
December 17, 2018

Peter Mucchetti
Chief, Healthcare and Consumer Products Section
Antitrust Division
Department of Justice
450 Fifth Street NW, Suite 4100
Washington, DC 20530

Re: *United States v. CVS Health Corp.*, No. 1:18-cv-02340, Comments of the American Antitrust Institute

Dear Mr. Mucchetti:

The American Antitrust Institute (AAI) is an independent nonprofit organization devoted to promoting competition that protects consumers, businesses, and society. It serves the public through research, education, and advocacy on the benefits of competition and the use of antitrust enforcement as a vital component of national and international competition policy. See http://www.antitrustinstitute.org.[1]

AAI submits these comments pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16 ("APPA" or the "Tunney Act"), to object to the settlement in this case. AAI respectfully submits that the settlement does not resolve the competitive problems raised by the combination of CVS and Aetna because it does not address the vertical concerns raised by the transaction, which AAI set forth in a March 26, 2018 letter to the Antitrust Division (hereinafter "AAI Letter"). The AAI Letter is enclosed for further consideration by the Antitrust Division and consideration by the Court during the course of its Tunney Act review.

AAI requests that the Antitrust Division withdraw and revise the consent agreement to address the vertical concerns raised by the transaction. Barring withdrawal, AAI requests in the alternative that the Antitrust Division publicly explain the basis for its apparent conclusion that a vertical remedy is unnecessary to prevent the multiplicity of anticompetitive harms raised in the AAI Letter and to preserve competition in the market for the sale of individual Medicare Part D prescription drug plans ("individual PDPs"), which is the focus of the complaint. An explanation as to why the Division believes vertical concerns can be safely ignored in this case would help assure the Court that entry of the Proposed Final Judgment is within the reaches of the public interest and

[1] AAI enjoys the input of an Advisory Board that consists of over 130 prominent antitrust lawyers, law professors, economists, and business leaders. Individual views of members of AAI's Board of Directors or its Advisory Board may differ from AAI's positions.

would not make a mockery of judicial power. It would also help the Division make good on its commitment to provide transparency to the business community and the public in enforcement matters.

## I. Explaining the Decision to Forego Vertical Relief Would Assist the Court in Making Its Public Interest Determination

When district courts make public interest determinations under the Tunney Act, "the relevant inquiry is whether there is a factual foundation for the government's decisions such that its conclusions regarding the proposed settlement are reasonable." *United States v. SBC Commc'ns, Inc.*, 489 F. Supp. 2d 1, 15-16 (D.D.C. 2007). In applying this standard, "the court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its Complaint [.]" *United States v. US Airways Grp., Inc.*, 38 F. Supp. 3d 69, 76 (D.D.C. 2014) (quoting *United States v. Graftech*, No. 1:10-cv-02039, 2011 WL 1566781, at *13 (D.D.C. 2011)); *see SBC Commc'ns*, 489 F. Supp. 2d at 14 (although "the government could constrain Tunney Act review by drafting a narrow complaint, . . . this argument has little force because the 'court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in the first place'" (quoting *United States v. Microsoft Corp.*, 56 F.3d 1448, 1459-60 (1995))).

Nevertheless, the D.C. Circuit has made clear that matters outside the scope of the complaint cannot necessarily be ignored during Tunney Act review. Among other things, the D.C. Circuit recognizes the "eventuality" that "when the government is challenged for not bringing as extensive an action as it might," the district court may find that the decree, "on its face and even after government explanation, appears to make a mockery of judicial power." *Microsoft Corp.*, 56 F.3d at 1462. Because a consent decree, even when entered as a pretrial settlement (where no factual findings have been made), is still "a judicial act," a court is not obliged to accept one that cannot clear this low bar. *Microsoft*, 56 F.3d at 1462; *SBC Commc'ns*, 489 F.Supp. 2d at 13. In particular, a district court can "reject a consent decree due to matters outside the scope of the underlying complaint" if "the complaint underlying the consent decree is drafted so narrowly as to make a mockery of judicial power." *SBC Commc'ns*, 489 F. Supp. 2d at 14; *US Airways*, 38 F. Supp. 3d at 76.

Matters outside the scope of the complaint also can inform the district court's evaluation of objections to the decree that can be "narrowly cast as objections to the remedies sought." *Microsoft*, 56 F.3d at 1461 ("The district court understandably questioned the government as to why the decree did not forbid Microsoft from using the alleged anticompetitive licensing practices with respect to all of Microsoft's operating systems.").

Here, there is a question whether the Antitrust Division's narrow drafting of its complaint to completely exclude the vertical competitive effects of the transaction renders the complaint "so narrow" as to make a mockery of judicial power. *See* Christopher Cole, *Gov't Told to Say Why CVS-Aetna Deal Needs Quick Wrap-Up*, Law360 (Dec. 3, 2018) (quoting Judge Leon as stating "I am concerned that your complaint raises anticompetitive concerns about one tenth of 1 percent of this $69 billion deal").

