COMPETITION IN THE PHARMACEUTICAL SUPPLY CHAIN: THE PROPOSED MERGER OF CVS HEALTH AND AETNA

HEARING

BEFORE THE

SUBCOMMITTEE ON
REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

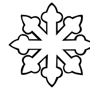
ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

FEBRUARY 27, 2018

Serial No. 115–28

Printed for the use of the Committee on the Judiciary



Available via the World Wide Web: *http://judiciary.house.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

30–952 WASHINGTON : 2018

COMMITTEE ON THE JUDICIARY

BOB GOODLATTE, Virginia, *Chairman*

F. JAMES SENSENBRENNER, Jr., Wisconsin
LAMAR SMITH, Texas
STEVE CHABOT, Ohio
DARRELL E. ISSA, California
STEVE KING, Iowa
LOUIE GOHMERT, Texas
JIM JORDAN, Ohio
TED POE, Texas
TOM MARINO, Pennsylvania
TREY GOWDY, South Carolina
RAÚL LABRADOR, Idaho
BLAKE FARENTHOLD, Texas
DOUG COLLINS, Georgia
RON DeSANTIS, Florida
KEN BUCK, Colorado
JOHN RATCLIFFE, Texas
MARTHA ROBY, Alabama
MATT GAETZ, Florida
MIKE JOHNSON, Louisiana
ANDY BIGGS, Arizona
JOHN RUTHERFORD, Florida
KAREN HANDEL, Florida

JERROLD NADLER, New York
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, Jr., Georgia
THEODORE E. DEUTCH, Florida
LUIS V. GUTIÉRREZ, Illinois
KAREN BASS, California
CEDRIC L. RICHMOND, Louisiana
HAKEEM S. JEFFRIES, New York
DAVID CICILLINE, Rhode Island
ERIC SWALWELL, California
TED LIEU, California
JAMIE RASKIN, Maryland
PRAMILA JAYAPAL, Washington
BRAD SCHNEIDER, Illinois
VALDEZ VENITA "VAL" DEMINGS, Florida

SHELLEY HUSBAND, *Chief of Staff and General Counsel*
PERRY APELBAUM, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW

TOM MARINO, Pennsylvania, *Chairman*
BLAKE FARENTHOLD, Texas, *Vice-Chairman*

DARRELL E. ISSA, California
DOUG COLLINS, Georgia
KEN BUCK, Colorado
JOHN RATCLIFFE, Texas
MATT GAETZ, Florida
KAREN HANDEL, Florida

DAVID CICILLINE, Rhode Island
HENRY C. "HANK" JOHNSON, Jr., Georgia
ERIC SWALWELL, California
BRAD SCHNEIDER, Illinois
VALDEZ VENITA "VAL" DEMINGS, Florida

CONTENTS

FEBRUARY 27, 2018

OPENING STATEMENTS

	Page
The Honorable Tom Marino, Pennsylvania, Chairman, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Committee on the Judiciary	1
The Honorable David Cicilline, Rhode Island, Ranking Member, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Committee on the Judiciary	2
The Honorable Jerrold Nadler, New York, Ranking Member, Committee on the Judiciary	5

WITNESSES

Mr. Thomas M. Moriarty, Executive Vice President, Chief Policy and External Affairs Officer, General Counsel, CVS Health	
Oral Statement	7
Mr. Thomas J. Sabatino, Jr., Executive Vice President, General Counsel, Aetna, Inc.	
Oral Statement	8
Dr. Craig Garthwaite, PhD., Director, Health Enterprise Management Program, Kellogg School of Management, Northwestern University	
Oral Statement	22
Dr. Lawrence Wu, PhD., President, NERA Economic Consulting	
Oral Statement	24
Mr. George Slover, Senior Policy Counsel, Consumer Union	
Oral Statement	26
Mr. Geoffrey A. Manne, Executive Director, International Center for Law and Economics	
Oral Statement	27

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statements submitted by the Honorable Tom Marino, Pennsylvania, Chairman, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Committee on the Judiciary. These materials are available at the Committee and can be accessed on the Committee Repository at:

https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-20180227-SD003.pdf

Statement submitted by the Honorable Bob Goodlatte, Virginia, Chairman, Committee on the Judiciary. This material is available at the Committee and can be accessed on the Committee Repository at:

https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-MState-G000289-20180227.pdf

COMPETITION IN THE PHARMACEUTICAL SUPPLY CHAIN: THE PROPOSED MERGER OF CVS HEALTH AND AETNA

Tuesday, February 27, 2018

HOUSE OF REPRESENTATIVES

COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW

Washington, DC

The Subcommittee met, pursuant to call, at 1:30 p.m., in Room 2141, Rayburn House Office Building, Hon. Tom Marino [Chairman of the Subcommittee] presiding.

