact, in the healthcare industry the
5 strategy of vertical integration usually leads to higher
6 prices, higher cost, and higher utilization, and
7 sometimes it also results in greater market power. So
8 there are grounds to be cautious, if not suspicious, of
9 vertical mergers.
10 Based on the research evidence, one cannot
11 assume that the consumer benefits will automatically
12 flow from such a vertical merger in the healthcare
13 industry, and there is oftentimes a disconnect between
14 the rationales espoused by the company executives who
15 engage in vertical integration versus those enunciated
16 in and academic theory and research. And based on my
17 experience having studied this for 30 years, such
18 disconnects often portend strategic failures to deliver
19 on the promised benefits.
20 Now some specific conclusions. First, one
21 must examine the specific merger benefits advanced by
22 the parties. And I have gone through the prior
23 testimony of the witnesses from Aetna and CVS, and I was
24 here this morning listening to what they said, and I'm
25 just going to reiterate some of the promised benefits

1 from this vertical merger.
2 Put the consumer at the center of the
3 healthcare delivery system. Remake the consumer
4 healthcare experience. Engage and empower consumers.
5 Help consumers achieve their best health. Improve the
6 coordination of care. Address simultaneously chronic
7 illness, primary care, and prevention. And also
8 simultaneously solve the three problems that have vexed
9 our healthcare system since the 1930s: rising costs,
10 unsure quality, and poor access to care. What we call
11 the iron triangle of care.
12 If the two parties in this proposed merger are
13 able to pull all these things off, they deserve the
14 Nobel prize. If they delivered on any one of those, I
15 would be willing to put them up and nominate them for
16 the prize, but these things are incredibly difficult to
17 do, and we haven't really done any of these things to
18 date.
19 The reason why I'm skeptical of their ability
20 to do so, is you look at where these parties play in the
21 healthcare system -- so I have a chart up here of a
22 portrayal of the healthcare system. There are basically
23 five verticals here.
24 On the left you have the people who pay for
25 healthcare, that's government, employers, and ultimately

1 individuals.
2 In the middle you have the providers of
3 healthcare, hospitals and doctors which count for
4 53 percent of all healthcare expenditures.
5 And on the right you have the producers of
6 healthcare products, the technology sectors, pharma,
7 biotech, medical device.
8 And so separating the payers, providers, and
9 producers are two sets of intermediaries, the
10 insurers -- the second box from the left -- and then the
11 distributors -- the second box from the right.
12 Not what's instructive is if you look at where
13 Aetna and CVS play in this entire healthcare value
14 chain -- I have put in red where Aetna-CVS CareMark and
15 CVS pharmacies play here -- these are not typically
16 considered to be the levers to change the healthcare
17 system and deliver on cost, quality, and access.
18 They are certainly not prime movers to improve
19 social determinants of health, population health, or
20 public health. They are not prime movers to really do
21 what's needed to improve the healthcare system, that's
22 to improve the economy, which finances the healthcare
23 system.
24 And lastly they are not really fundamentally
25 positioned to change the behaviors of the population

1 that is the most costly population to deal with in the
2 healthcare system, which we call the poly-chronics.
3 Those are the chronically ill patients who have multiple
4 chronic conditions.
5 Roughly 20 percent of the Medicare population
6 accounts for three-quarters of all Medicare
7 expenditures. It's like the Pareto principle, 20
8 percent explains 80 percent. That 20 percent has five
9 or more chronic conditions such as chronic obstructive
10 pulmonary disease, diabetes, asthma, hypertension,
11 depression, and other things, and there's nothing in any
12 of the documents that I have seen that suggests that
13 anybody, let alone in the proposed merger parties, have
14 an ability to address the needs of that population.
15 So quickly, I'll just give you some supporting
16 arguments for my general conclusions.
17 First off, this merger is what I call a
18 defensive merger. The two parties to this merger are
19 merging for defensive reasons, primarily not to deliver
20 on all the supposed promises that I enumerated.
21 First part, CVS has been losing business to
22 Walgreens, its major competitor, and CVS also feared the
23 potential entry of Amazon into the pharmacy business.
24 Both of those things have catalyzed the merger from
25 their end.

1 For its part, Aetna failed to grow, which is a
2 major thing. And they failed to grow because its merger
3 with Humana was blocked by the Department of Justice in
4 early 2017. And Aetna needed that merger to grow into
5 the Medicare Advantage market, which is one of the major
6 growing markets. So it was foreclosed on growth there.
7 Secondly, Aetna has been watching as its major
8 competitor, United Healthcare, has been building up its
9 delivery system, which includes lots of physicians,
10 surgery centers, urgent care centers, and things like
11 that. So Aetna is looking for some way to sort of
12 counterbalance what its prime competitor has been doing.
13 In this case it's trying to acquire a chain of retail
14 clinics, which you find in CVS.
15 Second set of supporting arguments. The
16 retail clinics which are part of the CVS pharmacy have a
17 lot of hype and B.S. surrounding them. Back in, right
18 before 2000 Clay Christensen, very famous professor at
19 the Harvard Business School, published a book on
20 disruptive innovation in healthcare. He held out three
21 exemplars of that disruptive innovation in healthcare,
22 one of them was retail clinics, that disruption never
23 happened.
24 First the forecasted growth of retail clinics
25 never came to pass. In fact the growth of retail

1 clinics has been stagnant for the last three years, and
2 that stagnant growth also characterizes the pharmacy
3 industry in which you find these retail clinics. So
4 this is not a booming industry. It's not a booming
5 industry, and therefore that's one reason why it's not
6 going to disrupt anything.
7 Secondly, retail clinics supply only
8 one-to-two percent of primary care, so it's not a really
9 big player in the primary care area. The MinuteClinics,
10 part of CVS pharmacies, generate less than 1 percent of
11 CVS' retail pharmacy dispensing revenues. Oftentimes
12 these retail clinics are unprofitable.
13 And what most of the players in the retail
14 clinics industry have found, is they are unable to
15 effectively cross-sell products that people would come
16 to a pharmacy for, such as drugs, visits to the
17 MinuteClinic, or what we call HABA or Health and Beauty
18 Aids. And so people usually go to a pharmacy for one of
19 those, but not necessarily to get all three of them at
20 the same time.
21 A third set of supporting arguments is that
22 these retail clinics have major shortcomings as a
23 provider of healthcare. First off, there is documented
24 evidence that the retail clinics fail to serve the
25 underserved. And that was a core principle of the

1 theory of disruptive innovation.
2 So the retail clinics have studiously avoided
3 poor neighborhoods, rural areas, low income areas, and
4 instead they have gone after the higher income, higher
5 insured populations.
6 Secondly, they have failed to target the
7 chronically ill, and that's because they go after the
8 minor acute care thing, scrapes, bruises, people needing
9 vaccines. This is not where you're going to find the
10 poly-chronics coming to get their chronic illness care
11 taken care of.
12 Third, they do not have the personnel and the
13 capacity to address chronic illness. So with all due
14 respect to what I heard this morning, these are not
15 chronic care sites.
16 They have an inability to succeed in wellness
17 and prevention. And I need no further than to point out
18 reports that have come out by the Rand Corporation out
19 here, just how unsuccessful corporate wellness and
20 prevention efforts have been.
21 Typically the only people who enroll in
22 wellness and prevention efforts are voluntary enrollees
23 who are the worried well, who just want to take better
24 care of their health. They are not the poly-chronics
25 and the people who are underwater both physically and

1 financially.
2 Related to this, the clinics have an inability
3 to conduct medication therapy management which
4 oftentimes requires ongoing supervision by a physician.
5 Maybe working with a pharmacist is a good thing, but
6 medication therapy management has been something that's
7 been a real thorny problem that has not been addressed,
8 and I doubt that's going to be taken care of by a
9 MinuteClinic inside of a retail pharmacy.
10 In general, the community health center
11 movement has been a failure in this country. It's also
12 been a failure in other countries. I have written books
13 on India's healthcare system, China's healthcare system.
14 All of these countries would like to have a more
15 community health center base to their healthcare system,
16 nobody has bothered to pull it off, and we have failed
17 at this since the 1960s.
18 Finally, these clinics have a limited ability
19 to reduce cost and improve quality. There is just no
20 evidence that these things can improve quality, and
21 because they are treating the minor conditions, they are
22 not going to make a dent in the rising cost the
23 healthcare. And because they're dealing with people who
24 are coming in for minor conditions, they're not going to
25 be addressing the costs of specialty pharmaceuticals,

1 which are the fastest growing portion of expenditures in
2 the pharmacy area.
3 Then the last thing I'll say is that CVS
4 operates roughly 10,000 pharmacies in this country, but
5 they only operate about 1000 or 1100 retail clinics. So
6 CVS itself does not possess the capability to roll out
7 this retail clinic concept in its pharmacies. They're
8 going to have to invest an awful lot of money in what,
9 to date, has been a money losing operation.
10 Thank you so much.
11 COMMISSIONER JONES: Thank you very much.
12 I just had one or two questions. Let me start
13 first with our last witness.
14 I guess the slide supporting arguments No. 2,
15 where you address the success of retail clinics
16 generally. There's a bullet "May supply only one or two
17 percent of all primary care."
18 Is that measured -- well, let me just ask:
19 How is that measured? Is it by volume of incidents and
20 provision of primary care or revenues of primary care or
21 some other --
22 MR. BURNS: It's encounters.
23 COMMISSIONER JONES: It's encounters. Okay.
24 The other question that I had was for
25 Professor Sood.

