

VIA COURIER

December 10, 2018

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

Re: Comments to the United States v. CVS Health Corporation and Aetna Inc.; Proposed Final Judgment and Competitive Impact Statement (Document Citation: 83 FR 52558).

Dear Mr. Mucchetti:

The National Community Pharmacists Association (“NCPA”) appreciates the opportunity to provide comments to the United States District Court for the District of Columbia (“District Court”) and the Department of Justice (“DOJ”) on the United States v. CVS Health Corporation (“CVS”) and Aetna Inc. (“Aetna”) (collectively, the “Parties”) Proposed Final Judgment (“Proposed Final Judgment”) and Competitive Impact Statement. NCPA represents the interests of America’s community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together, they represent an \$76 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

In our comments, NCPA will highlight how the proposed merger of CVS and Aetna, together with other consolidation in the healthcare industry will lessen competition, may be contributing to higher costs, and negatively impacting patient choice. NCPA will also address several anticompetitive issues related to the CVS/Aetna merger and the broader implications on the healthcare industry. NCPA recommends that the District Court not approve the proposed consent decree between CVS and Aetna as this transaction will lead to lower quality/fewer options for patients, higher costs, and less competition in the healthcare market.

The Merger Will Lead to Decreased Competition and Fewer Choices for Patients

The proposed CVS/Aetna merger is likely to significantly decrease competition for pharmacy products and services. Although the Parties agreed to sell Aetna’s Part D prescription drug plan business to address their horizontal competitive overlap as a condition of approval of the deal, substantial anticompetitive concerns have not been addressed. In fact, Aetna’s Part D assets have been sold to WellCare Health Plans, Inc. who is using *CVS Caremark as their PBM*.

Therefore, this divestiture of Aetna's Part D business essentially just maintains CVS' market share instead of resolving any anticompetitive concerns.

Recent consolidation amongst major Pharmacy Benefit Managers ("PBMs") has led to extraordinary PBM market dominance. The top three PBMs control approximately 85-89% of the market.¹ CVS Caremark, the PBM for CVS, is the second largest PBM in the U.S., accounting for nearly 34% of covered lives.² This significant market share allows CVS Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves.

Community pharmacies have very little negotiating power when contracting with PBMs like CVS Caremark, and routinely must agree to take-it-or-leave-it contracts to be a part of a PBM's pharmacy network. In some cases, even if a pharmacy is willing to accept onerous contract terms, the PBM will exclude certain pharmacies from their networks altogether, limiting patient choice and access. For example, Aetna, for which CVS Caremark administers the pharmacy benefit, had already engaged in this practice as the 2018 plan year marked the second consecutive year that Aetna excluded independent pharmacies from the opportunity to bid for preferred status in its Part D pharmacy networks. Having the opportunity to be a part of a plan's preferred network is critical, as nearly all Part D plans in 2018 include preferred networks that offer lower co-pays to beneficiaries in exchange for lower reimbursement to the pharmacy. Additionally, the opportunity to participate in preferred networks allows pharmacies to evaluate a potential benefit of an increased volume of consumers.

CVS has already been investigated by some states due to questionable pricing and reimbursement practices towards pharmacies. In July this year, the Kentucky Department of Insurance fined CVS Caremark a \$1.5 million civil penalty for violations related to reimbursements to pharmacists. These violations included 454 violations related to reimbursement claim denials that were issued to Kentucky pharmacists and 38 violations due to CVS Caremark providing inaccurate or inconsistent information.³

Further, the Auditor of the State of Ohio found that Ohio, where CVS Caremark is the PBM for four of Medicaid's five managed care plans, was charged around \$225 million in spread amounts for Medicaid prescription drugs in a one-year period while other pharmacies were

¹ Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad*, Feb. 2018, *available at* <https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf>; *see also* Testimony of Mark Merritt, Pharmaceutical Care Management Association ("PCMA"), before the United States House of Representatives Energy and Commerce Committee Subcommittee on Health, "Examining the Drug Supply Chain," Dec. 13, 2017 (hereinafter "Testimony of Mark Merritt, PCMA").

² According to CVS, it has 90 million PBM plan members. *See* CVS, *available at* <https://cvshealth.com/about/facts-and-company-information>. The Pharmaceutical Care Management Association testified that PBMs administer drug plans for more than 266 million Americans. *See also* Testimony of Mark Merritt, PCMA.

