

**Statement of Professor Thomas L. Greaney
University of California Hastings College of Law**

Before the

**Investigatory Hearing on Merger of Aetna Inc. into CVS Health Corporation
State California Department of Insurance**

June 19, 2018

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Thank you Commissioner Jones for the opportunity to participate in this important investigative hearing. In my remarks today, I'd like to first offer a brief summary of the role of antitrust enforcement in health care and the current state of the law and economic analyses of vertical mergers, and then move on to specifically address some issues presented by the CVS/Aetna merger. My bottom line is this:

- Market concentration is a leading cause of high costs in health care;
- Antitrust enforcers have neglected the risks associated with vertical combinations;
- The CVS/Aetna merger is likely to lessen competition in the standalone prescription drug plan market;
- The CVS /Aetna combination, along with Express Scripts/Cigna merger will likely enhance incentives to stifle competition by foreclosing competition or raising rivals costs

Background

By way of introduction, I am currently Visiting Professor of Law at the University of California Hastings College of Law and Distinguished Senior Fellow with the UCSF/UC Hastings Consortium on Law, Science and Health Policy. I am also the Chester A. Myers Professor Emeritus at Saint Louis University School of Law where I served for 29 years and directed that school's Center for Health Law Studies. I have devoted most of my 30-year academic career to studying issues related to competition and regulation in the health care sector, writing numerous articles on the subject and co-authoring the leading casebook in health law. I have recently co-authored with Professor Barak Richman of Duke a two-part white paper for the American Antitrust Institute analyzing consolidation in the delivery and payment of health care services.¹ Before joining academia, I served as Assistant Chief in the Antitrust Division of the United States Department of Justice, litigating and supervising cases involving health care. My professional affiliations include membership in the American Health Lawyers Associations and I serve on the Advisory Board of the American Antitrust Institute.

The Role of Antitrust Law in Health Care

American antitrust enforcement agencies (the Federal Trade Commission, Department of Justice and State Attorneys General) have long devoted an extraordinary proportion of their resources to the health care sector. For example, challenges to hospital mergers, physician cartels, and "reverse payments" by pharmaceutical companies, insurance company mergers, and anticompetitive practices have featured prominently in government litigation, advisories, and

policy statements. In recent years, the Agencies have won a series of important cases challenging horizontal mergers in the hospital,² physician,³ and insurance⁴ sectors that have clarified the law and sent a clear message that combinations of competitors in concentrated local markets will face close scrutiny. Reversing a series of losses in litigated hospital merger cases, these decisions established what are likely to be enduring precedents. Among other things, they clarified that provider and health insurance markets are highly localized; rejected arguments that provider market power will be checked by the countervailing power of large or sophisticated buyers; declined to accept arguments that uncertainties arising from rapidly-changing market conditions undermine inferences of market power; and rejected claims that consolidation is essential to achieve integrative efficiencies.⁵

That said, there is considerable evidence that past consolidation—including many acquisitions that have gone unchallenged—is responsible for the high cost of health care that American consumers and government programs endure today. An extensive economic literature documents the enormous consolidation that has occurred in hospital, physician, health insurance and PBM markets.⁶ In each sector there is evidence that entry barriers are high, as market shares have grown or stabilized at high levels of concentration and entry has been limited or non-existent.⁷ In addition, numerous studies demonstrate that concentration in health care is associated with high prices,⁸ and in some cases reduced quality.⁹ Moreover, a variety of health market characteristics including inelasticity of demand, imperfect information, and imperfect agency relationships make health care markets vulnerable to the exercise of market power.

It is noteworthy that the markets involved in the CVS/Aetna merger exhibit the problematic characteristics associated with high concentration. Studies show that commercial insurance markets and Medicare Part D markets with few competitors are associated with higher premiums for consumers.¹⁰ Pricing in the PBM market is particularly troubling, as the payment structure actually encourages higher drug prices and PBM customers have scant information about the rebates supposedly negotiated on their behalf.¹¹ The reason such peculiar, upside-down arrangements persist is the durable market power of entities offering PBM services.

In sum, the underlying conditions of the markets affected by the CVS/Aetna merger exacerbate risks of competitive harm associated with both horizontal consolidation and vertical stacking of one dominant firm on another.

