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# CVS/Aetna: Interviewed Health Plans Express Limited Concern on Confidential Business Information, Pharmacy Foreclosure Issues

*This article has been updated slightly for clarity.*

## Transaction Update

Executives representing six regional health plans—covering roughly 3.2 million medical members in total—expressed little concern about vertical effects arising from the CVS/Aetna merger in interviews with *The Capitol Forum*.

Health plan representatives generally support the argument that a strong firewall aligns with CVS's commercial incentives, and that the company is therefore unlikely to misuse rivals' confidential business information post-merger. Each of the health plans reports working with UnitedHealth Group's Optum in some capacity, and broadly praise that vertically-integrated firm's ability to effectively separate its health plan and PBM segments.

Health plans also generally express limited concern about the possibility that CVS would exclude Aetna's competitors from access to its pharmacy post-merger, viewing withholding as cutting against CVS's incentives, given Aetna's relatively small presence in many regional markets.

Importantly, health plan executives spoke prior to Cigna's March 8 announcement that it would acquire Express Scripts in a roughly $52 billion transaction. The deal, which—like CVS/Aetna—combines a large PBM with a national health insurer, will drive PBM bidding effects questions that could exacerbate concerns arising from the CVS/Aetna tie-up.

However, at least pre-Cigna/Express Scripts announcement, regional health plan representatives generally project the CVS/Aetna deal's near-term impact as minimal. To be sure, respondents include a limited subset of payers, and other health plans may view the deal more negatively. That said, *Capitol Forum* interviews ultimately provide little support for health plan-targeted misuse of confidential business information or pharmacy foreclosure theories of anticompetitive harm.

## In depth: Misuse of Confidential Business Information

**Firewalls and CVS's commercial incentives.** Regional health plans may be the most likely targets of vertical harm flowing from the CVS/Aetna transaction, through withholding or raising costs for CVS pharmacy access, or misuse of confidential business information.

Of these issues, misuse of competitively sensitive information may be the most straightforward vertical theory arising from the deal. CVS's Caremark segment provides PBM services to many health plans, and a post-merger CVS could share rivals' information with Aetna, potentially driving unilateral or coordinated anticompetitive effects in health plan markets.

A key question in DOJ's CVS/Aetna review is whether this concern will prove sufficiently serious so as to drive a government enforcement action. DOJ antitrust chief Makan Delrahim, of course, is famously skeptical of conduct

conditions, and may reject the view that a behavioral, firewall remedy separating CVS's health plan and PBM segments would adequately address any post-merger incentive to misuse rivals' business information.

CVS, however, will argue that because strong firewalls align with its business incentives, a DOJ-imposed remedy is unnecessary. And in fact, health plans generally support this position—voicing an expectation that CVS will maintain robust separation between its Aetna and Caremark units post-merger, given commercial incentives to do so.

"We feel confident that they have the right firewalls and they're committed to the business and they're going to put the resources into it," said Ken Provencher, president and CEO of PacificSource, a roughly 300,000-member health plan in the Pacific Northwest, and Caremark PBM partner.

Provencher said that firewalls are necessary for Caremark's business to thrive post-merger and—therefore—align with the company's incentives. "It's going to be critical for CVS Caremark—they're going to have to reassure their clients that they can work with them and maintain the right kind of firewalls," he adds. "If they achieve the merger with Aetna and let all the PBM business fall aside, they just reduce the value of the company significantly."

In fact, health plan executives say that any indication of weakness in the Caremark/Aetna firewall would lead health plans to terminate existing Caremark partnerships. In a scale business such as PBM, the prospect of losing Caremark members would provide a significant deterrent to CVS improperly sharing information between business units.

"CVS is going to have to have very strong firewalls and separation of the new Aetna relationship," said Scott Schnuckle, SVP of pharmacy and business development at HealthPartners, which partners with CVS on specialty pharmacy and counts 1.2 million medical members nationwide, with most in Minnesota and Wisconsin. "I have every expectation that they will because they don't want to lose a single one of their health plan customers, not one."

Schnuckle adds that health plans that remain with Caremark will monitor the PBM closely. "Those that choose to stay with CVS—and I think it will be the substantial majority that would stay with them at least in the short-run—they'll be watching the heck out of them," he said, adding that firewall breaches or other improper information sharing would spur significant health plan departure.

"CVS Health already operates stringent firewall protections between our retail and PBM businesses in order to protect confidential information, and those protections will extend to Aetna," a CVS spokesperson told *The Capitol Forum.*

**Health plans' existing partnerships with vertically-integrated UnitedHealth Group.** At a high level, a combined CVS/Aetna would resemble UnitedHealth Group, which combines the nation's largest health insurer (UnitedHealthcare) with a services segment (Optum) that includes a large PBM and other health plan-focused products.

In fact, although many health plans compete head to head against UnitedHealthcare, all interviewed executives describe working with Optum in some capacity—on services ranging from PBM to subrogation to analytics—and report broadly positive feedback on UnitedHealth Group's firewalls which, are voluntary, and not the result of government merger condition.