In addition, vertical considerations bear directly on the adequacy of the divestiture remedy in the relevant individual PDP markets alleged in the complaint. Several of the vertical issues identified

by concerned stakeholders focus on the threat of input foreclosure directed at Aetna's health insurance rivals, who are or may become Part D plan sponsors. *See* AAI Letter at 6-7 ("In gaining the upper hand in negotiations between CVS and rival health insurers, the merged firms could impose any number of conditions on rival insurers and harm competition and consumers in downstream health insurance markets"); *accord Hearing on Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna Before the H. Comm. on the Judiciary*, 115th Cong. 5-6 (2018) (statement of the American Medical Association); *see also* Comments from Consumer Reports, U.S. PIRG, and Consumer Action Concerning the Proposed Final Judgment in United States v. CVS Health Corporation and Aetna, Inc., No. 1:18-cv-02340 (RJL) 5-6 (Dec. 17, 2018). The divestiture will be a fig leaf if the merged firm can simply foreclose WellCare and other Part D sponsors post-merger, or leverage its vertical assets to insulate itself from hard competition in individual PDP markets by constraining Wellcare and other Part D sponsors to remain stagnant and ineffectual as competitors. *Id.*

Explaining the Division's rationale for ignoring vertical concerns in the complaint and remedy would assist the Court in performing all of the necessary aspects of Tunney Act review. A fulsome explanation may also obviate the need for the Court to conduct hearings, take testimony of government officials, appoint a special master and outside consultants or expert witnesses, and authorize examination of witnesses or documentary materials by interested persons or agencies to satisfy itself that it has adequately fulfilled its obligations under the Tunney Act. *See* 15 U.S.C. § 16(f); *cf. United States v. Comcast*, 808 F. Supp. 2d 145, 148-49 (D.D.C. 2011) (Leon, J.).

## II. Explaining the Decision to Forego Vertical Relief Would Honor the Division's Commitment to Transparent Decision-Making

Explaining the Division's rationale for ignoring vertical concerns in the complaint and remedy is also the right thing to do. As Assistant Attorney General Delrahim emphasized in his first public remarks following Senate confirmation, "we must be willing and able to open up our policies and decisions to review and challenge." Makan Delrahim, Asst. Att'y Gen., Antitrust Div., U.S. Dept. of Justice, Remarks at New York University School of Law (Oct. 27, 2017), https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-remarks-new-york-university-school-law; *see also* Roger Alford, Dep. Ass't Att'y Gen., Antitrust Div., Dep't of Justice, Remarks Delivered at China Competition Policy Forum (Aug. 30, 2017), https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-roger-alford-delivers-remarks-china-competition-policy ("To retain the confidence of both the business community governed by our laws and the public we protect, we must be willing to expose our agencies' policies and practices to aggressive scrutiny and challenge."); *id.* ("[W]hen agencies make unexplained decisions, it is easier for parties to believe that an agency's outcome is flawed. In contrast, when transparent decision-making processes are in place, the legitimacy of the agency's outcome is enhanced.").

Opening up the Division's decision to forego vertical relief to judicial and public scrutiny would serve the public and the business community by fostering transparency and predictability, and enhancing the legitimacy of the outcome in this case. Indeed, the benefits of transparency would be magnified here because of the unique importance of this merger, which has attracted national media attention, has been the subject of a Congressional hearing, and occurs in a vital sector of the U.S. economy that implicates core aspects of human health and well-being.

## III. Conclusion

For the foregoing reasons, the Antitrust Division should withdraw and revise the consent agreement to address the vertical concerns raised by the transaction. In the alternative, it should publicly explain the basis for its apparent conclusion that a vertical remedy is unnecessary to preserve competition in any of the relevant markets implicated by the transaction, including but not limited to individual PDP markets.

Respectfully submitted,

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Enclosure

March 26, 2018
Mr. Makan Delrahim
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950 Pennsylvania Ave. NW
Washington, DC 20530

**Re: Competitive and Consumer Concerns Raised by the CVS-Aetna Merger**

Dear Assistant Attorney General Delrahim:

The American Antitrust Institute (AAI) has long advocated for competition and consumers in healthcare, including the pharmaceutical, hospital, health insurance, and intermediary (i.e., group purchasing organization and pharmacy benefit manager (PBM)) sectors.[1] AAI writes to express concern that the proposed merger of the retail pharmacy chain/PBM CVS Health and health insurer Aetna will potentially harm competition and consumers. This letter adds to the concerns raised by other important voices, including the American Medical Association (AMA) and Consumers Union.[2] We note that at the time of this writing, the parallel merger of the PBM Express Scripts and health insurer Cigna was recently announced. We provide some additional analysis of the competitive implications of *both* mergers and the resulting restructuring of key segments of the health care industry that they would bring about.

## I. Overview

CVS-Aetna would pair up the largest retail pharmacy chain and one of the two largest PBMs with the 3rd largest health insurer in the U.S.[3] The proposed merger raises a number of questions for