Present: Representatives Marino, Goodlatte, Farenthold, Issa, Collins, Buck, Ratcliffe, Gaetz, Handel, Cicilline, Nadler, Johnson of Georgia, Swalwell, Schneider, and Demings.

Staff Present: Dan Huff, Counsel; Andrea Woodard, Clerk; and Slade Bond, Minority Counsel.

Mr. MARINO. The Subcommittee on Regulatory Reform, Commercial and Antitrust Law will come to order. Without objection, the Chair is authorized to declare recess of the committee at any time. We welcome everyone to today's hearing on Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna. And I now recognize myself for my opening statement.

Welcome to this hearing on the proposed merger of CVS Health and Aetna. I am interested in how this merger would help deliver *consumer value*, particularly in regard to drug prices. Prescription drug expenditures are nearly 20 percent of the healthcare costs and they are rising. In fact, prescription spending is growing faster than any other part of the healthcare system. Four of the top 10 prescription drugs in the United States have increased in price by more than 100 percent since 2011. President Trump has made lowering drug costs a priority.

This administration's recently released budget includes initiatives, such as caps on copays. Here in Congress, we have been hard at work as well. I, along with the Ranking Member Congressman Cicilline, introduced the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act earlier this term. This bipartisan legislation targets abusive delay tactics that are being used to block the market entry of affordable generic drugs.

Specifically, the legislation ensures that pharmaceutical companies provide generic manufacturers access to samples needed to perform comparisons required for FDA approval. In helping generics get to market faster, the Congressional Budget Office estimates the bill would save government insurance programs alone $3.8 billion. The American people should not need to wait for this bill. I urge my colleagues to join me and Ranking Member Cicilline in making it a priority to pass the CREATES Act this year.

Another factor influencing healthcare costs is market consolidation. Such concerns may be lessened in the context of a vertical merger. As Judge Bork has explained, as a general matter, vertical mergers "may cut sales and distribution costs, facilitate the flow of information [and] create economies of scale in management." The proposed CVS Health and Aetna merger is a vertical merger. It is my hope that it presents an opportunity for cost savings. Uniting a provider and an insurer to create an alignment of incentives as well as valuable data-sharing opportunities that can pay dividends in the long run.

For example, the integrated post-merger entity could run a pilot program offering zero copays on preventive medicines such as cholesterol drugs. It could track the data to test the hypothesis that the lost copay revenue is more than made up for by reduced hospitalizations.

Proven concepts could then be rolled out across the healthcare delivery network. Of course, we also have to be sensitive to potential concerns. Vertical mergers can create anticompetitive problems such as foreclosure.

Consider an integrated health insurer-pharmacy benefits manager (PBM) pharmacy. The integrated entity must offer less competitive terms for its PBMs and pharmacies services to competing insurance companies. Competition should deter such discrimination, but the healthcare industry is increasingly consolidated.

Accordingly, I think it would be helpful for the Subcommittee to hear what assurances the parties can give that the proposed CVS/Aetna entity will not favor Aetna over its insurance business competitors in CVS' PBM contracts.

In short, there are important considerations on all sides. It is the task of this Subcommittee to conduct a thorough examination. To that end, we have assembled a distinguished panel of witnesses. And I look forward to hearing from each of them.

The Chair now recognizes the Ranking Member of the Subcommittee on Regulatory Reform, Commercial and Antitrust Law, the Congressman from Rhode Island, Mr. Cicilline for his opening statement.

Mr. CICILLINE. Thank you, Mr. Chairman, and thank you for calling today's hearing on the impact of CVS Health's proposed acquisition of Aetna on the pharmaceutical supply chain. The high cost of healthcare is squeezing the budgets of American families. We need a competitive healthcare system that delivers lower prices, more access to improved quality of care, and better outcomes for patients. That starts with tackling the sky-rocketing price of prescription drugs, one of the main drivers of high healthcare costs.