1 So one of your points was that based on a SEC
2 or other financial filing by Aetna, that it was already
3 providing some level of PBM services, and I believe it
4 was your argument that, therefore, there would not be
5 much benefit associated with the merger.
6 But then later on you make a different point,
7 which is that Aetna is relying on CVS CareMark for
8 pharmacy care benefit services, and that the merger may
9 result in anticompetitive effects because of that
10 reliance.
11 So those two points seem to be in conflict,
12 and I'm wondering, if I'm making myself understandable,
13 if you might explain why they are not in conflict if
14 they're not.
15 MR. SOOD: Sure. Based on Aetna's SEC's
16 filings, both are true, that Aetna claims to be
17 providing PBM services to its own subscribers, and at
18 the same time they have a contract with CVS to provide
19 certain other PBM services.
20 So CVS is the PBM for Aetna and Aetna is the
21 PBM for Aetna. And the question who's doing what part
22 of the PBM services is unclear. So my argument was if
23 Aetna is providing its own core PBM services -- which is
24 negotiating with pharmaceutical firms, deciding which
25 drugs are in the formulary, the cost sharing and so

1 on -- so to the extent it's already doing all these core
2 functions, then merging with CVS does not the create
3 much sufficiency.
4 Because maybe CVS is just providing
5 administrative services related to being a PBM, so
6 they're processing the claims and doing things like that
7 rather than making the core strategic decisions for
8 Aetna. So that's the argument for why there might be
9 reduced efficiency.
10 And that you're right, on the PBM side of the
11 market, you know, at least for the administrative side
12 of PBM services, Aetna will no long are be in the market
13 because it will now have a more permanent relationship
14 with, CVS and therefore it's excluded from the market.
15 Or maybe another way to think about this is
16 that, you know, Aetna might never enter the PBM market
17 for either core services or administrative services
18 because now it has both those capacities in house. And
19 since it won't enter the PBM market, it's reducing the
20 size of the overall market and that might have
21 anticompetitive device effects.
22 COMMISSIONER JONES: I think I understand. In
23 part though, the weight of each argument is somehow
24 contingent on the degree to which Aetna is internally
25 providing its on PBM services versus the degree to which

1 it's relying on CVS Caremark for PBM services.
2 MR. SOOD: Yes, you're absolutely right.
3 COMMISSIONER JONES: Okay.
4 At some juncture we'll give Aetna and CVS a
5 chance to respond to that, but I just noted that there
6 seemed to be an inconsistency there, but I understand
7 now why there might not be.
8 Let me see if Ms. Rocco has any questions.
9 DEPUTY COMMISSIONER ROCCO: This question is
10 for whichever witness, or if more of you have a thought
11 on this.
12 In California the five largest health insurers
13 are not the same five companies that are our nation's
14 five largest health insurers. And as we've been talking
15 about today, whether we're talking about United and
16 Optum, whether we're talking about what Anthem is in the
17 process of doing, what Aetna would be doing with this
18 merger, what Cigna is trying to do with Express Scripts,
19 you may end up with the consolidation of the PBM
20 services with health insurers with most of the nation's
21 largest five health insurers -- which, as I'm saying,
22 are not the same five that are the biggest in
23 California.
24 So for those in California that would not be
25 merged with a PBM, how would we expect this merger or

1 the Cigna-Express Scripts proposed merger to impact
2 those companies in terms of drug costs, in terms of
3 contracting with PBMs, in terms of drug formulary
4 design. What are some of the impacts specifically, and
5 then if the merger does occur, are there any things that
6 we can do with the health insurers we regulate in terms
7 of agreements we might seek from them to mitigate those
8 impacts on the other health insurers in the market?
9 MR. GREANEY: That's a question that I thought
10 would be asked. There's a real question about what you
11 do about all this if you decide, if the Justice
12 Department decides there is a problem here.
13 One is they can litigate and try to block the
14 merger, get a full-stop injunction. But the other,
15 historically there have been ten or more vertical
16 mergers examined by the courts very succinctly because a
17 consent decree was the only thing in front of them, and
18 those consent decrees typically included promises to
19 change their conduct, to deal fairly with their upstream
20 or downstream rivals, and that's, you know, that's
21 attractive to courts because they, you know, they like
22 to settle cases.
23 On the other hand, those conduct behavioral
24 decrees are pretty problematic. Because I think you
25 heard a litany of potential tactics that might be

1 deployed vis a vis the pharmacies or rival insurers to
2 disadvantage them, and it's hard to cover all these
3 things in a consent decree.
4 That's why the current assistant attorney
5 general, one of his first speeches, was he doesn't
6 believe in those decrees because they have proven to be
7 evaded or ineffective, hard to predict the future.
8 So there's a real slippery slope here about
9 what kind of remedy is out there to get the promise of
10 good behavior and ultimately have somebody to monitor it
11 and enforce it.
12 The entities best positioned to do that, I
13 think, are the insurance commissions that are in
14 day-to-day regulation. But again, those are, those
15 behavioral decrees are hard to enforce and hard to
16 arrive at.
17 MS. MOSS: This is Diana Moss. If I may just
18 chime in on the first part of your question, which is
19 really a good one. And it harks back to a comment that
20 I made in my presentation, that if we do migrate, have
21 this sort of sea shift change in the industry from
22 unintegrated PBMs, pharmacies, and health insurers to
23 integrated PBM, insurers, and that is a massive, massive
24 change in the landscape.
25 And what comes with it are some pretty

1 troubling, concerning things, not only for competition
2 but for consumers.
3 And one is, of course, that if you have a
4 bunch of vertically integrated PBM insurers lined up in
5 the industry, you can pretty much forget about new entry
6 at any single level, whether it be at the PBM level, say
7 a smaller innovate PBM or a retail pharmacy or mail
8 order pharmacy, standalone pharmacies, or a new health
9 insurance model, you can forget about that.
10 Because the only way those firms are going to
11 be able to compete is if they themselves enter at two
12 levels. This is sort of an old antitrust concern that
13 surrounds vertical consolidation and it's called
14 two-level entry. Meaning that it's now, you know, you
15 just raised the bar on everybody trying to get in to the
16 industry. Now it's going to be harder to get in at one
17 level and it's going to be a forced march towards
18 two-level entry.
19 And that immediately peels off a whole bunch
20 of possible entrants who could have been innovative,
21 disruptive, brought competitive discipline to the
22 market. I think it's a huge risk, an enormous risk in
23 the bigger landscape, particularly as we look at
24 CVS-Aetna, also Express Scripts-Cigna against, you know,
25 United-Optum already in the market as an integrated

1 entity.
2 So I think it raises very serious concerns.
3 COMMISSIONER JONES: So another question that
4 I have is, and this is to any of the witnesses, each of
5 you has identified a number of problems associated with
6 the vertical integration of CVS and Aetna and some of
7 those problems are specific to the kind of behavior that
8 you anticipate might occur as a result of that merger.
9 We have an example in United and Optum of a
10 vertically integrated health insurer and health plan
11 with a PBM, and I'm just curious what does the evidence
12 or data show with regard to how they are been behaving
13 in the market, if there such evidence or data, if
14 anybody knows.
15 MS. MOSS: This is Diana Moss. I'll just
16 chime in that I think, from my understanding, is that
17 United Healthcare and Optum have kept the doors open.
18 They will deal with all comers. They have not gone to a
19 closed system where they only serve, you know, to a
20 exclusive exclusivity model.
21 But at the same time Optum is small. It's not
22 an enormous dominant PBM as we see with Express Scripts
23 and CVS. That's a very very different fact pattern than
24 what we see with these proposed mergers that are on the
25 table.

1 So it's also true that they are the only
2 vertically integrated PBM insurer. If others pop up in
3 the industry landscape, that will change, potentially
4 change United-Optum's incentives themselves, right?
5 It's all about the competitive landscape around you and
6 how you fit into that, that governs competitive
7 strategy, decisions to keep your system open and deal
8 with all comers or whether to engage in sort of an
9 exclusionary or, exclusionary conduct or to go to an
10 exclusive model.
11 So I think that is a really really good
12 question, but I think, you know, all bets are off. If
13 these deals go through and we see this massive sea
14 shift, we're going to see some very different incentives
15 for how these vertically integrated entities behave.
16 COMMISSIONER JONES: Anyone else want to add
17 anything?
18 MR. SOOD: I think the other thing is that
19 it's just very difficult to monitor the behavior of a
20 PBM and how well it is serving the health plan. These
21 contracts are fairly complicated. You know, there could
22 be can kind of complex effects of the decision that PBM
23 makes on healthcare costs in the future. You might not
24 see them right away.
25 So I think in general it's very difficult, we

1 know the incentives are there, but to find actual
2 behavior that hurts consumers or -- it's very difficult
3 to figure that out because these contracts are shrouded
4 in, kind of, they are not very transparent. It's very
5 difficult to though what's going on.
6 COMMISSIONER JONES: That's a good point. I
7 mean as a state regulator, we have very little line of
8 sight into the contracts or the behavior of PBMs, and no
9 direct regulatory authority over them. So the point you
10 make is, I think, a good one from the state regulatory
11 standpoint.
12 I think one of you made a point earlier that
13 once the merger occurs, the ability to utilize antitrust
14 law to go after some of the behavior that each of you
15 have described, is very limited. So that may be even
16 more acute with regard to PBMs since state regulatory
17 apparatuses have little, if any, oversight with regard
18 to their behavior.
19 Any other questions you have? Okay.
20 I want to thank each of the panelists very,
21 very much for your taking the time to travel here to
22 testify. I want to thank Ms. Moss for appearing
23 telephonically. I know she would have been here if she
24 could have. And we have your oral testimony as well as
25 any written materials that have you provided that will

1 be made a part of the record. And we do really
2 appreciate your participation in today's hearing.
3 Thank you very, very much. Thank you.
4 MS. MOSS: Thank you.
5 COMMISSIONER JONES: So now we'll move to our
6 next panel, which is a Provider panel. And I would like
7 to welcome those witnesses.
8 So welcome. Maybe I could just ask if each of
9 you could introduce yourselves in turn, and then I'm not
10 sure which order you would like to go in, but it's up to
11 you as to which order you'd like to go in.
12 Welcome.
13 MR. DO: Good afternoon, Commissioner. My
14 name is Long Do, and I'm legal counsel with the
15 California Medical Association.
16 MS. MCANENY: I'm Barbara McAneny. I'm
17 president of the American Medical Association.
18 COMMISSIONER JONES: We're delighted to have
19 both of you here today, and we want to thank Ms. McAneny
20 for having traveled a great distance to be with us, and
21 it's a real privilege to have you here, too.
22 Our agenda has you starting. Would you like
23 to start?
24 MS. MCANENY: I would be honored to. Thank
25 you.