³ Kentucky Department of Insurance Issues Penalty Against PBM, CaremarkPCS Health LLC, a subsidiary of CVS Caremark, Commonwealth of Kentucky Public Protection Cabinet Department of Insurance, *available at* <http://ppc.ky.gov/Lists/News%20Releases/Kentucky%20Department%20of%20Insurance%20Issues%20Penalty%20Against%20PBM,%20CaremarkPCS%20Health%20LLC,%20a%20subsidiary%20of%20CVS%20Caremark.pdf>.

reimbursed at, or below, cost.⁴ The report also confirmed that these drastic reimbursement cuts from the Ohio Medicaid PBMs caused a significant amount of independent pharmacy closures in the state. Similar investigations are underway in Pennsylvania, where CVS is one of the four PBMs.⁵

The merger of the largest pharmacy chain/PBM with a major health plan will only solidify these problems with respect to competition and patient choice, especially in underserved areas. CVS Caremark already routinely steers patients to its own pharmacies based on the prescription benefit design that it has structured for plan customers. For example, one plan design CVS Caremark offers, ironically called Maintenance Choice, generally limits patients to the pharmacy of their choice for only the prescription's first fill. Thereafter, in order to benefit from their prescription insurance, the consumers' "choice" is a CVS retail or CVS mail order pharmacy. It is critical to understand that CVS Caremark significantly influences the co-pay or coinsurance amounts competing pharmacies can charge for a prescription to an insured patient (as well as how much that competitive pharmacy is reimbursed for the drug), so they can distort competitive forces by incentivizing or forcing the patient to use its own pharmacy. An entity that controls the healthcare benefit as well as the prescription drug benefit will only exacerbate this problem.

We ask that the District Court consider whether this transaction, which will create a vertically integrated health plan, pharmacy benefits manager, and pharmacy chain, will result in less competition and substantial access issues for patients who want to continue to use their local community pharmacy or existing healthcare providers. As the largest pharmacy chain in the United States with approximately 9,700 retail locations and significant share in many geographic markets, the merged entity is likely to be able to use its dominant position to increase payments to its own CVS pharmacies and effectively foreclose other pharmacies from its networks. Conversely, CVS will have the incentive and ability to foreclose CVS pharmacies from competing health plans.

For example, will Aetna adopt a plan design that only allows Aetna customers to use CVS pharmacies or raise costs to health plan competitors who want access to CVS pharmacies to provide pharmacy network access? Will Aetna direct patients into CVS Minute Clinics rather than the healthcare provider of their choice? Will those patients also be incentivized or forced to use the CVS pharmacy where the Minute Clinic is located, leaving the patient with little choice in where they receive their healthcare and increasing patient costs if they choose to go elsewhere?

⁴ Ohio's Medicaid Managed Care Pharmacy Services, Auditor of State Report (Aug. 16, 2018), *available at* https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

⁵ Auditor General DePasquale Initiates Review to Bring Transparency, Accountability to Prescription Drug Pricing (June 13, 2018), *available at* <https://www.paauditor.gov/press-releases/auditor-general-depasquale-initiates-review-to-bring-transparency-accountability-to-prescription-drug-pricing>.

We request that the District Court also examine whether Aetna will require or strongly incentivize patients to use CVS' mail order and/or specialty pharmacies. Forcing patients, particularly those that have more complex conditions, to get their prescriptions from a pharmacy with which it has no personal relationship not only eliminates competition, but also severely limits patients' choice and may impact the quality of care and adherence. Will this transaction force more patients to use CVS retail or mail order pharmacies despite a preference by consumers to use their pharmacies of choice?

NCPA is not alone with these competitive concerns. Recently, several HIV/AIDS patients sued CVS, alleging the pharmacy leveraged insurance laws to force patients to fill their prescriptions at CVS pharmacies or CVS' mail order company.⁶ If the patient chose to obtain their prescription drugs from a different pharmacy, the patient faced thousands of dollars in costs to obtain the drugs. Patients reported a number of other issues resulting from being forced into using one pharmacy provider; for example, one patient received drugs from CVS' mail order program that were left outside his home "baking in the afternoon sun."⁷ NCPA has also received more than one hundred photographs of mail order waste from CVS and other mail order pharmacies in which millions of dollars of unwanted prescription drugs have been sent to consumers. These consumers seek out their local pharmacists' help in disposing these unnecessary and often costly drugs.⁸

Thus, there continue to be serious competitive questions about this transaction that have not been addressed including the potential negative impact on patient costs, patient access, and quality and service.

No Evidence to Support that the Purported Cost Savings Will Be Passed on to Consumers

The merging parties have stated that the proposed transaction will create efficiencies and save hundreds of millions of dollars for consumers. They have not, however, explained whether those purported savings will be passed on to consumers. The largest PBMs already claim their size enables them to achieve significant efficiencies and cost savings. As patients' out of pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers. NCPA believes that a more thorough analysis of whether the purported cost savings will be passed on is warranted prior to approval of the Proposed Final Judgment.

As discussed above, many patients that visit CVS Minute Clinics are likely to pick up their drugs at the CVS pharmacy. Yet, there is ample evidence that many times CVS pharmacies are not the lowest cost providers. In fact, Consumer Reports has found that CVS pharmacies often have the highest retail prices—more than 400% higher in the Consumer Reports analysis—if patients

⁶ Herman, Bob, Axios, HIV patients sue CVS over pharmacy networks, Feb. 21, 2018, *available at* <https://www.axios.com/cvs-pharmacy-lawsuit-hiv-1519160365-c6f5527a-f5f2-429d-b817-6a9ea321335d.html>; *see also* John Doe One et al. v. CVS Health Corporation, Case No. 3:18-cv-1031, N.D. Cal. (filed Feb. 16, 2018).