The Importance of Stopping Anticompetitive Vertical Mergers in Health Care

Let me turn to the issue of how the law deals with vertical mergers. I've submitted a draft article soon to be published in the American Journal of Law, Medicine and Ethics that summarizes my views.¹² I begin this article with a quote from George Orwell's novel *Animal Farm* in which one of the animals, Snowball, describes his world view: "Four legs good, two legs bad". And I compare that to the Chicago School's view of mergers which is "Vertical Good, Horizontal (sometimes) bad". That pretty much describes how the government enforcers, and to a degree, the courts have treated vertical mergers. It also explains why case law is sparse and out-of-date in this area.¹³

However, contemporary economic analyses have sharply questioned the basis for a laissez-faire approach to vertical combinations. The modern account demonstrates that preconditions underlying Chicago School's analysis "rarely hold" and "can obscure how a particular merger may raise real competitive concerns."¹⁴ While vertical mergers do not increase concentration they may enable conduct that limits rivalry at the 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. For example, Professor Steven Salop's extensive body of work provides a sound economic model of foreclosure risks and maps the potential legal framework for applying the so-called "raising rivals' cost" principles to vertical mergers.¹⁵

Another faulty premises underlying the "vertical, good" view, is the assumption that cost savings and quality improvements inevitably flow from hierarchical structures. Economic evidence for this proposition is lacking. As Professor Burns analysis indicates, economic integration has often failed to generate clinical integration that results in either cost savings or improved efficiency.¹⁶ Not unlike horizontal mergers, vertical mergers are subject to problems associated with culture clashes, inadequate pre-merger information, and challenges inherent in management integration. As Martin Gaynor, a leading health care economist, has reminded, "consolidation is not coordination."¹⁷ It is noteworthy that antitrust case precedent appropriately places a high bar on "efficiency" justifications.¹⁸ To assuage competitive concerns, the claimed benefits must be achievable *only* through merger, must offset potential competitive harms, and, very importantly, must be passed on to consumers. Moreover, claimed benefits in markets outside the markets causing competitive harm are not considered.¹⁹

A further reason for increased vigilance over vertical consolidation is experience demonstrating that market dominance achieved by mergers can give rise to anticompetitive conduct. The history of antitrust law in the health care sector is littered with examples of hospitals, physician organizations, and insurers that have taken advantage of their dominant market positions, barriers to entry, and the absence of effective regulatory oversight to undertake actions that disadvantage rivals and impair competition. As an example, some insurers with market power have insisted that they be given "most favored nation" treatment by providers in order to lessen competitive challenges from rival insurers.²⁰ At the same time it must be remembered that antitrust law has been relatively lenient on exclusionary conduct and does little to deal with extant market power. Therefore, the prophylactic remedy inherent in enjoining anticompetitive mergers is especially important. As Professor Herbert Hovenkamp has argued, it is appropriate to apply the more demanding "incipiency" standard in cases such as vertical mergers "where a merger is likely to lead to conduct that is both anticompetitive but also is difficult or impossible for antitrust law to reach once the merger has occurred."²¹

Assessing the Risks to Competition Associated with the CVS/Aetna Merger

In health care, we've seen that provider consolidation is not the only source of high costs. The legion of "middlemen," many with market power, also extract excess profits. The overall risks from excessive vertical combinations was well summarized recently by FDA Commissioner Scott Gottlieb:

The top three PBMs control more than two-thirds of the market; the top three wholesalers more than 80%; and the top five pharmacies more than 50%. Market concentration may prevent optimal competition. And so the saving may not always be passed along to employers or consumers.

Too often, we see situations where consolidated firms -- the PBMs, the distributors, and the drug stores -- team up with payors. They use their individual market power to effectively split some of the monopoly rents with large manufacturers and other intermediaries rather than passing on the saving garnered from competition to patients and employers.²²

This observation finds support in Professor's Sood's empirical study which finds that out of every \$100 in spending by insured customers on pharmaceuticals, \$42 goes to middlemen: PBMs, pharmacies, wholesalers, and insurance companies.²³

Antitrust merger analyses are notoriously fact-intensive. Courts are asked to perform a predictive analysis as to the merging parties' future conduct and its effect on competition. That task necessarily involves a close examination of the markets affected and the incentives facing the firms involved. The Antitrust Division of the U.S. Department of Justice is hard at work sorting through documentary and potential testimonial evidence to make those assessments. However, the discussion today can shed light on some of the core facts that need to be explored in evaluating incentives, conduct and effects.