COMMISSIONER JONES: Great. Welcome.
MS. MCANENY: And I didn't actually travel that far. I live in New Mexico.
COMMISSIONER JONES: Parts of New Mexico are really hard to get to. I've been to Chaco Canyon, and that was a long drive from Albuquerque.
MS. MCANENY: That's one of the hardest.
COMMISSIONER JONES: But one of the most beautiful and inspiring places ever to visit.
MS. MCANENY: I have a clinic in the Gallup area, so, yes.
COMMISSIONER JONES: Well, kudos to New Mexico. Thanks.
MS. MCANENY: Thank you.
On behalf of the American Medical Association, the AMA, and its student and physician members, I really appreciate the opportunity to provide our views regarding the proposed CVS-Aetna merger and it's implications for California patients.
We commend the California Department of Insurance and California Commissioner David Jones for holding this hearing. You have shown great leadership, and I know the rest of the country is listening to you today as you examine this massive healthcare merger.
My comments will express my opinions as a

physician, as an oncologist who has treated some of the most vulnerable patients for over 30 years, and I will end by briefly stating the AMA's position on the merger.
I have practiced oncology in New Mexico for 30 years, and I currently am the president of the American Medical Association, and I believe that if approved, the CVS-Aetna merger could pose a very serious threat to the quality of care and safety of cancer patients in my practice and across the country because of the merger's potential impact on the specialty pharmacy market.
Oncologists rely heavily on specialty drugs to treat their patients. Those drugs are invaluable in the fight against cancer and can literally make the difference between life and death.
But oncology is not the only physician specialty that depends on specialty drugs. Rheumatologists, ophthalmologists, gastroenterologists, neurologists and others do as well.
Specialty drugs play a critical role in caring for patients, especially patients with complex diseases like cancer, cystic fibrosis, autoimmune disease, HIV Aids and many others.
Data indicates that the specialty pharmacies operate in a very concentrated market. Nearly 60 percent of all prescription revenues from specialty

pharmacies are collected by the three largest firms owned by CVS Health, Express Scripts, and Walgreens Boots Alliance.
CVS Specialty Pharmacy itself is the biggest player in the specialty business with a 25 percent market share measured by specialty pharmacy revenues, and CVS' specialty pharmacy market share is growing as described in CVS Health 2017 Annual Report where CVS specifically states, quote, "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." End quote.
Specialty pharmacy is driving the pharmacy industry's revenue growth. According to Pembrooke Consulting, quote, "The growth of specialty drugs is reshaping the pharmacy and the pharmacy benefit manager industries. The specialty pharmacy market represents a growing proportion of drug costs."
The proposed CVS-Aetna merger has worrisome ramifications in the specialty market where CVS is the largest player. Already CVS' status is one of the two largest PBMs in a concentrated market, has allowed it to effectively force many patients and third-party payers

to utilize CVS as their specialty pharmacy. If approved, the merged CVS-Aetna would permanently extend this practice to Aetna covered patients.
And there's tremendous incentive for CVS to do this. Not only does the specialty pharmacy market represent an growing proportion of drug costs, many specialty pharmacy drugs are very expensive, and as a PBM, CVS Caremark makes a profit on the percentage of drug costs. CVS can maximize these profits by using financial incentives to force patients, as a practical matter, to utilize CVS' specialty pharmacy for the dispensing or administration of specialty drugs rather than a treatment setting such as a hospital or a physician office.
For example, CVS-Aetna could set Aetna enrollees' copays for chemotherapy drugs at negligible levels when obtaining those drugs through the CVS specialty pharmacy, and impose a much higher level, like the 20 percent copay, on enrollees if they obtain the same drugs in treatment settings, such as physician practices or hospitals.
This is bad because it fragments care and removes the oversight of chemotherapy from the treating oncologist. Given the high cost of many specialty drugs, most Aetna patients will have no choice but to

1 utilize CVS' specialty pharmacy.
2 The potential for abuse is largest in the
3 commercial market. However, Aetna's Medicare Advantage
4 enrollees, for whom Aetna is responsible for drug
5 utilization regardless of the site of administration,
6 could be affected as well.
7 While the CVS specialty pharmacy might for
8 some patients be a lower cost setting for obtaining or
9 administering drugs, compelling patients to utilize CVS
10 specialty pharmacy as opposed to a hospital or physician
11 practice, raises quality of care and patient safety
12 concerns.
13 Patients' use of some specialty drugs requires
14 medical monitoring. Take oral chemotherapy drugs for
15 example, despite being in pill form, oral chemotherapy
16 drugs are powerful and potentially dangerous.
17 Consequently, cancer patients taking oral chemotherapy
18 have to be monitored by a physician trained in oncology
19 to ensure that these drugs are properly dosed, and
20 accordingly, there is a local market for dispensing and
21 administration of oncology drugs. Compelling the
22 patients to utilize CVS' specialty pharmacy can make it
23 difficult for an oncologist like me to perform this sort
24 of monitoring.
25 Cutting out clinical settings such as a

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1 physician practice or hospital from the dispensing or
2 administration of chemotherapy drugs raises other
3 patient safety concerns. For example, with any
4 chemotherapy drug, patient adherence to the medication
5 regimen is essential to maximizing the chances of the
6 drug's effectiveness, and consequently patients'
7 survival.
8 Removing clinical settings from the equation
9 compromises an oncologist's ability not only to ensure
10 adherence, but also to follow where the patient is in
11 his or her chemotherapy cycle.
12 It's important to understand how this works in
13 the real world. When chemotherapy medicines are not
14 dispensed or administered in the physician practice, all
15 too often the oncologist is not provided with key
16 information such as when, or if, the medication has been
17 delivered, when, or if, the patient has started taking
18 the medication, and when, or if, refills have been
19 requested, and if the refill request has been made that
20 incorporate the oncologist change in the dosage, dosage
21 intervals, or other instructions.
22 This lack of information greatly hinders my
23 ability to protect my patients from dangerous or
24 unwanted side effects, adverse patient reactions, or
25 toxic drug levels.

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1 Oral chemotherapy is just the beginning.
2 CVS-Aetna can financially compare Aetna patients needing
3 IV chemotherapy to have those drugs delivered at the
4 patient's home or at the CVS infusion centers where CVS
5 nurses would administer the chemotherapy.
6 This practice raises even greater quality of
7 care and patient safety concerns than those I have just
8 mentioned regarding oral chemotherapy. Patients can
9 have very serious reactions to IV cancer drugs, and in
10 such cases not having a trained oncologist on site to
11 manage the reactions and supervise patients is a recipe
12 for disaster.
13 What guarantees will there be that the person
14 CVS sends to perform administration will be sufficiently
15 trained to handle these life threatening contingencies
16 or even have the equipment or the drugs necessary?
17 When quality of care issues arise between me
18 and a PBM concerning one of my patients, I can currently
19 take the problem to the insurer. Today Aetna is free to
20 weigh my patient's quality demands against the financial
21 concerns. This weighing also occurs between Aetna and a
22 CVS at their contract renewal time.
23 However, once Aetna has a permanent ownership
24 in CVS, Aetna will have a financial interest in CVS'
25 specialty pharmacy continuing to gain market share and

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1 be less responsive to my patient demands.
2 Let me emphasize that the concerns I have
3 voiced today are not unique to me, nor is it mere
4 speculation. Indeed, the likely harmful effect that a
5 combined CVS-Aetna may have on the quality of patient
6 care is described in an online article appearing in The
7 Lancet, one of the world's most preeminent medical
8 journals.
9 In The Lancet article entitled, quote, "Major
10 Healthcare Companies Merge in the USA," the author
11 writes, quote, "A substantial share of CVS Health's
12 pharmacy revenue are derived from specialty pharmacies
13 which distribute expensive drugs including chemotherapy
14 agents. The company might press patients to obtain
15 drugs that would be better provided through a
16 physician's office internally."
17 "These are very expensive drugs and they can
18 hurt you if they aren't managed closely," explained Ray
19 Dean Page, the incoming chair of the Clinical Practice
20 Committee of the American Society of Clinical Oncology.
21 Finally, I ask you to not forget that CVS'
22 tieing of the purchase of its specialty drugs to
23 reasonable access to health insurance is among the
24 allegations against it in a class action suit filed in a
25 California federal court entitled John Doe 1 et al.