[1] The AAI is an independent non-profit education, research and advocacy organization. Its mission is to advance the role of competition in the economy, protect consumers, and sustain the vitality of the antitrust laws. For more information, see www.antitrustinstitute.org. Many thanks to David Balto for help in reviewing an earlier draft, Bill Comanor for important insight, and to AAI research Fellow Mark Angland for valuable research assistance.
[2] *See*, separate statements of the American Medical Association and George Slover, Senior Policy Council, Consumers Union, to the Subcommittee On Regulatory Reform, Commercial and Antitrust Law House Committee On the Judiciary On Competition In the Pharmaceutical Supply Chain: The Proposed Merger Of CVS Health and Aetna (Feb. 27, 2018), https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/2018-2-17+AMA+Statement+for+the+Record+-+CVS-Aetna+Merger+-+House+Judici....pdf; and https://judiciary.house.gov/wp-content/uploads/2018/02/Slover-Testimony.pdf. *See also*, David Balto, CVS-Aetna merger is a robber baron's dream come true (Dec. 6, 2017), http://thehill.com/opinion/finance/363510-cvs-aetna-merger-is-a-robber-barons-dream-come-true.
[3] America's Biggest Health Insurance Providers, Forbes (May 4, 2016), https://www.forbes.com/pictures/fefi45ejdih/3-aetna/#1cdc25644d93 (market shares measured by net sales in 2014); AIS HEALTH DATA, PROFILES OF THE EIGHT

competition and consumers. Our letter, based on publicly available information, focuses on the merger's potential to (1) enhance the incentive of CVS-Aetna to exclude rivals and (2) facilitate anticompetitive coordination among health insurers served by PBM CVS-Caremark. CVS and Aetna already wield significant market power in the retail pharmacy, PBM, and health insurance markets. High concentration in these markets exacerbates competitive concerns.[4] The U.S. Department of Justice's (DOJ's) successful challenges to the Anthem-Cigna and Aetna-Humana mergers highlight this issue, as does a Council of Economic Advisers report that concludes that drug pricing suffers from high concentration in the PBM market.[5] Market idiosyncrasies heighten the proposed merger's potentially anticompetitive effects. These include the role of health insurers in paying for most prescriptions filled and of PBMs in managing the flow of prescription drugs to millions of Americans, and PBM markets that lack important transparency.[6]

Together with the merger of Express Scripts-Cigna, CVS-Aetna would trigger a fundamental restructuring of the U.S. healthcare system. Stronger incentives to exclude rival PBMs and health insurers and to engage in anticompetitive coordination would harm competition and consumers at all levels. Assuming both mergers move forward, the three large integrated PBM-insurer systems (i.e., CVS-Aetna, Express Scripts-Cigna, and Optum Rx-United Healthcare) that would dominate the markets would have weak, if any, incentives to compete. This stands in stark contrast to the competition that is fostered by standalone rivals. Moreover, entry barriers would increase dramatically, scalable only by those players who could enter and compete effectively at *two levels* – PBM and health insurance. This would effectively lock out competition by standalone PBMs, insurers, and other market participants – competition that is badly needed to foster innovation, to protect the stability of the healthcare supply chain, and promote the welfare of the U.S. consumer.

Any of the anticompetitive effects discussed in this letter would be detrimental to consumers through potentially higher prices, lower quality, less choice, and less innovation in markets for prescription drugs and health insurance. In healthcare, these effects can make the difference between wellness or disease, and life or death. CVS-Aetna should face a high hurdle in explaining how any claimed efficiencies assuage the significant competitive concerns that pervade their merger. Such efficiencies would have to be achievable *only* through merger; demonstrated in post-merger operations; passed through to consumers in the form of lower prices; and sufficiently large to offset substantial potential competitive harms. This is a tall order – one that CVS-Aetna cannot fulfill. Moreover, there is little evidence that past vertical acquisitions by CVS, including its acquisition of Caremark, have resulted in significant benefits and have even harmed consumers and independent pharmacies.[7] In light of all of this, the *only* effective remedy is for the government to move to block the proposed merger.

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LARGEST HEALTH INSURERS: 2016, 13 (2016), https://aishealth.com/sites/all/files/bp82016.pdf (market shares measured by percentage of covered lives in 2016).

[4] *See* U.S. Dept. of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* §5.3 (2010).

[5] The Council of Economic Advisors, *Reforming Biopharmaceutical Pricing at Home and Abroad*, THE WHITE HOUSE at 10 (Feb. 2018), https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

[6] *Id.* at 43.

[7] *See* Change to Win, *Growing Problems for CVS Caremark: Multi-state investigation looms as bill banning retail/PBM business model in FEHBP clears House Subcommittee and gains momentum in Congress (*Mar. 25, 2010), https://www.businesswire.com/news/home/20100325006026/en/Change-Win-Growing-Problems-CVS-Caremark.

## II. Vertical Merger Enforcement is Vitally Important

Both the DOJ and the Federal Trade Commission (FTC) have a long history of vertical merger enforcement.[8] The DOJ recently challenged the merger of AT&T and Time Warner, articulating cogent theories of competitive harm and adverse effects on consumers.[9] The CVS-Aetna merger also raises many of these competitive concerns, which are magnified by highly concentrated markets. The proposed Express Scripts-Cigna merger is likely to raise similar concerns. Vigorous vertical merger enforcement is vitally important, for a number of reasons.

First, while vertical mergers do not eliminate rivals and increase market concentration, they can enhance the ability and/or incentive for a merged firm to behave in ways that harms competition at a horizontal level. By combining inputs with distribution, for example, a vertical merger can enhance incentives for the merged firm to exclude its downstream or upstream rivals, either by raising their costs or cutting off their access to critical resources.[10] The magnitude of horizontal effects from a vertical combination depends on a number of factors, including concentration in "upstream" and "downstream" markets. Second, there are well-founded concerns about the effectiveness of past conduct remedies in vertical mergers.[11] There is also growing skepticism over whether vertical mergers actually deliver the efficiencies claimed by their proponents. With no ability to hold merging parties' "feet to the fire" to make good on the purported benefits of their deal, the antitrust agencies must be vigilant.