Horizontal Effects of the Merger

The years of experience dealing with horizontal mergers teach us several things. The case law appropriately places a presumption of competitive harm where market shares and concentration is high and new entry is not likely, timely or sufficient. There are good reasons for this, not the least of which is that mergers are permanent.²⁴ The CVS/Aetna merger raises serious concerns about horizontal effects. First, the two firms compete head to head in a number of standalone PDF markets. There are good reasons to regard the standalone PDF market as a distinct market from Medicare Advantage markets in view of the nature of services provided, consumer preferences and regulation. Professor Richard Scheffler's analysis points to 10 of the nation's 34 bidding regions in which the presumption of illegality may attach and another 20 which potentially raise competitive concerns under government merger guideline standards.²⁵ Given the economic studies cited in that report there are strong reasons to believe that increased concentration will lead to higher prices and reduced quality competition.

There are other horizontal aspects to the merger that merit close scrutiny. One is the loss of potential competition. Aetna has acknowledged that it was contemplating entering the PBM market de novo, a move that would add to the limited number of firms competing. The elimination of a likely entrant into a concentrated market lacking other potential entrants has been recognized to eliminate actual or perceived potential competition under Section 7 of the Clayton Act. In addition, CVS has contracted with the nation's second largest health insurer, Anthem, to assist in the latter's provision of PBM services. The inherent conflict of interest in having CVS serve its new health insurance division, Aetna and its rival, Anthem presents serious

concerns about anticompetitive coordination (e.g. price fixing or market allocation) between the firms either through direct agreement or information sharing.

Finally, if the CVS/Aetna merger and the Express Scripts/Cigna merger are allowed to proceed, consumers will be faced with three entities (including UnitedHealthcare/OptumRx) that control an enormous share of the management of health services and pharmaceutical payment. The incentives of the three behemoths will be aligned. As discussed below, none will have incentives to offer favorable competitive terms to small insurers that are rivals of their insurance divisions. Their market power will be protected by the widely recognized and sizeable barriers to entry into both health insurance and PBM markets. Moreover those barriers will be greater because a new firm contemplating entry will likely have to enter two markets, and the largest potential “customers” in those markets will not be available due to their integrated structure. The emergence of a tight oligopoly of this magnitude may be the most significant risk associated with this merger.

Vertical Effects of the Merger

As mentioned earlier, antitrust law on vertical mergers is sparse and largely out of date. However, a few things are clear about the harm that section 7 is designed to address. First, concerns are raised when a merger creates or strengthens the incentives of firms to foreclose or raise rivals’ costs for inputs necessary for them to compete. As described in the letter from Diana Moss of the American Antitrust Institute, the merger changes the incentives that CVS as a standalone PBM firm previously had and increases its leverage in bargaining.²⁶ Post-merger it will take into account the benefit its insurance subsidiary may achieve by providing less favorable terms to insurance rivals. As discussed by Professor Sood, the relative margins of insurance versus PBM services suggests this is a very possible scenario.²⁷ Likewise, the CVS/Aetna combination may create incentives to disadvantage retail pharmacies that are rivals of CVS. The risk here is what economists call “customer foreclosure”: CVS will have strong incentives to deprive rival pharmacies of competitive access to Aetna’s insureds. Where Aetna has a sizeable market presence, a variety of raising rivals cost tactics can be destructive of price and service competition in retail pharmacy markets.²⁸

Overlooking Market Concentration: A Cautionary Tale

The nation has learned the hard way that overlooking consolidation in health care is costly. A seven-year period during which no hospital mergers were challenged in the 1990s produced extensive concentration that in turn has resulted in higher prices for consumers ever since. Likewise, the benign neglect of vertical mergers between hospitals and physicians has resulted in excessive pricing of physician services. With most health care sectors already highly concentrated and competition anemic at best, vertical consolidation should be closely monitored.

¹ See Thomas L. Greaney and Barak D. Richman, CONSOLIDATION IN PROVIDER AND INSURER MARKETS: ENFORCEMENT ISSUES AND PRIORITIES, Part I of the American Antitrust Institute White Paper Series on Competition in Payment and Delivery of Health Care Services (June, 2018), available at

<http://www.antitrustinstitute.org/content/aai-issues-part-i-new-white-paper-series-competition-delivery-and-payment-healthcare>.

² FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d Cir. 2016); ProMedica Health Sys., Inc. v. FTC, 749 F.3d 559, 571 (6th Cir. 2014).

³ Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke’s Health System, 778 F.3d 775, 793 (9th Cir. 2015); FTC and North Dakota v. Sanford Health, Case No. 1:17-cv-00133 (D.N.D. Dec. 15 2017).

⁴ U. S. v. Anthem, Inc., 855 F. 3d 345 (D.C. Cir. 2017); United States v. Aetna, Inc., 240 F. Supp. 3d 1 (D.D.C. 2017).