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1 versus CVS Health Corporation filed February 16th, 2018.
2 This suit claims that many enrollees in health
3 plans where CVS controls and administers the pharmacy
4 benefits are told they have to obtain their HIV Aids
5 medications from CVS' California specialty pharmacy, a
6 wholly owned subsidiary of CVS.
7 It is asserted in this lawsuit that patients
8 allegedly are, quote, "Told they must either pay more
9 out of pocket or pay full price with no insurance
10 benefits, whatever, thousands of dollars or more each
11 month to purchase their medications at an in-network
12 community pharmacy where they are receive counseling
13 from a pharmacist and other services that they made need
14 to stay alive."
15 While these claims are not yet proven, similar
16 allegations are being made in a Florida lawsuit, Sentry
17 Data Systems versus CVS Health. In Sentry, the
18 Plaintiff alleges that CVS forces patients and
19 third-party payers to utilize CVS as their specialty
20 pharmacy.
21 In sum, CVS' acquisition of Aetna exacerbates
22 the concerns I've described personally as an oncologist,
23 as well as the allegations in these lawsuits. So thank
24 you again for allowing me to present my opinions as a
25 practicing oncologist strongly opposed to this

1 healthcare merger that would impede my caring for cancer
2 patients.
3 Also, as president of the AMA, I can report
4 that the AMA has been painstakingly analyzing this
5 merger, an analysis that started almost as soon as the
6 merger was officially announced. The AMA sought the
7 view of prominent health economists, health policy and
8 antitrust experts, some of whom you heard from today.
9 After very carefully considering this merger
10 over the past months, the AMA has come to the conclusion
11 that this merger would substantially lessen competition
12 in many healthcare markets to the detriment of patients.
13 What we heard today corroborates this conclusion.
14 From my vantage point as a physician, the
15 reduction in competition threatens to have real life
16 consequences for patients struggling for survival.
17 Accordingly, based on the mutually confirming analysis
18 and conclusions presented by the nationally recognized
19 experts heard from today, and other experts, as well as
20 extensive research, the AMA is now convinced that the
21 proposed CVS-Aetna merger should be blocked.
22 Thank you.
23 COMMISSIONER JONES: Thank you, very much
24 Dr. McAneny. Thank you, again, for your testimony and
25 for joining us here.

1 Let's hear now from Mr. Long Do from the
2 California Medical Association.
3 MR. DO: Thank you, Commissioner.
4 I will be making statements on behalf of the
5 California Medical Association. CMA thanks you for the
6 opportunity to present comments on the proposed merger
7 between CVS Health and Aetna.
8 The California Medical Association is one of
9 the nation's largest and oldest state physician
10 organizations currently comprised of about 45,000
11 members. Our mission is to promote the science and art
12 of medicine, protection of public health, and the
13 betterment of the medical profession. As a pillar of
14 California's healthcare provider community, CMA has
15 serious concerns about the negative impact of the
16 proposed merger of Aetna in to CVS Health.
17 Several prominent organizations have raised
18 red flags over the anticompetitive effects and harm to
19 consumers that could result from the proposed merger.
20 The AMA and the American Antitrust Institute are opposed
21 to it. CMA finds many of the concerns that have been
22 raised by these organizations to be both on point and
23 deeply troubling. We find strong merit in the analysis
24 that a combined CVS-Aetna venture has great potential to
25 raise barriers to market entry in the PBM market.

1 Additionally, CVS' acquisition and control of
2 the nation's third largest healthcare insurer has real
3 potential for abuses in price manipulation, unlawful
4 tying arrangements, unequal treatment of other
5 competitors, and other anticompetitive behavior.
6 Ultimately, California consumers may have to
7 pay more for healthcare in a more concentrated
8 healthcare market while having less access to care.
9 CMA is continuing to evaluate recent expert
10 reports and comments, and we intend to express further
11 views on the proposed merger in our written comments to
12 the Department, including whether CMA opposes it.
13 Now I would like to focus the Department's
14 attention on a different sort of problem with the
15 proposed merger, one that has not been discussed today.
16 Aetna and CVS claim their combined businesses
17 would create an alternative front door to healthcare
18 where patients can go to retail pharmacies with walk-in
19 clinics for primary and preventative care.
20 Such a proposed business could run afoul of
21 California's bar on the corporate practice of medicine,
22 which for more than 100 years has ensured that
23 Californians have access to professional care by
24 physicians who have an undivided loyalty to their
25 patients and who are bound by legal and ethical

1 obligations to put the health interests of their
2 patients first.
3 CVS currently owns 10,000 retail pharmacy
4 chain stores and another 1100 MinuteClinics within these
5 stores. Aetna and CVS claim that they could keep
6 healthcare costs down under their proposed merger by
7 routing patients to CVS stores and the MinuteClinics,
8 away from hospital emergency departments or urgent care
9 centers that are staffed by physicians.
10 CVS stores and clinics, however, are staffed
11 by nonphysicians, pharmacists, nurse practitioners, and
12 physician assistants. CVS claims these nonphysicians
13 can provide routine and diagnostic care.
14 California's corporate bar prohibits lay
15 individuals, organizations, and corporations from
16 practicing medicine. It also prohibits direct and
17 indirect controls over the practice of medicine. Thus,
18 lay persons and entities cannot hire or employ
19 physicians to provide medical care or otherwise
20 interfere with or control a physician's professional
21 judgment.
22 The underlying rationale of the corporate bar
23 can be found in our state decision as early as 1938,
24 when the California Supreme Court explained that "The
25 bar guards against the evils of divided loyalty and

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1 impaired confidence in the practice of medicine."
2 The medical board of California has identified
3 numerous aspects of the practice of medicine that would
4 be violated when undertaken or influenced by non
5 physicians. Some of these include determining what
6 diagnostic tests are highly appropriate for a particular
7 condition, determining the need for referrals to or
8 consultation with another physician or specialist, lay
9 ownership over a patient's medical records, and
10 selection of professional physician extenders or other
11 allied health staff.
12 CVS' MinuteClinics, to the extent they engage
13 non physicians such as nurse practitioners or
14 pharmacists to practice medicine, sometimes perhaps
15 beyond the scope of their professional license, poses
16 substantial concerns under the corporate bar. The
17 increased reliance on these practices as a claimed
18 efficiency of the proposed CVS-Aetna merger, should
19 raise serious read flags.
20 Finally, it is not enough that the
21 MinuteClinics in California may be individually
22 physician-owned, as has been suggested by CVS during
23 public testimony before the Department of Managed
24 Healthcare. One California court's view on the use of
25 such captive professional corporations is worth quoting

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1 here, and here is the quote: "We cannot imagine any
2 consideration of public policy that would cause us to
3 impute to the legislator the intent to, on the one hand,
4 ban corporate ownership of medical practices, and on the
5 other, permit such ownership through mere straw
6 MinuteClinic acting on behalf of the corporation."
7 CMA thanks the Commissioner again for focusing
8 attention on this historic merger and for considering
9 our comments.
10 COMMISSIONER JONES: Thank you. Do you have a
11 citation to that case?
12 MR. DO: I do. We will provide it in our
13 written comments, but the latter case is San Joaquin
14 Community Hospital versus San Joaquin Valley Medical
15 Group. It comes out of the 5th District Court of
16 Appeal. The Westlaw citation is 2004 Westlaw 139855.
17 COMMISSIONER JONES: Great, thank you.
18 Let me see if Ms. Rocco has any questions for
19 this manufacturer.
20 I don't. Thank you very, very much. I really
21 appreciate the opportunity to get the physician view
22 with regard to the impacts of the proposed merger, and I
23 appreciate both of you taking the time to testify. We
24 will give, obviously, very strong and serious
25 consideration to your testimony. So thank you. Thank

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1 you both.
2 So we have a consumer panel, but maybe we'll
3 take -- you're okay?
4 COURT REPORTER: It hasn't been two hours yet.
5 COMMISSIONER JONES: Well, you haven't heard
6 the consumers yet, either.
7 COURT REPORTER: That's true.
8 COMMISSIONER JONES: Okay, why don't we go to
9 the consumer panel.
10 We welcome the three witnesses on this panel.
11 So welcome. And perhaps you might introduce yourselves
12 in turn, and then I think in order of the agenda it's
13 Dena Mendleson with Consumers Union, Yasmin Peled with
14 Health Access, and then Ben Powell with Consumer
15 Watchdog.
16 But please introduce yourselves, and if you
17 want to go in a different order, that's fine, too.
18 MS. MENDLESON: Commissioner, thank you for
19 the opportunity to be here today and to discuss the
20 proposed merger of CVS and Aetna.
21 My name is Dena Mendleson. I'm a senior staff
22 attorney at Consumer Union, the advocacy division of
23 Consumer Reports.
24 Our mission is to work for a fair, just, and
25 safe marketplace for all consumers, and to empower

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1 consumers to make educated decisions that are right for
2 themselves and for their families.
3 For consumers to have a meaningful choice,
4 there must be effective competition. One piece of
5 advice that we give again and again, is to shop around
6 for health insurance, for the lowest cost prescription
7 drug, and for the best value provider.
8 When consumers can have options, businesses
9 are motivated to provide more affordable, better
10 quality, and new thinking in response to consumers'
11 wants and needs. Unchecked consolidation could
12 eliminate that.
13 Because of the complexities of this
14 marketplace in particular, it is important that there be
15 competitive market forces at work to discipline these
16 profit maximizing incentives to make sure the
17 marketplace works effectively for consumers.
18 A merger between CVS and Aetna would have a
19 major impact on nearly every segment of the healthcare
20 system. Combining these two giants would create an even
21 bigger giant with a new corporate structure, straddling
22 more market sectors and creating new and potentially far
23 reaching profit maximizing incentives.
24 To the extent those new incentives drive the
25 combined company to integrate its resources in new ways