## III. The Markets for Pharmacy, Pharmacy Benefit Management, and Health Insurance Are Concentrated

The proposed merger will affect three major markets in which CVS and Aetna wield significant market power. These are the upstream markets for retail pharmacy and PBM and the downstream market for health insurance. The specific relevant markets that will ultimately be defined by DOJ in its investigation are likely to be more focused on specific products and geography. However, the market descriptions and competitive issues outlined below are likely to be consistent with what the government would draw from an analysis of even more narrowly defined markets.

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[8] *See e.g.*, *AAI Applauds Move to Block AT&T Time Warner Merger Sets Record Straight on Vertical Merger Enforcement*, AM. ANTITRUST INST. (Dec. 6, 2017), http://antitrustinstitute.org/content/aai-applauds-move-block-att-time-warner-merger-sets-record-straight-vertical-merger.

[9] Complaint, United States v. AT&T Inc., No. 1:17-cv-02511 (D. D.C. Nov. 20, 2017), https://www.justice.gov/atr/case-document/file/1012916/download.

[10] *See, e.g.,* Steven C. Salop, *Invigorating Vertical Merger Enforcement*, Yale L.J. (forthcoming, 2018), https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=3020&context=facpub; Michael Riordan & Steven Salop, *Evaluating Vertical Mergers: A Post-Chicago Approach* 63 Antitrust L. J. 513 (1995); and William S. Comanor & Patrick Rey, *Vertical Mergers and Market Foreclosure*, *in* 21 JOHN B. KIRKWOOD, 21 ANTITRUST LAW AND ECONOMICS (Research in Law and Economics) 445 (2004).

[11] *See* United States v. Comcast Corp., 808 F. Supp. 2d 145 (D. D.C. 2011), Makan Delrahim, Asst. Att'y Gen., Dep't of Justice, Antitrust Div., Keynote Address at American Bar Association's Antitrust Fall Forum (Nov. 16, 2017), https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-keynote-address-american-bar; Ted Johnson, *Senator Asks DOJ to Take Another Look at Comcast-NBCUniversal Merger*, VARIETY (Dec. 13, 2017), www.heritage.org/technology/commentary/time- repeal-the-ftcs-common-carrier-jurisdictional-exemption-among-other.

### A. Health Insurance Markets Are Highly Concentrated and Aetna Is a Leading Player

Aetna is the 3rd largest health insurer in the U.S. Along with its rivals United Healthcare, Anthem, Cigna, and Humana, it is one of the "Big 5."[12] The health insurance industry is concentrated and has become increasingly so over the last twenty years. Nationally, the share of the largest four insurers increased from 74% to 83% from 2006 to 2014.[13] Notably, the high and increasing cost of insurance has persisted while the annual growth in healthcare costs has been declining over the last decade.[14] The 2017 comprehensive study of competition in health insurance markets by the AMA finds that nearly 70% of combined, locally defined health maintenance organization, preferred provider organization, point-of-service, and public health exchange markets are highly concentrated.[15]

Much of the growth in market shares and concentration over time is attributable to horizontal mergers of health insurers. Aetna is now either the first or second largest insurer in 57 of the 389 Metropolitan Statistical Areas studied by the AMA.[16] High market concentration was at the root of the DOJ's concern in the Anthem-Cigna and Aetna-Humana mergers. The government's complaint opposing the proposed merger of Aetna and Humana alleged, for example, that the merger would be likely to substantially lessen competition in 364 county-level Medicare Advantage markets across 21 states.[17] Aetna is also one of the largest participants in the individual insurance market on the public exchanges.[18]

### B. PBM Markets Are Highly Concentrated and CVS-Caremark Wields Significant Market Power

Pharmaceutical expenditures account for about 17% of total health care outlays in the U.S.[19] Sources estimate that PBMs manage prescription drug benefits for 95% of Americans with prescription drug coverage.[20] PBMs like CVS-Caremark manage prescription drug insurance coverage for health insurers, managed care companies, and plan sponsors such as employers and labor unions.[21] PBM

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[12] United States v. Aetna Inc., 250 F. Supp. 3d 1, 11 (D. D.C. 2017).

[13] *Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask? Hearing Before the Subcomm. On Antitrust, Competition Policy, and Consumer Rights of the S. Comm. On the Judiciary*, 114 Cong. 5 (2015) (testimony of Leemore Dafny), http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[14] *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 114 Cong. 10 (2015) (testimony of Rick Pollack, President and CEO of the American Hospital Association), https://judiciary.house.gov/wp-content/uploads/2016/02/Pollack-Testimony.pdf.

[15] Am. Med. Ass'n, Health Policy Grp., *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2017); *see* U.S. Dept. of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* §5.3 (2010).

[16] Am. Med. Ass'n, *supra* note 15.

[17] Complaint at 5, United States v. Aetna Inc., No. 1:16-cv-01494 (D. D.C. July 21, 2016), https://www.justice.gov/atr/file/878196/download.