Today, Americans pay more for prescription drugs than people in any other country. Over the past decade, prescription drug costs have sky-rocketed by 200 percent, resulting in higher insurance premiums, larger hospital bills, and billions of taxpayer dollars that are unnecessarily going into the pockets of the largest prescription drug companies. This out of control spending, primarily for brand-name drugs, accounts for nearly a quarter of all healthcare costs and 19 percent of Medicare's spending.

And for many Americans, including, for example, cancer survivors and people with multiple sclerosis, who have good health insurance, drug prices just are not outrageous, they are life-threatening for people are skipping doses and cutting pills, because they cannot afford their medications. To quote David Mitchell, "People are angry and they are hurting, and they do not understand how this could be happening to them in the United States of America." Mr. Mitchell founded Patients for Affordable Drugs, an independent, nonprofit organization dedicated to lowering the price of prescription drugs—and I agree very much with his statement.

We must end this moral outrage that is bankrupting American families, particularly those that are most vulnerable. And the first step on the path to fixing this life-threatening problem is creating timely and effective generic drug competition.

The Federal Trade Commission reports that generic drugs can reduce the price of branded drugs by more than 85 percent. While the presence of just one generic competitor can decrease subscription drug pricing by 20 to 30 percent. That is why, as Chairman Marino mentioned, he and I proposed have H.R. 2212, the CREATES Act, a targeted solution to reducing drug prices through generic competition.

It is also why I am skeptical of claims that the pharmacy benefit managers, or PBMs, that should negotiate for lower drug costs on behalf of health insurance payers and employees, are the cause of high-drug costs. To the contrary, there is evidence that PBMs reduce costs and improve patient outcomes, while retail pharmacies save consumers and health insurers billions of dollars by automatically substituting generic drugs for branded drugs available, as Professor Robin Feldman and other leading researchers have noted. I strongly support promoting competition in every market, including within pharmaceutical supply chain, albeit that it is critical that consumers ultimately are seeing benefits from lower drug prices.

But make no mistake: simply demonizing PBMs and retail pharmacies of the drug supply chain is a distraction from the leading cause of high drug prices. These include: the lack of competition in the manufacturing of prescription drugs, regulatory abuse by branded drug companies to delay generic competitors, and barriers to generic competition—such as pay-for-delay settlements—that keep drug prices at artificially high, monopoly levels.

Addressing these issues head-on is a precondition for lowering the cost of prescription drugs. CVS Health's proposed acquisition of Aetna occurs within this backdrop and emits ways of consolidation of fair markets. Last year, in a very different merger proposal, the district court for the District of Columbia blocked Aetna's attempt to acquire Humana, a rival health insurer, concluding that the

transaction was "presumptuously unlawful, a conclusion that is strongly supported by direct evidence of head-to-head competition, as well." As the Justice Department noted in response to this decision, blocking that merger will save consumers and taxpayers up to $500 million per year and results in more generous benefits at lower prices.

There appear to be significant differences between CVS Health's proposed acquisition of Aetna and prior attempted mergers that would have contributed to the collapse of competition in health insurance markets. And I want to take a moment here to thank the CVS team who have provided really important information data to me on this proposed transaction.

And with this in mind, I look forward to hearing from our distinguished witnesses on this subject. It is incredibly important that working Americans understand how the proposed transaction will affect their access to care, their prescription drug costs, and the health insurance premiums, and whether we can do more to promote competition to lower prices in the drug supply chain. With that, I thank Chairman Marino for calling today's hearing and yield back the balance of my time.

Mr. MARINO. Thank you, Mr. Cicilline. Without objection, other Members' opening statements will be made part of the record.

Chairman Goodlatte's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-MState-G000289-20180227.pdf.

Mr. MARINO. And I will begin by swearing in our witnesses before introducing them. Would you please rise? Please raise your right hand. Do you swear that the testimony you are about to give to this committee is the truth, the whole truth, and nothing but the truth so help you God?

Let the record reflect that the witnesses have affirmatively said yes and please take your seat.

The Ranking Member, Mr. Cicilline, is going to introduce Mr. Moriarty of CVS because he is from his home State.