1 to bring costs down and improve quality of services --
2 or what we have heard referred to today as
3 efficiencies -- that could be good for consumers and
4 good for the overall economy. That is the picture CVS
5 and Aetna are painting.
6 Some of the picture may actually prove to be
7 accurate. For example, encouraging Aetna policy holders
8 to use a CVS MinuteClinic for simple routine care
9 instead of a hospital emergency room would cut expenses
10 for Aetna. That might be passed along in lower costs or
11 improved services. Might. It's far from certain.
12 For one thing, we would need enough
13 transparency and competition so that the one on the
14 receiving end, the consumers, not only can account for
15 that saving, but can also check that it's not coming out
16 are their pockets, and has some of the realistic ability
17 to insist on a share or go elsewhere. That seems
18 unlikely within our current healthcare system.
19 Furthermore, efficiencies, which companies
20 proposing to merge will always claim, often ultimately
21 are shown to be unsubstantiated or exaggerated, and they
22 could be achieved without merging. Why does Aetna need
23 a merger to encourage policy holders to visit
24 MinuteClinics instead of emergency rooms?
25 Reduced competition would bring no benefit

1 except to CVS-Aetna. For example, CVS-Aetna might tell
2 Aetna policy holders they can only go to a MinuteClinic,
3 not to a conveniently located walk-in clinic run by
4 someone else. Or they might direct them to fill
5 prescriptions only at CVS. Or to use MinuteClinics for
6 an expanded set of medical needs instead of seeing their
7 own doctor. Or CVS Caremark might negotiate different,
8 better prescription drug deals but only for Aetna
9 insurance or only for purchasers at CVS.
10 The black box surrounding back-end PBM rebates
11 and side agreements make this area particularly open to
12 abuse. And as you mentioned earlier today,
13 Commissioner, PBMs do not have a clear regulator, and
14 once this merger goes forward it would be difficult to
15 understand what is going on or to control it.
16 Moreover, sometimes what we're loosely
17 describing as "efficiencies" are revealed on closer
18 inspection to involve reducing competition in ways that
19 harm consumers and harm quality. CVS and Aetna insist
20 that their goals will always be focused on putting
21 consumers at the center of care, taking a holistic
22 approach to health, and addressing the rising costs of
23 healthcare.
24 But this is not about their current plans.
25 It's about how incentives and capabilities will be

1 altered by the new market-straddling corporate structure
2 that the merge would create and whether this would lead
3 to improved products and services, or instead to
4 restrictive competition and choice and to poorer
5 products and services. Genuine risks to competition
6 will not be fixed by pledges of good behavior.
7 Furthermore, as we have heard today, vertical
8 mergers like the one discussed including major
9 corporations operating on multiple levels to supply a
10 marketing chain, can most certainly raise competition
11 concerns and falls squarely within established antitrust
12 laws.
13 Furthermore, we would wager that there is also
14 a horizontal dimension to this merger investigation.
15 One of the attractions of this merger to Aetna is that
16 it would get is own in-house PBM in CVS Caremark. But
17 it doesn't need a merger to get one, that's just a
18 shortcut. If this merger is challenged and doesn't go
19 through, Aetna is in the position to create a PBM for
20 itself, and that would add some much needed competition
21 to this highly concentrated market sector. The
22 Department should also take that into prospect in its
23 consideration.
24 At the conclusion of all the public meetings
25 and hearings to inspect the proposed merger, we are

1 counting on our regulators and the Department of Justice
2 to take whatever action is necessary to ensure that
3 consumers can benefit from a healthy dose of competition
4 in the healthcare marketplace. That could potentially
5 even require a full challenge of this merger.
6 Thank you again for the opportunity to discuss
7 this merger and its importance to consumers. We
8 appreciate your time in gathering evidence today and in
9 the opportunity to shed light on how the proposed merger
10 could effect competition in California's healthcare
11 marketplace, and ultimately how it could negatively
12 impact consumers.
13 COMMISSIONER JONES: Thank you.
14 MS. PELED: Thank you. My name is Yasmin
15 Peled on behalf of Health Access California, the
16 statewide healthcare consumer advocacy coalition.
17 We strongly request the insurance commissioner
18 to heavily scrutinize this proposed merger and to
19 evaluate whether it is actually good for patients, the
20 public interest, and our state's market competition.
21 While we recognize that you are still
22 collecting information from the companies and elsewhere,
23 we are deeply skeptical that this merger is in the
24 interest of patients and the public. I would like to
25 echo the points made by our coalition partner, Ms.

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1 Mendleson, from Consumers Union.
2 Experience and research shows that consumers
3 do not often benefit from mergers. Rarely do these
4 mergers result in lower costs or better access to care
5 or quality of care. We are skeptical that the
6 combination of CVS and Aetna will yield the benefits
7 that the executives claim. They should be willing to
8 put threes benefits in writing as conditions of the
9 merger.
10 In particular, CVS has not offered any
11 information on how it would correct Aetna's failure to
12 abide by basic consumer protections. We are deeply
13 concerned about giving more market power to a company
14 with Aetna's past practices, given its track record of
15 not abiding by basic patient protections.
16 Here are some of California's experiences with
17 Aetna: First, Aetna has repeatedly pursued unreasonable
18 rate increases, which you, Mr. Commissioner, have also
19 repeatedly deemed excessive and unreasonable, including
20 in 2014 and 2015.
21 While other companies have at times rolled
22 back or restricted rate increases deemed unreasonable by
23 state regulators, Aetna, and their egregious history of
24 imposing rate increases despite such findings, meant
25 California consumers had to pay unnecessarily high

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1 rates, undermining their family finances, especially
2 those who live paycheck to paycheck. Small business
3 purchasers had to pay more for health coverage with
4 negative impacts on our economy and health system.
5 We have no confidence that a consolidated
6 company would act differently, nor are we convinced that
7 the cost savings or efficiencies would be passed on to
8 consumers and other purchasers.
9 It is of great concern that neither party here
10 today can provide concrete information on how premiums
11 will actually be reduced due to the $750 million in
12 savings as a result of this merger. Given Aetna's
13 previous practices of unreasonable rate increases,
14 consumers and the public should be assured in writing
15 that these unreasonable rate increases will cease in the
16 face of immense savings.
17 Second, in the midst of ongoing excessive rate
18 hikes, Aetna has continued to reject needed care for its
19 enrollees. The California Department of Managed
20 Healthcare's most recent medical survey shows Aetna
21 continues to have major deficiencies in its grievances
22 and appeals and utilization management processes.
23 In addition, a number of states, including
24 California, are investigating Aetna for claims that one
25 of its medical directors did not examine patients'

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1 medical records before deciding whether to approve or
2 deny care. We appreciate your work, Mr. Commissioner,
3 for investigating Aetna's processes on claims denials,
4 prior authorizations, and utilization reviews.
5 We question how Aetna can promise greater
6 access to care with this merger when currently the
7 company's policies revolve around keeping coverage and
8 care away from patients in order to keep their profits.
9 Aetna's most recent quarterly profits soared, and it was
10 yielded primarily from high premiums charged on
11 consumers.
12 CVS Health has testified that part of the cost
13 savings of this merger will be directed to improving
14 quality for consumers and patients, yet no specific
15 information has been provided. Before getting bigger
16 and creating new programs, it would be in the interest
17 of consumers that Aetna's failure to abide by basic
18 consumer protections is remedied, yet CVS as provided no
19 information on how it will do so.
20 Finally, we're concerned that vertical, or
21 even diagonal mergers such as this one, will ultimately
22 reduce competition not only in the healthcare market but
23 also in the pharmacy business, which will lead to prices
24 going up. The Consumer Financial Protection Bureau
25 recently released grim findings from a survey that shows

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1 nearly half of Americans have a tough time paying for
2 basic needs, including healthcare. A recent UC Berkeley
3 PETRA Center report confirms that consolidation in the
4 healthcare industry leads to higher costs.
5 By engaging in this unprecedented
6 consolidation, we are deeply concerned that the lack of
7 competition will provide little incentive for CVS-Aetna
8 to right the wrongs that have been done to consumers.
9 Your review of this merger should include not just a
10 traditional antitrust review, but a focus on Aetna's
11 past practices, whether this merger would allow bad
12 behavior to get bigger, whether the companies will
13 actually commitment to the promises being made, and
14 whether consumers will actually benefit.
15 Thank you for your consideration.
16 COMMISSIONER JONES: Thank you very much.
17 Next witness.
18 MR. CANETTI: Thank you, Commissioner, and the
19 Department for the opportunity to be heard.
20 My name is Benjamin Powell. I'm a litigation
21 attorney with Consumer Watchdog. We're a public
22 interest organization based in Los Angeles with offices
23 in Washington DC as well.
24 Consumer Watchdog is a nonprofit tax exempt
25 consumer research, education, litigation, and advocacy

1 organization. We were established in 1985, and we
2 utilize a combination of litigation, advocacy, and
3 public education to effectuate our mission.
4 Our staff includes some of the nation's
5 foremost consumer advocates and experts on consumer
6 matters. Our legal staff advocates on behalf of
7 consumers before regulatory agencies, the legislature,
8 and the courts.
9 Over the course of three decades, consumer
10 watchdog attorneys have represented consumers in
11 numerous class actions, civil lawsuits, and
12 administrative complaints, challenging unfair business
13 practices by insurers and large corporations.
14 Relevant to today, a particular focus of our
15 litigation has been to challenge the illegal and unfair
16 business practices of health insurance companies,
17 healthcare providers, health maintenance organizations,
18 and property casualty insurance companies, including the
19 unlawful practices that violate consumer privacy and
20 healthcare rights.
21 As we've heard today, I understand the
22 Department has asked for testimony on a number of
23 important topics related to the impact of the proposed
24 merger of CVS and Aetna on market consolidation,
25 healthcare costs, and provider networks.