[18] *See* Susan Ladika, *The New Era of Mega-Plans,* MANAGED CARE (Sept. 2015), http://www.managedcaremag.com/archives/2015/9/new-era-mega-plans (describing mergers of large insurers since 2011).

[19] US DEPARTMENT OF HEALTH AND HUMAN SERVICES, OBSERVATIONS AND TRENDS IN PRESCRIPTION DRUG SPENDING (Mar. 8, 2016), https://aspe.hhs.gov/system/files/pdf/187586/Drugspending.pdf.

[20] Emily Maltby, *The Death of the Corner Pharmacy*, CNN MONEY (June 16, 2009), http://money.cnn.com/2009/06/16/smallbusiness/small_pharmacies_fight_for_suivival.smb/index.htm.

[21] Plan sponsors can negotiate directly with PBMs for prescription drug benefits for their subscribers or members in a "carve-out" arrangement or work through their health insurer for medical coverage *and* drug benefits under a "carve-in"

activities affect multiple levels of the supply chain. They negotiate with drug companies on formulary drugs and on wholesale pricing and rebates that are retained by the PBM and/or passed on to payers. PBMs also assemble networks of affiliated and independent retail pharmacies so that plan sponsors' subscribers can fill prescriptions at retail and mail order pharmacies under a co-payment or co-insurance system.[22] The ability of large PBMs to offer exclusive distribution contracts and to secure discounts and rebates from drug suppliers is a major factor in entrenching their market power and raising barriers to entry.

CVS-Caremark has a national market share of 25% and Express Scripts' market share is 24%.[23] Together, the two PBMs have a combined national market share of over 50. The third largest PBM, Optum Rx, which is integrated with health insurer United Healthcare, has a 22% market share. Other sources estimate that the three largest PBMs control as much as 85% of the market.[24] In some locally defined geographic markets, CVS has a particularly hefty presence. For example, CVS accounts for 30% or more of contract pharmacy networks for 180 large covered entities such as hospitals and medical centers in local geographic markets in the U.S.[25] It makes up 80% or more of the contract pharmacy networks of over 20 covered entities and 100% of the contract pharmacy networks of at least 14 covered entities.

CVS-Caremark and Express Scripts have achieved their significant market positions through a series of mergers and acquisitions. The 2007 merger of CVS and Caremark reduced the number of large PBMs from four to three and the 2012 merger of Express Scripts and Medco further reduced that number from three to two. As they have grown, the large PBMs have secured protected positions in servicing the needs of their clients' customers. For example, once a health insurer has contracted with a particular PBM, subscribers are limited to the affiliated pharmacy services. This includes mail order pharmacy, which accounts for 41% of CVS's drug sales revenues.[26] They may not take their prescriptions elsewhere without being charged "cash" prices, which are much higher than co-pay or co-insurance prices.

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arrangement. The majority of health insurance members still take the carve-in route for prescription drug coverage. https://www.medscape.com/viewarticle/467890

[22] Press Release, Fed. Trade Comm'n, FTC Issues Report on PBM Ownership of Mail-Order Pharmacies (Sept. 6, 2005), https://www.ftc.gv/news-events/press-releases/2005/09/ftc-issues-report-pbm-ownership-mail-order-pharmacies.

[23] Pharmacy Benefit Management Institute, *PBM Market Share, by Total Equivalent Prescription Claims Managed, 2017,* https://www.pbmi.com/PBMI/Research/Industry_Research/PBMI/Research/PBMI___Industry_Research.aspx?hkey=22023612-80c4-4ada-a17e-85e7dfcbc1f8. *See also The State of Competition in the Pharmacy Benefit Manager and Pharmacy Marketplaces Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 114 Cong. (2015) (Testimony of David Balto, Esq.).

[24] *See, e.g.*, *Balto, supra* note 23; *see also Industry Research: PBM Market Share*, PBMI, (citing Adam J. Fein, *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, DRUG CHANNELS INSTITUTE, (2016)), https://www.pbmi.com/PBMI/Research/Industry_Research/PBMI/Research/PBMI___Industry_Research.aspx?hkey=22023612-80c4-4ada-a17e-85e7dfcbc1f8. .

[25] Complaint Exhibit A at 2-0, Sentry Data Systems, Inc. v. CVS Health, No. 0:18-cv-60257-BB (S.D. Fla. Feb. 5, 2018), http://res.cloudinary.com/gcr-usa/image/upload/v1517936494/CVSWellpartnerComplaint_jzjdpy.pdf.

[26] CVS Health Corp., Quarterly Report (Form 10-Q) at 31, 34 Â (Nov. 6, 2017), http://otp.investis.com/clients/us/cvs_caremark1/SEC/sec-show.aspx?Type=html&FilingId=12362467&CIK=0000064803&Index=10000; CVS Health Corp., Annual Report (Form 10-K), Exhibit 13 at 6, 8 (Feb. 9, 2017), http://otp.investis.com/clients/us/cvs_caremark1/SEC/sec-show.aspx?Type=html&FilingId=11837374&CIK=0000064803&Index=10000.