Mr. CICILLINE. Thank you, Mr. Chairman for the opportunity to introduce our esteemed witness from CVS health; a constituent company that is headquartered in my district and employs 6,792 hard-working Rhode Islanders. As one of Rhode Island's leading job-creators, CVS is an incredible corporate citizen. From providing access to healthcare for underserved populations, to pharmacy school scholarship programs to support talented students, CVS' actions continue to make Rhode Island, and, indeed, this country a better place.

CVS also continues to lead the way in promoting public health and wellness in pharmacies. I was very proud to stand on the House floor to applaud CVS Health's decision to stop selling cigarettes and other tobacco products in its more than 7,600 stores across the United States. And I hope other pharmacies will soon follow their example.

Our country faces tremendous challenges in creating an equitable and affordable healthcare system, and CVS Health has helped countless Rhode Islanders and people across the Nation bet-

ter manage their health and improve access to affordable prescription drugs.

It is my pleasure to introduce Mr. Thomas Moriarty, the executive vice president, chief policy and external affairs officer, and general counsel for CVS Health, a position he has held since March of 2017. In this role, Tom leads the company's external affairs programs including the policy, government, and public affairs, corporate communications, and legal and regulatory teams.

He received his law degree from the University of Virginia School of Law and his undergraduate degree from Lafayette College. We thank him for appearing before our community today. And thank you, Mr. Chairman, for the opportunity to make that introduction. And with that, I yield back.

Mr. MARINO. Thomas J. Sabatino, Jr. is Aetna's executive vice president and general counsel, the chief legal officer of the company with worldwide responsibilities for leading its legal operations. Mr. Sabatino has received numerous rewards from his peers including inside counsels, Transformative Leader Award in 2012, the National Bar Association Gertrude E. Rush Award in 2013, and the Equal Justice Works Scales of Justice Award in 2014. In addition, the Women's In-House Counsel Leadership Institute created the Sabatino Advocacy Award in his honor in 2016.

Now the Ranking Member of the full Judiciary Committee, Mr. Nadler of New York, will make his opening statement.

Mr. NADLER. Thank you, Mr. Chairman. Mr. Chairman, while I do not prejudge the merits of the proposed merger of CVS Health and Aetna, healthcare is an incredibly complex industry and we must consider carefully the potential impact of this transaction on competition and, ultimately, on consumers.

CVS Health is one of the Nation's two largest retail pharmacy chains with more than 9,700 retail pharmacy locations and 1,100 walk-in health clinics. It is also one of the two largest pharmacy benefit managers or PBMs. PBMs are entities that are responsible for administering prescription drug benefits through negotiations and contracts with drug manufacturers, health insurers, healthcare providers, and pharmacies and they represent a crucial part of the process by which prescription drugs are provided to consumers.

Aetna, meanwhile, is the Nation's third largest health insurance company, which had previously pursued a merger with Humana, the fourth largest health insurer, until the Department of Justice filed suit to challenge that merger. Proponents of this merger make a number of arguments in its favor centering on the potential for efficiencies, enhanced consumer services, and lower drug prices if the merger were to be approved.

Additionally, some contend that a vertical merger, that is a merger between companies that operate at different stages or levels of a given industry supply chain such as a proposed CVS–Aetna merger, raises few, if any, competition concerns compared to a merger between two direct competitors. Some other noted antitrust thinkers, however, are skeptical of this view, a skepticism I generally share.

Moreover, I note that even the Trump Administration's Department of Justice recently filed a lawsuit challenging the AT&T/Time Warner transaction; another vertical transaction, although it re-

mains to be seen whether that lawsuit represents any sort of longer-term philosophical shift in antitrust enforcement. With this background in mind, I hope that our discussion can focus on two points about the impact on consumers of the transaction that is before us.

To begin with, the healthcare sector is already highly concentrated, and there remains a concern that dominant firms, including a post-merger CVS–Aetna, would have the ability and the incentive to exclude competitors or to diminish competition, an issue that I would like all of our witnesses to address today.

In November 2015, this Subcommittee held a hearing on the state of competition in the pharmacy benefit manager and pharmacy markets. We learned then that most studies show that just three companies, including CVS, control 80 percent of the PBM market. Additionally, the largest PBMs also owned the largest retail pharmacy chains and concerns were expressed at the 2015 hearing that these firms have the incentive and the ability to leverage their dominance in the PBM marketplace to steer business to their pharmacies; a concern exacerbated by fact that it is difficult for the public to know whether any cost savings were ultimately being passed on to consumers.