John Snyder, CEO of Health Alliance, which covers about 250,000 members in five states, notes that his company partners with Optum for both PBM and non-PBM functions, including data analysis. "On the provider side, I don't have any concerns or hesitations working with them on the analytics," he said.

"They're very good at separating what they do at Optum from what they do at UnitedHealthcare," said Schnuckle. "And I'd anticipate the Aetna/CVS combination will do the exact same thing with their Caremark business."

In fact, these existing relationships with UnitedHealth Group may lessen health plans' reticence on the CVS/Aetna combination. "Many regional health plans across the country work with subsidiaries of United and long have, so I don't think that's a new element," said Provencher. "I think the nature of today's world is you partner with all kinds of folks, some of whom are competitors in one environment and some of whom are collaborating in another environment."

**Firewall questions.** UnitedHealth Group aside, health plan partnerships with vertically-integrated competitors have become increasingly common. For example, Al Wearing, chief insurance services officer of Group Health Cooperative (GHC) of South Central Wisconsin, a roughly 80,000-member health plan, said that GHC uses Navitus for PBM services, despite rival Dean Health Plan's ownership of the PBM.

To be sure, CVS has faced criticism around the existing firewall between its PBM and pharmacy business units. In fact, independent pharmacists' complaints about the firewall's weakness played a key role in the 24-month plus FTC investigation into the company. Although the commission concluded its investigation in 2011 with no action, there remain some ongoing industry concerns around the CVS firewall's effectiveness.

Importantly, however, CVS/Caremark and CVS/Aetna situations are not necessarily analogous. As it relates to the company's existing firewall, independent pharmacies have no choice but to contract with Caremark and—given the PBM's size—cannot credibly threaten to walk away from the relationship. By contrast, CVS's incentives to maintain a robust firewall between the Caremark and Aetna units are significant, given that health plan departure from Caremark relationships in response to misuse of competitively sensitive information is a much more credible threat.

Fundamentally, then, health plan representatives support the argument that a robust firewall between Caremark and Aetna aligns with CVS's incentives. "In the case of Optum and United, if they had not figured out those firewalls and worked hard to make sure they're intact they would not have been able to build the business they have," said Terri Kline, president and CEO of HAP, which covers 570,000 medical members primarily in Southeastern Michigan, and partners with OptumRx on PBM services. "And I think the same will have to happen with a CVS/Aetna merger."

## In depth: Retail Pharmacy Foreclosure

**Retail and specialty foreclosure questions.** Although health plans' experience with vertically-integrated UnitedHealth Group is generally positive for the CVS/Aetna combination, the Aetna deal adds a new element to the vertical calculus—CVS's large retail pharmacy business.

A key—and novel—competition question arising from the tie-up is whether CVS will gain the post-merger ability and incentive to foreclose Aetna's health plan competitors, by withholding or raising rivals' costs for access to some or all of its roughly 9,803 retail pharmacies.

Health plans typically outsource pharmacy contracting to PBMs, and in other cases negotiate pharmacy contracts directly. Even if a PBM manages a health plan's pharmacy network, the PBM sometimes bargains for unique pharmacy reimbursement structures on the health plans' behalf. Given this dynamic, the Aetna combination could provide CVS an incentive to decline to participate in health plan rivals' networks—or threaten to do so to raise competitors' pharmacy costs—in order to harm Aetna's rivals.

In a February 27 hearing before the House Judiciary subcommittee on antitrust, CVS general counsel Thomas Moriarty said that post-merger pharmacy withholding is highly unlikely. "The risk of foreclosure, we feel, really doesn't exist. And, in fact, the economic interest would argue very strongly that it simply cannot happen," Moriarty said.

In fact, interviewed health plans largely support this argument, given Aetna's relatively low shares in many markets. "Aetna's one of the top insurance companies, but they just don't have that large of a market share for CVS to say we're not going to work with anybody else—that would not make any business sense right now," said Kline.

Kline's statement speaks to the fact that even in CVS retail's strongest areas, a foreclosure strategy is economically feasible only where Aetna controls a substantial pharmacy share. Schnuckle likewise views Aetna as too small to provide CVS with retail or specialty pharmacy foreclosure incentives. "They're not going to be able to try to do exclusive deals just with Aetna and sustain their market share," he said.

Snyder also expresses no real concerns on retail foreclosure: "It's a different part of their business, and to remain competitive in that business they're going to have to firewall that off and compete with the Walgreens and the Walmarts and everybody else," Snyder said. The fact that CVS must attract foot traffic to drive front end sales is another factor lessening the risk that the pharmacy would exclude non-Aetna members, adds Sinéad Rice Madigan, Health Alliance's vice president for government business.