### C. CVS is the Leading Retail Chain Pharmacy

Twenty-eight percent of total spending on pharmaceuticals in 2016 was at the retail pharmacy level. This includes the dispensing of drugs through chain, independent, and food-store pharmacies.[27] CVS's share of drug sales from retail pharmacy chains in the U.S. is about 25%.[28] Together with Walgreens, the two chains control 50% of national drug sales. CVS acquired its market position in the retail pharmacy market through merger and acquisition, as opposed to organic growth. The firm expanded nationwide from a regional player in the 1990s through the acquisition of the Revco and Longs Drugs chains and thousands of stores from Eckerd, Sav-On, Osco, Arbor Drugs, and others. Nearly 24% of total prescriptions filled in retail pharmacies are now filled at CVS retail stores.[29] In local retail pharmacy markets, CVS has even larger positions. CVS itself noted, for example, that it operates in "98 of the top 100 United States drugstore markets" and held "the number one or number two market share in 93 of these markets."[30]

## IV. The Proposed Merger Could Harm Competition and Consumers Through Exclusionary Conduct and Anticompetitive Coordination

High market concentration and the significant market power held by CVS and Aetna in markets for retail pharmacy, PBM, and health insurance sketch a troubling landscape against which the proposed merger would occur. The lack of transparency in drug pricing and the idiosyncratic nature of drug distribution and insurance markets also bear materially on an analysis of the proposed merger's competitive effects.

### A. The Proposed CVS-Aetna Merger Could Disadvantage Rival Health Insurers and Impede Competition in Health Insurance Markets

The proposed merger of CVS and Aetna will strengthen the ability and incentive for the merged firm to impede competition in health insurance markets. This would be a particularly attractive strategy for Aetna where it seeks to consolidate its dominant market position in certain local health insurance markets. CVS's significant market position gives it the ability to influence which drugs are dispensed and what sources they are dispensed from.[31] Before the merger, a standalone CVS has strong incentives to sell its PBM services to all health insurers. By integrating with CVS, Aetna gains control of rival health insurers' access to an important PBM. This exacerbates the risk of "input foreclosure," or the possibility that the merged company could frustrate rivals' access to CVS products and services, raising their costs or cutting them off completely, thus impairing their ability to compete. This is a particularly important since controlling drug spend is a crucial issue for all insurers.

The likely mechanism for foreclosing rivals is CVS-Aetna's enhanced bargaining leverage vis-à-vis rival health insurers. In gaining the upper hand in negotiations between CVS and rival insurers, the

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[27] *Id.* at 41.

[28] Based on 2016 data. *See, e.g., 2016's Top Retail Pharmacy Chains, According to Drug Store News* (Jul. 20, 2017), http://www.drugchannels.net/2017/07/2016s-top-retail-pharmacy-chains.html.

[29] CVS Health Corp., Annual Report (Form 10-K) at 6 (Feb. 9, 2017).

[30] *Id.* at 9 (citing CVS Health Corp., Annual Report (Form 10-K) at 6 (Feb. 10, 2015).

[31] A number of states have proposed to regulate the non-price aspects of PBM activity, calling for regulatory oversight of conflicts of interest, contractual relationships between PBMs and health plans, and disclosures on PBM contracts with drug manufacturers.

merged firm could impose any number of conditions on rival insurers and harm competition and consumers in downstream health insurance markets. For example, CVS-Caremark could: (1) develop formularies for rivals that do not include important drugs that are in demand by their subscribers; (2) refuse to provide transparency about the actual costs of the drugs or the various payments or rebates they secure from manufacturers; (3) offer pharmacy networks that do not provide important options (e.g., independent specialty pharmacies) or force rival insurers into CVS-Caremark mail order pharmacy services; (4) gather information about the subscribers and drug spend of rival insurers, targeting rival insurers' customers in ways that would impair their ability to compete; and (5) simply decline to fill prescriptions for rival insurers' enrollees.

Plan sponsors and subscribers would have limited ability to switch quickly away from a disadvantaged, rival insurer in response to a CVS-Aetna input foreclosure strategy. Even if they could, limited competition in the PBM market provides few other choices relative to an integrated CVS-Aetna. Smaller PBMs lack the bargaining power and the sophisticated drug management programs of the three dominant PBMs and may not be able to meet the prescription drug management needs of rival insurers. Moreover, smaller integrated PBMs may be integrated with other insurers (e.g., Humana) and unwilling or unable to deal with rival insurers. The fact that CVS-Caremark loses few customers to these smaller PBMs documents illustrates the difficulty of switching to smaller PBMs. For example, the next largest independent PBM, MedImpact Healthcare Systems, has a market share of approximately 6%, almost 20% less than that of CVS and Express Scripts.[32]

The foregoing analysis highlights the multiple strategies that a merged CVS-Aetna could pursue to exclude rivals and frustrate competition in health insurance markets. High PBM market concentration and the inability of smaller PBMs to discipline competition increases the risk of input foreclosure and raises barriers to entry to potential entrants in health insurance. Higher insurance premiums, lower quality, and less innovation in relevant health insurance markets would be the likely outcome, to the detriment of consumers.

