HEALTH CAPITAL Topics ©
Volume 11
Issue 10
October 2018
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DOJ Approves CVS-Aetna Merger

On October 10, 2018, the *U.S. Department of Justice* (DOJ) approved the proposed merger of CVS Health Corporation and Aetna, Inc.[1] CVS publicly announced their intent to acquire Aetna in December of 2017 upon unanimous approval by the boards of directors of each company, combining the largest *retail pharmacy chain* and the third largest health insurance company in the U.S., respectively.[2] This $69 billion merger, financed by CVS, was initiated on their belief that the transaction would fulfill an unmet need of consumers (i.e., patients) in the healthcare system, providing low cost, high quality care through the integration of Aetna's analytical capabilities and CVS's vast market presence.[3] Larry Merlo, President and CEO of CVS, envisions that this merger will *combine capabilities in technology, data and analytics to develop new ways to engage patients in their total health and wellness*.[4] Merlo asserts that consumers will benefit from the integrated, community-based healthcare experience with more "*personalized care*" by combining Aetna's providers and consumer access through CVS's 9,800+ pharmacy locations and 1,100+ *MinuteClinics*.[5] Shareholders of the companies are also projected to benefit in terms of the new competitive positioning and the long-term added value of the merger, potentially generating $750 million in savings after two years and $2.4 billion annually by the fifth year.[6]

The likelihood of the DOJ approval of the CVS-Aetna merger was anticipated by the greenlight of the Cigna-Express Scripts merger last month, considering that both mergers involved vertical integration (defined as the combination of separate sections in the supply chain of an industry[7]), i.e., a major health insurer and a *pharmacy benefit manager* (PBM).[8] However, the CVS-Aetna merger, under the proposed structure, also incorporated aspects of horizontal consolidation, i.e., a combination of similar entities in the same industry.[9] Both CVS and Aetna provide a Medicare Part D plan to consumers, if combined would have served approximately 6.8 million beneficiaries.[10] Currently, the three largest providers of Medicare Part D plans (by enrollment numbers) include CVS Health Corporation, UnitedHealth Group, Inc., and Humana, Inc., with Aetna close behind, posing a potential domination of the market with the merger, considering CVS already serves the greatest number of enrollees.[11] The DOJ antitrust division and five state attorneys general (California, Florida, Hawaii, Mississippi, and Washington) filed a federal lawsuit against the horizontal aspect of this merger, while simultaneously proposing a settlement wherein Aetna would divest of its Medicare Part D program to resolve the DOJ's anticompetitive concerns associated with the merger.[12]

According to the DOJ, a merger without this divestiture of the Medicare Part D plans would have resulted in major market domination concerns; reduction of competition; increased prices for Medicare beneficiaries and taxpayers; reduced quality; and, less innovation.[13] An expert testimony report was one source that set forth the reasoning behind the *American Medical Association*'s (AMA) opposition of the merger with the Medicare Part D plans, and support of the divestiture. The study analyzed market share effects if the Part D plan was included in the merger, and concluded that this merger would indeed enhance the market power of CVS-Aetna and would be anticompetitive for a majority of the states, with the market being moderately to highly concentrated.[14] To alleviate these anticompetitive concerns, Aetna announced that WellCare Health Plans would buy Aetna's Medicare Part D business for an undisclosed amount, transferring approximately 2.2 million members; however, this sale will not affect Aetna's individual or group Medicare Advantage, Medicare Advantage Part D, or Medicare Supplement plans.[15] WellCare, predominantly serving Medicaid consumers, will be assisted by Aetna in the transition of its Medicare Part D business into 2019.[16] This purchase will triple WellCare's Medicare Part D membership from 1.1 million to 3.3 million consumers upon federal regulatory approval.[17]