In short, health plans describe the CVS pharmacy foreclosure math and incentives as largely failing to line up. And incentives aside, health plans, through their own vertical integration, oftentimes retain additional levers to pull in negotiating with pharmacies. Kline, for example, notes that HAP's parent company, Henry Ford Health System, owns mail order and specialty pharmacies. And GHC, said Wearing, operates its own retail pharmacies, through which roughly half of its members' prescription volume flows. These dynamics may provide an additional constraint on CVS's ability to withhold or raise Aetna rivals' costs for retail pharmacy access.

**Markets with upstream, downstream shares necessary for foreclosure appear limited.** An important caveat to health plans' general lack of concern over post-merger pharmacy foreclosure is that most interviewed executives report limited competitive interaction with Aetna. In fact, none describe Aetna as their closest competitor. For health plans that compete relatively closely with Aetna, post-merger foreclosure concerns could be more pronounced.

Importantly however, Aetna's membership is nationally distributed, and therefore oftentimes fairly small in many states. Put differently—given the firm's footprint, relatively few regional health plans will view Aetna as a close competitor, let alone their closest competitor.

Per AMA numbers measuring health plan shares, Aetna is the market leader in just one state—Alaska (56 percent), as of February 2016. Aetna holds the no.2 position in eight additional states—New Jersey (24 percent), West

Virginia (21 percent), Delaware (19 percent), Kansas (19 percent), Maine (18 percent), North Dakota (17 percent), Wisconsin (17 percent), and Virginia (16 percent).

As a general matter, health plans serving these states may face greater foreclosure risk, given CVS's heightened incentives to exclude competitors in Aetna's high-share regions. However, even in larger Aetna markets, a successful foreclosure strategy is contingent on the CVS retail pharmacy having at least some degree of market power.

Alaska, for example, is the one state in which Aetna controls a dominant share. Yet, per CVS's most recent 10-K, the company operates just six pharmacies in the state. A CVS move to withhold, or threaten to withhold, access to a half dozen pharmacies is unlikely to have any real effect on Aetna's competitors, even in a sparsely-populated state such as Alaska.

To be clear, CVS could exclude rivals in narrower geographic markets, or MSAs in which Aetna is uniquely strong. For example, although Aetna is not a top-two insurer in Utah, the company is the no.2 player in the state's Ogden-Clearfield (21 percent), and St. George (18 percent) MSAs, in both cases trailing SelectHealth, a 750,000-member plan serving Utah and Idaho.

CVS may therefore have some incentive to exclude SelectHealth, Aetna's ostensibly closest competitor in these markets. However, CVS operates just 25 retail pharmacies in Utah, including one in Ogden, and one in St. George. "CVS in our particular geography has a very very small footprint," said a SelectHealth representative, who adds that CVS accounts for a single digit share of the plan's prescription volume. "They represent just very small percentage of what we do businesswise," the representative adds.

**Foreclosure math, critical input questions.** Limited health plan concern around retail foreclosure is in many cases a function of the fact that either Aetna, CVS, or both are relatively small players in their regions. This may also speak to the larger point that there may be few—if any—markets in which both Aetna and CVS control significant shares, and therefore have the incentive and ability to foreclose competitors' pharmacy access.

CVS does not have a significant retail pharmacy presence in Alaska, Aetna's strongest state. Even in markets in which Aetna is no.2, CVS may lack a "must-have" retail pharmacy presence. By pharmacy counter metrics, CVS trails Walgreens in Delaware (Walgreens 64, CVS 20), Kansas (Walgreens 71, CVS 58), and Wisconsin (Walgreens 225, CVS 90) and Rite Aid in West Virginia (Rite Aid 103, CVS 59), Delaware (Rite Aid 43, CVS 20) and Maine (Rite Aid 79, CVS 29). Regional player Thrifty White (30) significantly outpaces CVS (6) in North Dakota.

Many of these numbers will change in the near-term, given Walgreens' pending agreement to acquire 1,932 Rite Aid stores primarily in the Northeast and Southern U.S., of which 1,651 have been transferred as of March 2. That said, per pre-transaction numbers, in only two states—New Jersey and Virginia–would Aetna be the no.2 health plan, and CVS the leading retail pharmacy. And in New Jersey, Rite Aid (260), and Walgreens (198) are collectively larger than CVS (345), and the acquisition could position Walgreens as the state's new market leader.

Virginia (Rite Aid 184, Walgreens 139), then, may be the only state market in which Aetna occupies a top two position, and CVS (358) is the largest retail pharmacy. Whether CVS would actually have an incentive or ability to leverage its pharmacy presence to harm rivals to Aetna—a 16 percent share competitor in the state—is not entirely clear.

Ultimately, the foreclosure math may not lead to an anticompetitive result in most—or any—markets. And, incentives aside, retail and specialty pharmacy may not be an actual critical input to health plan networks—at least relative to, for example, physician groups or hospitals. Fundamentally, then, even if CVS operates a large retail pharmacy presence in a given market, health plans will view the issue as much less problematic than, for example, a health plan acquiring "must-have" physician groups, as is the case in UnitedHealth Group's recent $4.9 billion agreement to purchase DaVita Medical Group.