Similarly, this Subcommittee previously examined the health insurance market when it held a hearing on the proposed Aetna/Humana and Anthem/Cigna mergers in September 2015. During that hearing we learned that health in American Medical Association study concluded that health insurance markets in seven out of 10 metropolitan statistical areas were highly concentrated. It found that in almost 40 percent of the metropolitan areas studied, one health insurer controlled more than 50 percent of the market, as was the case in 14 States, raising concerns about excessive concentration among health insurers.

The basic concern expressed that these earlier hearings remains today. Namely, that in such concentrated markets, the dominant firm has the ability and the incentive to use its dominance to exclude potential competitors or to diminish competition, even in markets where the firm being acquired is not a direct competitor of the acquiring firm.

Another question that I hope the witnesses will address is why a merger is necessary at all to accomplish the goals of greater efficiency, lower costs for consumers, and more innovation in healthcare delivery that the merger reportedly will offer.

Where we can avoid concentrating economic power in one firm, particularly, when the potential harm to consumers outweighs the potential consumer benefits, we should do so. This merger may very well turn out to yield the benefits that its proponents claim. Nevertheless, antitrust enforcers and our witnesses should closely examine the overarching questions that I pose as they review the significant transaction.

I thank the Chairman for holding this timely hearing and I look forward, very much, to hearing from our witnesses. I thank you, I yield back.

Mr. MARINO. Thank you, Mr. Nadler. Each of the witness' written statement will be entered into the record in its entirety, and I ask that each of you summarize your statement in five minutes

or less, and to help you do that, stay within that timing, there are lights in front of you. You have been here before. When a light turns yellow, that means that you have one-minute left; when it is red, your time has run out. And if you go over that, we have a little leeway, but I will be polite and diplomatically pick up the gavel.

Mr. Moriarty, please.

STATEMENTS OF THOMAS MORIARTY, EXECUTIVE VICE PRESIDENT, CHIEF POLICY AND EXTERNAL AFFAIRS OFFICER, GENERAL COUNSEL, CVS HEALTH; AND THOMAS SABATINO, JR., EXECUTIVE VICE PRESIDENT, GENERAL COUNSEL, AETNA, INC.

STATEMENT OF THOMAS MORIARTY

Mr. MORIARTY. Chairman Marino, Ranking Member Cicilline, Ranking Member Nadler, and Members of the Subcommittee, thank you for having me here today to discuss CVS Health's proposed combination with Aetna. My name is Tom Moriarty and I am executive vice president, chief policy and external affairs officer, and general counsel for CVS Health.

Most of you know us as a local pharmacy in your community, but we are really more than that. We are the front door to a path to better health. We have long been at the forefront of putting our patient's health first and improving the public health of our communities. Over the past few years, we have taken bold steps to define us as a company. We have removed tobacco from our stores. We have been promoting healthier snack options, and we have been waging a multifront fight against the opioid epidemic.

Our proposed combination with Aetna is a natural extension of these commitments. We will put consumers at the center of healthcare to ensure that they can access convenient, high quality, more affordable care where they are when they need it.

Our health system, in many ways, is a work in progress. It was built for a different time, for a different consumer with different needs. It is fragmented, complex, burdensome for consumers and providers, and it is unsustainably expensive. It faces huge demographic and chronic care challenges. And too often, the tug of war between entities with conflicting incentives means that the patient is not always being looked at holistically with the goal of preventing disease and improving his or her health.

Our vision is to create a new, open healthcare model that will help consumers improve their health and simplify their healthcare experience. And I would like to highlight three ways this transaction does that.

First, we will put consumers at the center of their care. Consumers are looking for more value, greater convenience, and help in making healthier choices in their everyday lives. This new model will provide consumers the information and resources they need to better manage their own health and access care in more convenient community settings at an affordable price.

Second, we will focus on prevention and primary care. The combination of our companies will give us and physicians a holistic view of a patient's health. On average, your constituents see their pharmacists much more often than they see their doctor. In fact,

many see multiple specialists, but only see one pharmacist. We are going to build on that point of continuity by having pharmacists engage patients early and often to help prevent and manage illness more effectively.

And, finally, we will find ways to address the rising costs of healthcare. Aging populations and the rise of chronic diseases such as diabetes and heart disease are two of the biggest trends threatening to bankrupt our system.