1 Consumer Watchdog shares those concerns, but
2 today I would like to focus on concerns related to item
3 5 in the Department's notice, namely how the proposed
4 merger will impact the cost and quality of care
5 delivered to consumers.
6 In particular, today my testimony will focus
7 on medical privacy, which has been a major concern of
8 our clients in recent years, specifically the privacy of
9 those in California who require HIV and AIDS
10 medications.
11 In its announcement about the acquisition, CVS
12 CEO Larry J. Merlo said, "With the analytics of Aetna
13 and CVS Health's human touch, we will create a
14 healthcare platform built around individuals."
15 However, both CVS and Aetna have demonstrated
16 multiple reasons to be extremely concerned about their
17 lack of commitment to protecting the privacy of their
18 enrollees. Their failures in the realm of consumer
19 privacy should give the Department considerable pause
20 before deciding to approve this acquisition and subject
21 Californians to the mercy of this consolidated entity.
22 Persons with HIV are still unfortunately
23 subject to stigma, humiliation, mental anguish,
24 embarrassment and stress based on their HIV status. One
25 meta analysis of 119 studies demonstrated that perceived

1 interpersonal risks are associated with HIV disclosure,
2 and they outlined evidence of associations with anxiety,
3 fear, and worry. They may also run the risk of the loss
4 of housing, relationships, and employment when their HIV
5 status is revealed.
6 Such studies and analysis demonstrate that
7 even if HIV positive individuals do not know and cannot
8 show who may have been made aware of their HIV status,
9 the risk of disclosure increases stress and anxiety and
10 results in personal harm and injury to them.
11 Beginning with Aetna, Consumer Watchdog has
12 brought legal action against the company on multiple
13 occasions, including one case surrounding HIV/AIDS
14 privacy concerns over a mail order medication program.
15 Around 2013, HIV and AIDS patients began to
16 complain that several health insurance companies
17 intended to make radical and dangerous changes to their
18 policies with respect to HIV and AIDS medications.
19 One of the most critical of these changes was
20 the requirement that HIV and AIDS patients obtain their
21 medication via mail order, barring its plan members from
22 the longstanding practice of visiting a specialty retail
23 pharmacist to obtain and renew their prescriptions.
24 This constituted a threat to the health, safety, and
25 privacy of patients as well as violating both California

1 and Federal law.
2 Consumer Watchdog, along with our colleagues
3 at Whatley Kallas LLP, brought lawsuits against United
4 Healthcare Insurance Company and Anthem Blue Cross of
5 California, the nation's largest health insurers at the
6 time, challenging their new mail order policies. Those
7 two companies commendably agreed to resolve those cases
8 by, one, permitting members to opt out of the mail order
9 requirement, and, two, providing compensation to any
10 members who had already been compelled to use that
11 program. The cases garnered much national media
12 attention, and it highlighted the threat to patient
13 privacy and health synonymous with these mail order
14 programs.
15 Against this backdrop and despite the national
16 attention, in November of the 2014 Aetna sent letters to
17 its members announcing that it would be implementing a
18 mail order requirement of its own for certain HIV and
19 AIDS medications, raising all the exact same concerns as
20 the previous cases.
21 Aetna additionally made all visits to retail
22 brick-and-mortar pharmacies out of network, subjecting
23 plan members to potentially ruinous expenses. Aetna's
24 new mail order program proposed to replace the expertise
25 of pharmacists with access to an 800 number operated by

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1 Aetna and staffed by customer service representatives
2 rather than trained pharmacists. In 2014, Consumer
3 Watchdog sued Aetna over this mandatory mail order
4 program for HIV medications.
5 In 2015, we brought a related action against
6 Aetna's subsidiary, Coventry, in Florida. Consumer
7 Watchdog argued, and continues to argue, that Aetna's
8 treatment of HIV and AIDS patients was discriminatory
9 under the Affordable Care Act, the Americans With
10 Disabilities Act, and Civil Rights law due to a number
11 of reasons.
12 Due to the complex nature of HIV and AIDS drug
13 regimens, patients rely on their community pharmacists
14 who, working directly with them, monitor potentially
15 life threatening adverse drug interactions and side
16 effects.
17 Mail order delivery of these medications,
18 often requiring large refrigerated containers for
19 example, is not a viable option for many patients and
20 can raise major privacy implications, particularly for
21 those individuals who have not revealed their HIV status
22 with their employers, coworkers, friends, and roommates.
23 Because there's no cure for HIV and AIDS, the
24 virus continually mutates around medications prescribed
25 to treat it, requiring constant monitoring and immediate

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1 provision of new medication regimens to address changes
2 in the disease. Community pharmacists, who often have
3 greater contact with HIV and AIDS patients than
4 physicians -- which has been brought up before -- and
5 know their complete drug regimen, also provide essential
6 advice and counseling that help these patients and their
7 families navigate the challenges of living with a
8 chronic and often debilitating condition.
9 These HIV patients were forced to call in each
10 month to renew their prescriptions and work their way
11 through robo calls, messages, and call center staff,
12 increasing stress and fatigue for patients who are
13 literally fighting to stay alive and exacerbating their
14 condition.
15 If these HIV/AIDS patients did not obtain
16 their specialty medication by mail, they were required
17 to pay full price for their medication, easily thousands
18 of dollars or more each month, to purchase their
19 medications at a community pharmacy.
20 The lawsuits against Aetna and Coventry also
21 garnered extensive national media coverage, and after a
22 hard fought legal battle, we settled that case with a
23 great outcome. Aetna agreed to remove HIV and AIDS
24 medications from the exorbitantly priced specialty drug
25 tier, and discontinued the mandatory mail order

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1 prescription program that it put into effect for
2 individual plan members.
3 Now, unfortunately, we have come to find out
4 that even in settling that case, Aetna disregarded the
5 privacy rights of its members in favor of presumably
6 cutting costs. As part of that settlement, Aetna agreed
7 to send a notice to all affected enrollees, advising
8 them of their right to obtain HIV and AIDS medications
9 from community pharmacies of their choice where their
10 privacy would be protected.
11 In July of 2017, Aetna or its vendor mailed
12 the notice letter to approximately 12,000 individual
13 Aetna enrollees nationwide, using an envelope with an
14 oversized transparent window. The envelope window
15 displayed a portion of the text of the notice letter
16 itself, disclosing the fact that the notice letter was
17 being sent to those members of Aetna health plans who
18 had been prescribed HIV medications.
19 In so doing, Aetna disclosed approximately
20 12,000 individuals' HIV status to any person coming in
21 to contact with that letter, including coworkers,
22 neighbors, family members, roommates, apartment
23 managers, and postal workers, egregiously violating
24 their rights.
25 Attorneys for Consumer Watchdog represent a

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1 John Doe HIV patient in an action against Aetna for this
2 latest violation of patient privacy. We allege that
3 Aetna breached the settlement agreement in the prior
4 case by disclosing patients' HIV status in the new case
5 in the mailing sent out by Aetna. Rather than accepting
6 responsibility, Aetna has blamed others, including
7 lawyers for Consumer Watchdog, for its own privacy
8 breaches.
9 While we would like to believe that if CVS is
10 permitted to acquire Aetna, it would help Aetna solve
11 these problems, we simply cannot expect CVS to acquire
12 Aetna to clean up the mess as CVS has demonstrated on
13 multiple occasions that it does not put a priority on
14 its own enrollees privacy rights.
15 For example, Consumer Watchdog is also
16 involved in one lawsuit currently in California federal
17 court against CVS for implementing its own mail order
18 requirement for HIV and AIDS medications, very similar
19 to the programs that were implemented by United and
20 Anthem Blue Cross that I mentioned previously.
21 CVS refuses to end that program, despite the
22 aforementioned litigation, and despite our continued
23 insistence that the program has serious and unavoidable
24 privacy consequences for its members taking HIV and AIDS
25 medications.

1 Additionally, in a case strikingly similar to
2 Aetna's egregious privacy breach, in the state of Ohio
3 CVS took almost exactly the same steps Aetna did,
4 sending a letter to approximately 6000 enrollees taking
5 HIV medications in an envelope with two glassine
6 windows, showing the CVS logo, the words "Ohio
7 Department of Health" and the designation PM6402 HIV
8 above the enrollee's name.
9 The reference to the recipients HIV status was
10 plainly visible through the glassine window, with the
11 envelope referring in big red letters to new
12 prescription benefits, the privacy of enrollees were
13 once again blatantly violated in a very similar way.
14 Consumer Watchdog, along with our co-counsel,
15 represent three John Doe plaintiffs in a lawsuit against
16 CVS in Ohio for that privacy breach. The John Doe
17 plaintiffs who have brought the class action anonymously
18 to protect their privacy, seek an injunction against CVS
19 barring it from using the transparent-windowed envelopes
20 in the future for any communications where HIV status is
21 referenced in any way.
22 In sum, both Aetna and CVS have demonstrated a
23 lack of concern about the privacy of their enrollees,
24 especially with regard to their customers who take HIV
25 and AIDS medications. There is simply no reason to

1 expect that allowing CVS to acquire Aetna will result in
2 any improvement whatsoever in these blatant violations
3 of patient privacy.
4 These companies have already exhibited that at
5 current sizes, privacy considerations are simply not a
6 priority. Allowing these organizations to consolidate
7 into one larger entity would surely worsen these
8 problems, as more enrollees to manage will result in
9 decreased attention to the problems plaguing this very
10 at-risk and vulnerable segment of their customers.
11 We urge the Department and the Commissioner to
12 require these two companies to first demonstrate that
13 they have a greater respect for privacy rights before
14 the merger is consummated. To that end, as a condition
15 of approving the merger, the Commissioner should require
16 CVS to embed an independent privacy overseer in the
17 company, reporting annually to the Commissioner and to
18 the public, on the actions taken by CVS and its newly
19 acquired subsidiary, Aetna, to ensure patient privacy
20 within the merged company. This will provide the
21 third-party accountability necessary to ensure that the
22 health and privacy rights of affected consumers are
23 protected.
24 Thank you. I appreciate your time.
25 COMMISSIONER JONES: Thank you very much.