### B. The Proposed CVS-Aetna Merger Could Disadvantage Rival Retail Pharmacies and PBMS and Harm Competition in Prescription Drug Distribution Markets

The proposed merger strengthens the ability and incentive of the merged firm to impede competition in retail pharmacy and PBM markets. Before the merger, a standalone Aetna has stronger incentives to deal with all retail pharmacy and PBM rivals. Post-merger, these incentives change. By integrating with Aetna, CVS controls access to a key potential customer for rival retail pharmacies and PBMs. This exacerbates the risk of "customer foreclosure," or the possibility that a merged CVS-Aetna could cut off rivals' access to Aetna, thus impairing competition in the retail pharmacy and PBM markets. High market concentration in health insurance, particularly at the local levels where relevant markets will be defined, limits the number of alternative customers that rival retail pharmacies and PBMs could seek out post-merger, exacerbating the risk of customer foreclosure.

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[32] Pharmacy Benefit Management Institute, *PBM Market Share, by Total Equivalent Prescription Claims Managed, 2017,* https://www.pbmi.com/PBMI/Research/Industry_Research/PBMI/Research/PBMI___Industry_Research.aspx?hkey=22023612-80c4-4ada-a17e-85e7dfcbc1f8.

There are a number of mechanisms for foreclosing rival retail pharmacies. For example, CVS-Aetna could implement forced conversions to CVS-Caremark mail order for Aetna subscribers, despite evidence that "consumers strongly prefer retail pharmacies, which offer face-to-face consultations, medical information, and a range of healthcare services."[33] CVS-Aetna could also exercise its enhanced bargaining leverage post-merger with retail pharmacies, particularly independents. By virtue of their smaller size and lack of bargaining power, independent pharmacies are already susceptible to exclusionary conduct. With enhanced bargaining leverage post-merger, CVS could, for example: (1) drive down dispensing fees and delay reimbursement and (2) cherry-pick the most profitable prescriptions and enforce complex "take-it-or-leave-it" contracts with independents.[34] The risk of foreclosure for rival retail pharmacies is bolstered by CVS's past conduct, which includes persistent allegations of anticompetitive abuses designed to steer consumers away from its drug store rivals.[35] Such exclusionary behavior has harmed consumers by eliminating an important source of choice, which is particularly important for seniors under Medicare Part D.[36]

CVS-Aetna could foreclose rival PBMs by simply cutting them off from access to Aetna subscribers. For example, the Big 5 health insurers account for an overwhelming share of private pharmaceutical payments through reimbursements. The viability of rival PBMs therefore depends on access to insured consumers with co-pays or coinsurance. Aetna could refuse to grant an affiliation for a rival PBM to serve their insured members, which is critical for ensuring prescription drug coverage under co-pay and co-insurance arrangements. These affiliations are reportedly denied to competing mail order pharmacies in order specifically to reserve these sales for insurers' PBM affiliates.[37] Without the scale and scope to negotiate for rebates with drug manufacturers or for other network-related services, smaller PBMs are particularly exposed to potentially restrictive conduct.[38]

In sum, any exclusionary strategy that removes Aetna as a potential customer of upstream retail pharmacy and PBM rivals would make it more difficult for them to compete by raising their costs or cutting them off. This would potential impair competition in retail pharmacy and PBM markets.

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[33] Independent pharmacies offer a wide range of patient services, from immunizations to diabetes training and blood pressure monitoring. Stacy Mitchell, *Pharmacy Equity Laws*, NEWRULES.ORG (March 20, 2008), http://www.ilsr.org/rule/pharmacy-equity-laws/. A number of states have enacted legislation designed to level the playing field for consumers.

[34] Karen E. Klein, *End of Days for Independent Pharmacies?* BLOOMBERG BUSINESS WEEK (March 8, 2012), http://www.businessweek.com/articles/2012-03-08/end-of-days-for-independent-pharmacies. For example, in *Alameda Drug Co. Medco Health Solutions*, plaintiff pharmacies alleged that Medco unfairly increased market share and market power, and restricted price competition by reducing the amount of reimbursement to plaintiffs for dispensing drugs under Medco Health Plans. Complaint at ¶ 20, Alameda Drug Co., Inc, v. Medco Health Solutions, Inc., No. CGC-04-428109 (Cal. Super. Ct Jan. 20, 2004); *see also* DAVID A. BALTO, FEDERAL AND STATE LITIGATION INVOLVING PHARMACY BENEFIT MANAGERS (updated January 2011), http://www.ncpanet.org/pdf/leg/aug11/fed_state_litigation_pbms.pdf.

[35] *See CVS Takes Its Anti-Smoking Policy to The Next Level: AAI Urges Antitrust Scrutiny of Anticompetitive Scheme Masquerading as a Drive for Public Health*, AM. ANTITRUST INST. (Nov. 10, 2014), http://antitrustinstitute.org/content/cvs-takes-its-anti-smoking-policy-next-level-aai-urges-antitrust-scrutiny-anticompetitive.

[36] Press Release, PMCA: Lower Cost, Preferred Pharmacies Popular with Seniors in Medicare Part D, https://www.pcmanet.org/pcma-lower-cost-preferred-pharmacies-popular-with-seniors-in-medicare-part-d/ (last accessed Mar. 9, 2018).

[37] Charles Ornstein & Katie Thomas, *Prescription Drugs May Cost More with Insurance*, N.Y. TIMES (Dec. 9, 2017), https://www.nytimes.com/2017/12/09/health/drug-prices-generics-insurance.html.