Unfortunately, we simply do not provide enough assistance for physicians and their patients who are coping with a chronic illness. We know that things like patients not taking their medicines as prescribed, excessive administrative complexity, and unnecessary emergency room visits cost the healthcare system billions and billions of dollars, needlessly, each and every year.

We believe that this transaction, through better pharmacy care and coordination with primary care professionals, can make a significant dent in reducing healthcare costs. Put simply, to make real progress on behalf of consumers and the healthcare system, we have to break the current log jam. There is not a one-size-fits-all solution to these issues, and you should be suspicious of those who suggest there is.

But we do know, healthcare can only improve if consumers are connected to support from pharmacists and providers who live in their communities and understand their personal experiences. Healthcare, like politics, is very local.

For us, the combination with Aetna is the next step in our company's long-running commitment to the health of all Americans. We do not see it as more of the same, but, rather, as a bold innovation that will reshape how healthcare is accessed and delivered starting first by putting the patient at the center of all that we do.

And with that, Mr. Chairman, I look forward to taking your questions.

Mr. Moriarty's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-MoriartyT-20180227.pdf.

Mr. MARINO. Thank you, Mr. Moriarty. Mr. Sabatino.

STATEMENT OF THOMAS SABATINO, JR.

Mr. SABATINO. Mr. Chairman, Chairman Marino, Ranking Member Nadler, Ranking Member Cicilline, and the other Members of the subcommittee, thank you for giving me the opportunity to testify today about our efforts to improve the consumer health experience. Aetna serves 22.2 million medical members through our commercial Medicare and Medicaid products. And our nearly 50,000 employees are committed to helping our members achieve their best possible health. The acquisition by CVS is the next step in that journey to put consumers at the center of their care. And I am pleased to be here today to describe how we are going to do that.

Today's healthcare system is designed to fix people when they are broken, not keep them healthy throughout their lives. For decades, the system has focused on delivering new, clinical capabilities. But, research now shows that 60 percent of the factors impact-

ing premature death have nothing to do with the care that people receive in a doctor's office or in a hospital, or with their genetics.

The current system has taken a very narrow perspective of health that largely ignores the social, environmental factors that play a critical role in overall well-being. Aetna is joining with CVS Health to fortify the healthcare system. Together, we will work to create a value-based system that aligns with the goals of the physician payment reform passed by Congress 2 years ago, commonly known as MACRA.

We want to reward healthcare providers based on patient outcomes instead of a greater volume of services and work with our members to improve the social and environmental factors impacting their health. We will develop the system by focusing on the consumer; making healthcare simpler and easier to use. Our new company will learn about our member's individual health goals and connect them to the tools, information, and resources they need to achieve a lifetime of wellbeing.

This is not something Aetna can achieve on its own. To fulfill our shared vision for a value-based and consumer-focused experience, we need to have a significant presence in the communities where our members live. That is why our combination with CVS is so compelling. We plan to combine CVS Health's extensive retail footprint with Aetna's health plans, analytical capabilities, and our extensive network of medical professionals.

Together, we will create a new, consumer service model in the local community that enables us to learn about the health needs and ambitions of our members. We will then connect our members to relevant resources, including healthcare providers or community organizations, that can improve the social and environmental factors affecting health.

We understand the important relationships that consumers have with their physicians and other healthcare providers. Our new company will not replace this valuable relationship. Instead, we will work closely with local providers to help consumers achieve their personal care plans. For example, providers could encourage members to make regular visits to their local CVS store to get advice on fitness, on nutrition, on managing their medications.

We could also perform routine tests and share those results electronically with the member's primary care physician. I want to remind the committee that this is a vertical transaction, with no significant overlap in our existing businesses. The vast majority of CVS Health's revenues come from retail pharmacy and pharmacy management.

Aetna, on the other hand, is focused on health insurance and does not have a retail footprint in any of the communities we serve. It is also important to note that Aetna and other insurance companies are among the most highly regulated stakeholders within the healthcare sector. For example, in the bulk of our business, we are required to pay rebates to our customers if the proportion of premium revenues spent on clinical services and quality improvement is less than 85 percent. The remaining funds go towards all of our costs of doing business, including our investments in innovative healthcare solutions.