1 Let me see if Ms. Rocco has any questions for
2 the witnesses.
3 DEPUTY COMMISSIONER ROCCO: Just one.
4 For the last witness, this situation you
5 described with CVS and the window envelopes, was that
6 prior to the Aetna situation?
7 MR. POWELL: This was after the Aetna
8 situation.
9 DEPUTY COMMISSIONER ROCCO: Thank you.
10 COMMISSIONER JONES: Thank you each for your
11 testimony.
12 Just to clarify something I said at the
13 beginning, though, I don't have direct approval over
14 this merger. The legislature has declined so far to
15 give me that approval because in California, the
16 Commissioner only has approval where one of the
17 companies being merged is an actual domiciled insurance
18 company in California, and that's not the case here.
19 Clearly I have a keen interest in it as the
20 head of the Consumer Protection Agency, and for the
21 reasons I said at the beginning of the hearing, we are
22 holding this hearing to gather as much information and
23 evidence as we can, and I can certainly reach a
24 conclusion based on that information as to whether I
25 believe the merger is anticompetitive or not, but I

1 don't have direct approval authority for the merger.
2 So I appreciate suggestions about the
3 conditions that I might impose, but I want to make sure
4 that people's expectations are calibrated accordingly.
5 I don't have that authority.
6 But thank you very, very much. I really
7 appreciate your testimony and your taking the time to
8 participate in the hearing today, each and every one of
9 you.
10 So with that, my able senior counsel's
11 indicating a timeout, and we may just do that. Or we
12 may see if there are any other members of the public who
13 wish to comment at this point.
14 There are. Okay. So do you need a little
15 break?
16 COURT REPORTER: We can finish these two up as
17 long as they will breathe as they speak.
18 COMMISSIONER JONES: With that admonition, why
19 don't we see if there are any members of the public who
20 would like to comment. Did we have a sign-in sheet for
21 that purpose somewhere?
22 Okay. So a number of people filled out this
23 form, and some of them indicated they would like to make
24 a public comment.
25 Is Tanya Stevenson here from Breathe

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1 California? Welcome. Come on up.
2 And then Julian, is it Canetu?
3 MR. CANETTI: Canetti.
4 COMMISSIONER JONES: Sorry. Welcome.
5 And let's see, who else? Those are the
6 individuals that indicated, for the public, that they
7 would like to testify.
8 So if there is someone else who would like to
9 as well, we're happy to take you, too. We just want to
10 make sure that we get your information, so if you
11 haven't had a chance to fill out the form --
12 MR. GORDON: I did, actually.
13 COMMISSIONER JONES: You did? So come on up.
14 And the gentleman who did not, maybe one of the CDI
15 staff can have him fill out the form just so we capture
16 his information.
17 So why don't we start with Ms. Stevenson, and
18 then we'll go to Mr. Canetti from the California
19 Hispanic Chamber, and then we'll go to the third
20 individual.
21 Welcome.
22 MS. STEVENSON: Thank you.
23 I'm Dr. Tanya Stevenson. I'm the CEO of
24 Breathe California Golden Gate, the local lung and
25 environmental health organization. We are a nonprofit

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1 founded here in San Francisco about 100 years ago.
2 Breathe California as a whole is a statewide
3 network of five non profit organizations dedicated to
4 protecting lung health. We were thrilled to learn that
5 CVS Health made the decision to voluntarily stop selling
6 tobacco products in its stores in 2014.
7 Breathe California has worked for decades to
8 prevent teens and preteens from starting to use tobacco
9 products and to help smokers quit smoking. We also
10 provide services to many adults suffering from emphysema
11 and COPD, which are usually the result of years of
12 smoking. So removing tobacco products from its stores
13 is extremely significant.
14 Ninety-five million fewer packs of cigarettes
15 were sold just eight months after the end of tobacco
16 sales. CVS no longer believed it was okay for someone
17 to buy tobacco in the front of their stores, and then
18 walk to the back of the store to pick up the medication
19 they needed in the pharmacy to help fight their
20 tobacco-related disease.
21 And they were just in time. Because just what
22 when we thought smoking was no longer the epidemic that
23 it once had been, vaping and juuling have hit our middle
24 schools and high schools like a brick. Teachers,
25 parents, and administrators are unable to identify the

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1 new tobacco-use technology kids are using, let alone
2 know how to control it.
3 Through its five-year, 50 million Be The First
4 initiative, CVS Health is working to support youth
5 smoking prevention, and deliver the first tobacco free
6 generation.
7 Through partnership with CVS Health, Breathe
8 California has been able to provide tobacco prevention
9 programming to thousands of youth in low income
10 communities throughout the state of California. And due
11 to CVS' commitment to creating the first tobacco free
12 generation, in 2017 Breathe California of Los Angeles
13 County honored CVS Health with their prestigious Breath
14 of Life Award.
15 In March of 2018, CVS Health announced $10
16 million dollars in new grants and investments to support
17 the new endeavor, including a $500,000 grant to the
18 Stanford University School of Medicine.
19 CVS has been a leader in putting patients'
20 health first, and improving public health here in
21 California.
22 Other key CVS Health initiatives include
23 helping fight against the opioid epidemic. More
24 recently CVS Health has demonstrated its commitment to
25 public health by expanding their multi-front fight

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1 against the opioid epidemic through enhanced opioid
2 utilization management practices that follow the CDC
3 guidelines, as well as an expanded drug disposal
4 collection program. They also offer free health
5 screenings.
6 Every year through its Project Health
7 campaign, CVS Health offers free biometric screenings
8 for California families to help identify chronic
9 conditions before they become life threatening
10 illnesses.
11 As a network of organizations that strive
12 every day to advance the health of all Californians,
13 Breathe California strongly supports these important
14 initiatives and CVS Health's ongoing commitment to our
15 communities and to our state.
16 Throughout the state, Breathe California is
17 proud to call CVS Health a true community partner.
18 Thank you.
19 COMMISSIONER JONES: Thank you very much.
20 Mr. Canetti from the California Hispanic
21 Chamber, welcome.
22 MR. CANETTI: Thank you, Commissioner Jones,
23 and thank you to the CDI staff as well, and thank you
24 for the opportunity to address you this afternoon.
25 I'm Julian Canetti, president of California's

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1 Hispanic Chambers of Commerce. The chamber is a network
2 of over 65 Hispanic chambers and business associations
3 throughout California, and in that role we represent the
4 interest of more than 800,000 Hispanic business owners
5 residing in California. It also makes us the larger
6 regional ethnic business association in the nation
7 today.
8 I'm here today because healthcare is one of
9 the top priorities and issues of concern to our members.
10 It is not a surprise to anyone here how expensive and
11 time consuming acquiring healthcare coverage can be, and
12 even then it's not clear if it addresses the needs of
13 our members and their employees.
14 Eighty percent of all healthcare costs
15 currently stem from chronic can conditions, which
16 afflict 50 percent of Americans. This can be especially
17 true in Hispanic communities where, for example,
18 diabetes is 84 percent more prevalent among Hispanic
19 than non Hispanic whites, and we are 40 percent more
20 likely to die from diabetes than non Hispanic whites.
21 Because of this shift, we must have different
22 and innovative ways of addressing healthcare needs. In
23 the case of this potential acquisition, we know that
24 pharmacists are often more accessible than primary care
25 physicians. No appointments are needed, they are well

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1 placed in neighborhoods, and are available for
2 consultation at hours during the day and night when most
3 doctor's offices are closed.
4 The CVS-Aetna merger will provide a nice
5 complement to the services of primary care physicians by
6 arming patients more often and more completely with
7 information, and increasing the number of patient
8 interactions, especially where it is needed with chronic
9 condition care.
10 This merger, we feel, will provide cost saving
11 opportunities to improve the healthcare experience for
12 consumers and businesses. The combined assets of CVS
13 and Aetna will allow the company to be better equipped
14 to meet the health needs of a growing number of people.
15 In closing, I would like to emphasize that the
16 merger of CVS and Aetna will create a healthcare
17 platform that is the patient friendly and achieves
18 needed cost reductions.
19 Thank you.
20 COMMISSIONER JONES: Thank you, Mr. Canetti.
21 It's good to see you again, and thank you for your
22 leadership with the California Hispanic Chambers.
23 Your name is?
24 MR. GORDON: It's Bob Gordon.
25 COMMISSIONER JONES: Bob Gordon. And I think