[38] David A. Balto, Reviving Competition in Healthcare Markets: The Use of Section 5 of the FTC Act, Before the FTC Workshop: Section 5 of the FTC Act as a Competition Law 3, 11 (Oct. 17, 2008), http://www.ftc.gov/bc/workshops/section5/docs/dbalto.pdf.

Health insurers and their subscribers would be harmed by higher prescription drug prices, lower quality, and less innovation in drug distribution and health insurance markets.

### C. Anticompetitive Coordination and Potential Harm to Competition in Provider Markets

The possible post-merger scenarios described above involve the unilateral exercise of market power by a merged CVS-Aetna. The proposed merger also raises concerns about coordinated effects, through two major avenues. One is potential anticompetitive coordination between the downstream health insurers that are served by CVS. For example, the second largest health insurer, Anthem, signed a contract with CVS to begin in 2020. If the contract proceeds, notwithstanding the proposed merger, CVS would serve the needs of its health insurance affiliate (Aetna) *and* a rival (Anthem). It is therefore in a position to obtain information on *both* Aetna and Anthem subscribers, using CVS as a conduit. Such information exchange between Anthem and Aetna could facilitate anticompetitive coordination in health insurance markets, including price fixing, market allocation, and collusion on the "rules" of competition surrounding new products or services.

Incentives for anticompetitive coordination intensify as the number of vertically integrated PBM-insurers increases. If Express Scripts and Cigna merge, and if Express Scripts contracts with rival insurers, it too will be in a position to exchange competitively sensitive information on rivals' health insurer subscribers. The dominance of CVS and Express Scripts thus virtually guarantees the exchange of competitive sensitive information on millions of health insurance subscribers. Given the highly concentrated nature of health insurance markets, this could further facilitate coordination in downstream markets.

Establishing information firewalls between upstream PBM and downstream health insurer affiliates would be an ineffective approach to remedying this problem. The ineffectiveness of past conduct remedies in vertical mergers has been highlighted by antitrust scholars, and recently emphasized by the DOJ. The merged firm would likely find workarounds for a firewall, and it would impose regulatory-style arbitration and compliance burdens on the courts.[39] Such a remedy would not fully restore competition lost by the merger and provide little deterrence value.[40]

There is a second avenue through which the proposed mergers of CVS-Aetna could hamper competition through enhanced coordination. If the proposed merger proceeds, CVS-Aetna will join ranks with integrated PBM-insurer Optum Rx-United Healthcare. These two systems would account for a significant share of the healthcare insurance markets. There would thus be stronger incentives for similarly aligned, vertically integrated PBM-insurers to coordinate to prevent market entry by more other PBMs or innovative drug distribution business models.[41]

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[39] Makan Delrahim, Asst. Att'y Gen., Dep't of Justice, Antitrust Div., Keynote Address at American Bar Association's Antitrust Fall Forum (Nov. 16, 2017), https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-keynote-address-american-bar.

[40] See, e.g., John E. Kwoka & Diana L. Moss, *Behavioral Merger Remedies: Evaluation and Implications for Antitrust Enforcement*, 57 ANTITRUST BULL. 979, 994, 1010 (2012).

[41] *Supra*, note 9.

If the Express Scripts-Cigna merger moves forward, three integrated PBM-insurers will dominate the industry with vertically integrated aligned structures.[42] CVS and Express Scripts would have virtually all PBM demand locked up and Aetna, United Healthcare, and Cigna would account for an enormous share of the health insurance markets. There have been numerous allegations made against PBMs for allegedly coordinating to engage in anticompetitive conduct.[43] This should amplify concerns about the potential for anticompetitive coordination in the context of the CVS-Aetna and Express Scripts-Cigna mergers.

## V. Conclusions

CVS-Aetna should face a high hurdle in explaining to the DOJ how any claimed efficiencies assuage the significant competitive concerns that pervade their merger. Such efficiencies would have to be achievable *only* through merger, as opposed to arms-length contracting between CVS and Aetna. The companies would need to deliver on any promised reductions in transaction costs or benefits from enhanced coordination between their health insurance and PBM affiliates. Moreover, CVS and Aetna would need to explain why – in light of high concentration and limited competition in the affected markets – they have *any* incentives to pass through cost savings from their merger to consumers. Finally, any efficiencies would have to be sufficiently large to offset the substantial competitive harms that are likely to result from the proposed merger. This is a tall order – and poses an almost insurmountable burden for the merging companies given the myriad competitive concerns raised by their merger.

The merger of CVS and Aetna poses substantial anticompetitive risks for our health care markets and consumers. We hope the DOJ will give it the intense scrutiny it deserves. A move to block the proposed merger *and* the cascade of further restructuring of the healthcare sector that it would likely trigger would protect competition and consumers in vitally important healthcare markets. We appreciate the opportunity to provide our views. If you have any questions, we would be happy to meet with you and your staff.

Sincerely,

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[42] Reed Abelson & Katie Thomas, *CVS and Aetna Say Merger Will Improve Your Health Care*, N.Y. TIMES (Dec. 4, 2017), https://www.nytimes.com/2017/12/04/health/cvs-aetna-merger.html.

[43] *See, e.g., In Re: Pharmacy Benefit Managers Antitrust Litigation*, Case No. 2:06-md-01782 (E.D.Pa, filed 2003) (alleging coordination among the major PBMs in suppressing competition by paying independent pharmacies less than chains for drug sales).