⁷ *Id.*

⁸ NCPA, Waste Not, Want Not, *available at* https://www.ncpanet.org/pdf/leg/sep11/mail_order_waste.pdf.

were to pay for their prescriptions off-insurance as compared to independent pharmacies, who were found to offer significantly lower retail prices for the same prescription drugs.⁹

In addition, CVS will have every incentive to force more patients into their own mail order pharmacy, disingenuously arguing that mail order will likely lower costs. It is a common misconception that steering patients into mail order will lower drug costs for consumers.¹⁰ Evidence demonstrates that mail order pharmacies consistently dispense costlier brand-name drugs and fewer generics than retail pharmacies.¹¹ Using data from industry source, IQVIA, the average mail order prescription is \$626.44 compared to under \$60 at a community pharmacy. As a “price giver” and a “price taker,” mail order firms can manipulate pricing schemes. Plan Sponsors (employers, the federal government, individual purchasers) are often misled into thinking their overall prescription drug costs will be lowered by moving to mail order.

Several States have Acknowledged the Need of Protections from the CVS/Aetna Merger

Numerous states have expressed concern over the CVS/Aetna merger to protect their patients from anticompetitive effects that would result from the merger. To date, Georgia, New York, and California have obtained concessions from CVS and Aetna prior to approving the deal. The Georgia insurance commissioner requested several patient and pharmacy protections before approving the merger, which CVS agreed to, including:

- CVS/Aetna must invite non-CVS health care providers (pharmacies, physicians, clinics, etc.) to join its networks, and must set the same criteria for all those providers.
- CVS/Aetna must allow Georgia patients to use any health care provider – in or out of network – if that provider accepts the same conditions as those within the network.
- CVS/Aetna cannot require patients to use CVS-owned pharmacies, period – not for regular prescriptions, refills, or specialty drugs. These concessions reduce the chance that a combined CVS/Aetna can limit patients' choice of health care providers. (As a pharmacy benefits manager, CVS already requires patients on some plans to get their specialty medications from CVS pharmacies. This practice will no longer be allowed in Georgia.
- CVS/Aetna must disclose the amount of rebates it receives from drug makers and how much of those it passed on to insurers.

In New York, regulators set conditions on the merger, including enhanced consumer and health insurance rate protections, privacy controls, cybersecurity compliance, and a \$40 million commitment to support health insurance education, enrollment, and other consumer health

⁹ Gill, Lisa L., Shop Around for Lower Drug Prices, (Apr. 5, 2018), *available at* <https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/>.

¹⁰ Carroll, Norman V., A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies, *available at* http://www.ncpanet.org/pdf/leg/feb13/comparison_costs_dispensing_prescriptions_retail_mail_order.pdf.

¹¹ Johnsrud M, Lawson KA, Shepherd MD. Comparison of mail-order with community pharmacy in plan sponsor cost and member cost in two large pharmacy benefit plans. *J Manage Care Pharm* 2007; 13:122-134.

protections. Regulators required that participating provider networks for insured products will maintain access to non-chain New York pharmacies for three years. Lastly, in California, regulators approved the merger only if CVS and Aetna agreed to keep premium increases "to a minimum."

States have recognized that a single entity directing access to medications (through the CVS Caremark PBM), controlling health insurance, and acting as a pharmacy could be hazardous to patients' health. Significant concerns have been validated at the state level through these concessions as states acknowledge that the CVS/Aetna merger will likely impose anticompetitive restrictions on patient access to their preferred pharmacies and health care providers.

Other Competitive Questions about the Merger

Finally, NCPA would like to highlight several additional anticompetitive concerns about the proposed merger. Will a combined CVS/Aetna limit selling its PBM services to certain health plans or conversely, will health insurance payers exclude CVS pharmacies or the CVS Caremark PBM? Will the deal lessen bidding intensity by PBMs offering their services to health plans, thus leading to higher prices for PBM services? These questions remain and should be considered when determining whether the CVS/Aetna merger will intensify PBM market dominance that already exists today.

Conclusion

As the healthcare system continues to consolidate, healthcare costs continue to increase and patients have fewer choices. While we applaud DOJ's intent of requiring CVS and Aetna to divest Aetna's Part D business to address certain competition concerns, the merger continues to pose significant anticompetitive risks as discussed above, especially since Aetna's Part D business was sold to a plan whose PBM is CVS Caremark. Therefore, we urge the District Court to not approve the Proposed Final Judgment. Thank you for considering concerns of the pharmacy small business owners NCPA represents.

Sincerely,



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National Community Pharmacists Association