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1 what threw me was you didn't check the little box, Bob.
2 And also you didn't give us an address.
3 So I'm going to ask Mr. Hinze to bring this
4 down to you so you can fill out the rest of it at the
5 completion of your testimony. But welcome.
6 MR. GORDON: Thank you very much.
7 Good afternoon. My name is Bob Gordon, a
8 volunteer, today representing the American Cancer
9 Society Cancer Action Network, which is the advocacy
10 affiliate of the American Cancer Society. Thank you for
11 the opportunity to comment.
12 American Cancer Society Cancer Action Network
13 has worked closely with CVS on campaigns to prevent skin
14 cancer, to provide access to stop smoking products and
15 services, and to end the sale of tobacco products in all
16 of its stores.
17 American Cancer Society Cancer Action Network
18 has seen CVS grow to become a critical player in the
19 healthcare world, and have seen their commitment to
20 provide access to vital healthcare and anticancer needs.
21 But one vitally important point, the lure of increased
22 profits cannot further fragment care for cancer
23 patients.
24 Should this merger move forward, we expect the
25 Department will work closely with the combined entity to

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1 ensure that it will guarantee that patients have
2 affordable access to the medication and healthcare they
3 need to fight and prevent cancer.
4 Thank you.
5 COMMISSIONER JONES: Thank you very much,
6 Mr. Gordon. And I don't have a piece of paper, but --
7 MR. GALACE: I gave my contact information --
8 COMMISSIONER JONES: I know. I know. Why
9 don't you go ahead and introduce yourself. It's
10 Anthony --
11 MR. GALACE: Anthony Galace with the
12 Greenlining Institute.
13 COMMISSIONER JONES: Welcome.
14 MR. GALACE: Commissioner Jones, Deputy
15 Commissioner Rocco, and CDI staff, I just wanted to
16 thank you all for hosting this hearing.
17 Again, my name is Anthony Galace. I'm with
18 the Greenlining Institute, and we're a statewide policy
19 organization committed to racial and economic justice.
20 Greenlining has yet to take a position on the
21 proposed merger between CVS and Aetna, but we are
22 extremely concerned that neither entity has put forth a
23 plan that details how the expected efficiencies and
24 resources accrued will improve economic opportunities
25 for communities of color and other disadvantaged

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1 populations, either through their combined supplier
2 efforts or through expanding career opportunities.
3 Furthermore, neither company addresses how
4 they'll use their increased market power to reduce
5 racial and ethnic health disparities as was outlined by
6 the panelist on the second panel who mentioned there is
7 no plan as of yet to open up new branches in
8 disadvantaged, low income neighborhoods across the
9 state.
10 This ignores a majority of the state, which is
11 a majority minority population, and at the same time
12 neither entity, the combined entity, does not have any
13 plan that will show that its board of directors and
14 senior executives will reflect the growing diversity of
15 our nation, which is most prominent here in California.
16 While we await CVS and Aetna's response to
17 these questions that were posed today, we ask that both
18 of them detail plans that will address the needs of
19 California's growing majority, and that the Department
20 scrutinize the extent of these plans and make sure that
21 they are accountable to those who need it most.
22 Thank you so much.
23 COMMISSIONER JONES: Thank you very much.
24 And I would, on the issue of supplier
25 diversity, I appreciate Greenlining's leadership in that

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1 area and your close work with me and the Department, and
2 as you're aware, the reports from each insurer with
3 regard to their diversity and procurement as well as
4 their diversity in governing boards, are available on
5 our website. So those that want to do a deeper dive
6 with regard to any insurance company, including Aetna,
7 and the extent to which they have bought goods and
8 services from diverse suppliers, whether it's women
9 owned or Latino owned or African American owned or LGBT
10 owned businesses or Native American owned businesses,
11 you can find that information on our website.
12 And I appreciate Greenlining's partnership
13 with the Department in that endeavor.
14 So if there are no other members of the public
15 that wish to comment, I want to thank this panel, and
16 really appreciate your hanging with us for all four
17 hours, and appreciate your sharing with us your views
18 and input on the merger. Thank you very very much.
19 So with that, there are a couple of items that
20 I want to make sure the record is clear that I intend to
21 take notice of.
22 First is rate filings by Aetna to the
23 California Department of Insurance and the Department of
24 Managed Healthcare, and in particular those in which
25 either or both departments found the rates to be

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1 unreasonable, but not limited to those.
2 Second, data over the last five years on the
3 numbers of consumer complaints brought to the Department
4 of Insurance regarding alleged violations of the
5 insurance code by Aetna.
6 Third, various lawsuits that have been filed
7 against CVS and Aetna, some of which were referred to in
8 the hearing today.
9 And fourth, the entirety of the Form A filing
10 and any attendant filings with the Connecticut
11 Department of Insurance associated with this or any
12 other related matter.
13 The Connecticut Department of Insurance is the
14 were domiciliary regulator with which I believe the
15 Aetna parent company has filed the Form A, and so we
16 want to take notice in this proceeding of the Form A
17 filing and any proceedings of the Connecticut Department
18 related thereto.
19 In fairness, Aetna and CVS have asked for an
20 opportunity to respond to the voluminous testimony and
21 written submissions that were made today, and I want to
22 give them a chance to do that. And so they have asked
23 for two weeks in which to accomplish that.
24 I'm agreeable to that with one caveat, and
25 that is if we learn that the Federal Department of

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1 Justice is about to make a decision sometime prior to
2 that, then I may need to accelerate that deadline, and
3 they have consented that caveat.
4 All other written materials, written
5 testimony, written comments, unless already submitted
6 here, must be received by the Insurance Department no
7 later than 5:00 p.m. on Friday, June, 22nd, 2018 --
8 that's this Friday -- and these written materials,
9 written comments, written testimony, can be submitted in
10 one of two ways.
11 You can mail them addressed to me, the
12 Insurance Commissioner for the State of California, care
13 of Bruce Hinze, H-I-N-Z-E, Senior Counsel, California
14 Department of Insurance, 45 Fremont Street, 23rd Floor,
15 San Francisco, California 94105.
16 Or you may email any written materials to the
17 following email address: The email address is
18 mergercomments -- that's plural -- @insurance.ca.gov.
19 We ask that you please include in the subject
20 line, Aetna-CVS so we can distinguish those comments.
21 The mailed written comments would need to be
22 postmarked by no later than 5:00 p.m. on Friday, let me
23 just reiterate that. Those are the two ways in which
24 those that are listening or watching this hearing online
25 can submit -- or anybody else for that matter that wants

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1 to submit information -- in addition to what you have
2 already provided here.
3 The reporter is doing a very thorough job
4 capturing everything that was submitted here already, so
5 you need not repeat that, but if you want to send
6 something in in writing, we're happy to receive it.
7 So I believe that concludes the housekeeping
8 items associated with the hearing.
9 There is a question. Yes, please.
10 MR. MORIARTY: Yes. Thank you, sir. CVS and
11 Aetna would like to make sure we get the reports about
12 which the experts testified today in order to respond to
13 them.
14 COMMISSIONER JONES: Yes. We're happy to
15 provide you with copies of the written materials
16 provided to us, which we, in some cases, received only
17 at, like, 7:00 last night. But we will be happy to
18 share with you whatever we've received that was referred
19 to or referenced or introduced here at the hearing.
20 MR. MORIARTY: Thank you so much.
21 COMMISSIONER JONES: Absolutely. Very fair
22 request, and so Mr. Hinze will accomplish that for us.
23 So we received a lot of very helpful
24 information and testimony today. I want to thank the
25 representatives from CVS and the representatives from

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1 Aetna for their participation in the hearing and for
2 their testimony.
3 I want to thank the other expert witnesses who
4 attended, including the president of the AMA,
5 Dr. McAneny, and also the representatives from the CMA
6 and the consumer groups that were here. I also want to
7 thank my staff, Deputy Commissioner Rocco and Senior
8 Counsel Hinze and all of the other members of our
9 Department of Insurance team that made this hearing
10 possible.
11 There is a lot of evidence and testimony that
12 is going to give me a lot to think about and consider.
13 I do remain concerned about the potential
14 anticompetitive effects of the merger. There are
15 obviously competing considerations that have been raised
16 by various parties including the merger proponents, that
17 I will definitely think about and consider, and I look
18 forward to getting the additional written materials from
19 CVS and Aetna as part of that consideration.
20 At the end of the day, the question that I
21 think needs to be answered is is this in the public
22 interest? And that's what I will be considering as I
23 think about all of the information that everyone has
24 provided and as a way that competing arguments on the
25 various sides.

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1 So thank you very much again, and we
2 appreciate all that have participated in the hearing
3 today, and thanks to all of those that have been
4 listening and watching online as well.
5 With that, we are adjourned. Thank you.
6 (Whereupon, the proceeding was
7 concluded at 3:59 p.m.)
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1 REPORTER'S CERTIFICATE
2
3 I, ANDREA F. DANCE, CSR No. 12865, Certified
4 Shorthand Reporter, certify;
5 That the foregoing proceedings were taken before me
6 at the time and place therein set forth, at which time
7 the witness was put under oath by me;
8 That the testimony of the witness, the questions
9 propounded, and all objections and statements made at
10 the time of the examination were recorded
11 stenographically by me and were thereafter transcribed;
12 That the foregoing is a true and correct transcript
13 of my shorthand notes so taken.
14 I further certify that I am not a relative or
15 employee of any attorney of the parties, nor financially
16 interested in the action.
17 I declare under penalty of perjury under the laws
18 of California that the foregoing is true and correct.
19 Dated this 1st day of July, 2018.
20
21
22

23 ANDREA F. DANCE, CSR No. 12865.
24
25

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