Although the horizontal consolidation portion of the merger posed a problem for the DOJ, the vertical integration portion did not trigger anti-competitive concerns (as foreseen by the approval of the Cigna-Express Scripts merger).[18] However, vertical integration can create tension within an industry if the seller owns the supplier, potentially making it difficult for other sellers to use the supplier.[19] *CVS-Caremark*, the PBM subsidiary of CVS, negotiates prices with drug companies, and may use its already considerable leverage to offer Aetna larger rebates and discounts post-merger, so that Aetna can attract healthcare insurance consumers.[20] However, this could potentially increase the market share of an already large insurer, resulting in anticompetitive effects.[21] With the vertical integration, CVS's *MinuteClinics* may also benefit because more

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Aetna beneficiaries will be driven to their sites of service, causing a shift to retail clinics that are providing services that traditional providers once exclusively covered.[22] However, consolidation up and down the supply chain may actually serve to heighten competition, rather than eliminate it, by expanding the scope of services in the *MinuteClinics*, as it may put pressure on more traditional healthcare providers (e.g., hospitals and medical groups) to become more cost effective.[23]

Even with DOJ approval upon divestiture, the CVS-Aetna merger is awaiting state approvals, which may be difficult to obtain due to the concerns of the vertical integration effects on the healthcare industry and consumers. Maria Vullo, New York State Superintendent of Financial Services, led a public hearing on the merger on October 18, 2018, explaining the agency's concerns with both the merger's promise of financial cost savings, and the lack of commitment expressed by the companies to pass on any realized savings to consumers (e.g., lower premiums).[24] In addition, CVS will borrow $40 billion to fund the merger, which could potentially raise insurance premiums, by CVS-Aetna passing on this debt to consumers.[25] This merger could also incentivize Aetna to create cost-sharing structures to ensure that consumers are driven to CVS rather than other competitors, leading to increased drug prices.[26]

The preliminary approval by the DOJ supports the continuing of major mergers up and down the supply chain in the healthcare industry, potentially representing a future trend. More PBMs may consequently merge with insurance companies to match the scale of the two PBM/insurer mergers that have been approved this year.[27] In addition, various healthcare entities up and down the supply chain may combine (rather than only PBMs/insurers), to incorporate more coordination, which consumers are demanding.

Similar to the insurance industry, hospitals are also merging in order to protect their market position, perhaps in response to the price pressure and technology that is shifting medical care to the outpatient ambulatory setting.[28] Recently, Memorial Hermann and Baylor Scott & White, two of the biggest hospital chains in Texas, announced their intent to merge in order to create an integrated system with cost-effective care, which, combined, will serve 30+ Texas counties through their 68 hospitals.[29] However, the concern, as with any merger, is that this will negatively affect competition on price and quality.[30] Additionally, in April 2018, Advocate Health Care finalized its merger with Aurora Health Care; the combined entities will dominate the Illinois-Wisconsin region, setting a precedent for the merger of the Texas systems.[31] Findings regarding the effects of such "*mega mergers*" have been mixed. A study on behalf of the *American Hospital Association* revealed that hospital mergers increased cost savings, resulting from the collaboration related to technology, access to capital, and standardization of clinical protocols.[32] However, mergers can increase bargaining power with insurance companies that can lead to more expensive procedures resulting in rising healthcare prices.[33] A study based in California concluded that hospital prices increased the most in multi-hospital systems (e.g., at Dignity Health) that had considerable market power, where prices per patient admission were approximately $4,000 higher than other hospitals in the state due to the system's ability to demand higher prices.[34]

Overall, the trend in healthcare is consolidation. The approval of the CVS-Aetna merger is a major milestone in governmental acceptance and allowance of vertical integration, as it is the second PBM/insurer merger approved by the DOJ this year. Similar mergers between insurers and PBM are expected to ensue, as well as new combinations of providers within the healthcare industry, in order to match the scale of these merged entities. As demonstrated by these "*mega-systems*," there may be increased cost savings with coordination; however, prices continue to rise for certain procedures, providing uncertainty on the effects of healthcare consolidation on patients.

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