⁵ See Greaney and Richman supra note 1.

⁶ See Martin Gaynor, “Examining the Impact of Health Care Consolidation,” Statement Before Committee on Energy and Commerce Oversight and Insurance Subcommittee, U.S. House of Representatives (Feb. 14, 2018). Leemore Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?” Testimony Before the Subcommittee on Antitrust, Competition Policy, and Consumer Rights of the Senate Committee on the Judiciary (2015).

⁷ Id.

⁸ See generally id. See also Martin Gaynor and Robert Town, “The Impact of Hospital Consolidation,” The Synthesis Project, Policy Brief No. 9, Robert Wood Johnson Foundation (2012).

⁹ See Gaynor supra note 6.

¹⁰ See Dafny supra note 6 (commercial insurance); Kate Ho et al, *The Impact of Consumer Inattention on Insurer Pricing in the Medicare Part D Program*, 48 Rand J. Econ. 877 (2017) (Medicare Part D).

¹¹ See Robin Feldman, *Perverse Incentives: Why Everyone Prefers High Drug Prices—Except for Those Who Pay the Bills*, forthcoming Harv. J. on Legis., available at

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3162432) (PBM payment structure “minimizes the competitive pressure to reduce prices” and creates incentives “operating to drive prices higher”); Fiona Scott Morton & Lysle T. Boller, *Enabling Competition in the Pharmaceutical Market*, Hutchins Ctr. On Fiscal and Monetary Pol’y at Brookings (2017).

¹² Thomas L. Greaney, *The New Health Care Merger Wave: Does the “Vertical, Good” Maxim Apply?* J. Law, Medicine & Ethics (forthcoming 2018).

¹³ In its challenge the AT&T/Time Warner merger, the Department of Justice litigated its first vertical merger case in forty years; the badly out-of-date Non-Horizontal Merger Guidelines were issued in 1984; and the most recent Supreme Court decision dates back to 1972. See id.

¹⁴ Steven C. Salop & D. P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners* (Dec. 8, 2014).

¹⁵ See Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 127 Yale. L. J. 1962 (2018).

¹⁶ Lawton R. Burns, *CVS & Aetna: Analysis of the Proposed Mergers*; See also, Jeffrey Goldsmith, et al., *INTEGRATED DELIVERY NETWORKS: IN SEARCH OF BENEFITS AND MARKET EFFECTS* (National Academy of Social Insurance) 1 (2015)(summarizing literature and analyzing performance of 15 of the largest integrated delivery systems).

¹⁷ Martin Gaynor, “Examining the Impact of Health Care Consolidation,” Statement Before the Energy and Commerce Oversight Committee, U.S. House of Representatives, February 14, 2018 at 11.

¹⁸ See U. S. v. Anthem, Inc., 855 F. 3d 345 (D.C. Cir. 2017); U.S. Dep’t of Justice & FTC, *Horizontal Merger Guidelines* §10.

¹⁹ U.S. v. Philadelphia National Bank, 374 U.S. 321, 370 (1963).

²⁰ U.S. v. Blue Cross and Blue Shield of Michigan, 809 F. Supp. 2d 665 (E.D. Mich. 2011).

²¹ Herbert Hovenkamp, *Prophylactic Merger Policy*, University of California Hastings Law Journal (forthcoming 2018)

²² Scott Gottlieb, Commissioner of Food and Drugs, “Capturing the Benefits of Competition for Patients,” Speech before America’s Health Insurance Plans National Health Policy Conference (March 7, 2018).

²³ Neeraj Sood, *Potential Effects of the Proposed DVS Acquisition of Aetna on Competition and Consumer Welfare* (June 19, 2018).

²⁴ Herbert Hovenkamp & Carl Shapiro, *Horizontal Mergers, Market Structure and Burdens of Proof*, 127 *Yale L. J.* 1996 (2018).

²⁵ Richard M. Scheffler, Testimony Regarding CVS Health Corporation's Proposed Acquisition of Aetna, Inc. (June 19, 2018).

²⁶ Letter from Diana Moss, President of the American Antitrust Institute, to Makan Delrahim, Assistant Attorney General, Antitrust Division, U.S. Department of Justice (March 26, 2018).

²⁷ See Sood Statement, *supra* note 23.

²⁸ See AAI Letter *supra* note 26 (describing tactics including lowering dispensing fees, cherry picking profitable prescriptions, and insisting on "take-it-or-leave-it" terms for independent pharmacies).