So, in conclusion, the Aetna and CVS health transaction brings together two innovative businesses in a sector that needs to change. The new company will offer a local experience that is simpler to use and build around consumers. Our value-based model will help consumers receive higher quality, more affordable care, while also addressing the social and environmental factors that impact their health.

Thank you again for the opportunity to testify, and I look forward to addressing any questions you have.

Mr. Sabatino's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-SabatinoT-20180227.pdf.

Mr. MARINO. Thank you, Mr. Sabatino. We will now begin with the Members' 5 minutes of questioning. And I will recognize myself to begin the questioning. Mr. Moriarty, you mentioned in your opening statement the opioid epidemic, could you please tell me what you plan to do to help bring this epidemic to its knees and what the lateral merger would do, overall.

Mr. MORIARTY. Mr. Chairman, there is no question the opioid epidemic touches everywhere across this country. Over the last several years, I have traveled around to all the communities that we serve in our current operations. We have begun a very large initiative where we are placing drug disposal units in each of our pharmacies; 750 across the country.

Each time we go into these pharmacies I talk to the local police chiefs as to what they are dealing with. And one, in particular, in Wilmington, North Carolina, the night before that we actually did the drug disposal event, there were two overdoses just one block from our pharmacy. So, there is no question it touches everywhere. It knows no economic, social, or other bounds.

What we have been doing as a company, and we will continue to do and leverage through the combination with Aetna, is we have been able to put into a plan design that actually limits the amount of a first fill for an opioid-naïve patient to 7 days. Working with physicians directly, consistent with the recommendations for the Centers for Disease Control to limit the availability of those first fills as they go out the door.

We have made substantial investments in counseling with school kids, both at middle schools and high schools, having our pharmacists go back into the communities to educate them on the danger of just simply one bad choice. All those efforts will continue, and as we are better able to integrate the data with Aetna, we can work much more directly with the prescribing physicians to get our practices to change those practices to educate the physicians about the dangers of over-prescribing and really get at this.

This is a multifaceted problem. It will not go away quickly, and it is going to take multiple-pronged solutions to get at it.

Mr. MARINO. Thank you. Mr. Sabatino, would you like to respond?

Mr. SABATINO. Sure, I would add just a couple of things. First of all, I will echo what Mr. Moriarty said about the 7-day prescription that we will only pay for 7 days for the initial prescription, as well. So, we are in concert with that.

A couple of other things I would note that Aetna has done. We have identified the high-prescribing physicians and going after them. And, first of all, trying to educate them as to the fact that they are high-prescriber physicians; sometimes they are not fully aware of it. Understanding who they are. In some cases, for example, if you are an oncologist that may be appropriate. But, in other situations, it is not appropriate. And we will stop paying high-prescribing physicians when we think there is abuse. And we will work through that.

The other thing we are doing, for example, believe it or not, dentists have a high number of high-prescribing dentists in that network. So, when we identify that, we are trying to find ways to get non-opioid pain medication to patients that need it following, say, oral surgeries or something like that. So, we are trying to work with our enormous network of medical professionals to get at those issues.

Mr. MARINO. I am a former State and Federal prosecutor and what you two just said, I do not think I can hear anything better during this hearing. Thank you so much for what you have said, and I hope you really put that into effect.

Mr. Sabatino, I represent a rural district in Northeast Pennsylvania that has many independent pharmacies. What affect, if any will this merger have on independent pharmacies for my constituents?

Mr. SABATINO. Mr. Chairman, we believe that it will not impact independent pharmacies. Aetna now contracts with 65,000 pharmacists around the country to satisfy our network. We will have an open system that continues to provide for that. For us to be competitive, we need to provide the breadth of coverage for all of our members to be able to access healthcare. And so, we do not believe that it will impact the individual pharmacists in any significant way.

Mr. MARINO. Mr. Moriarty, would you like to respond to that?

Mr. MORIARTY. I would, sir. And I think, actually, it offers us a real opportunity to sort of change and further evolve the role of the pharmacists, both in rural communities and other areas. Eighty percent of the issues associated with healthcare costs today are behavioral in nature. That contact, that point of reference, that point of engagement that pharmacists have is real. Pharmacists are one of the most trusted professionals in the healthcare community.

We can, and we should, look to much more of a value-oriented system that rewards pharmacists for that activity, as opposed to just simply for dispensing. And, many Members of this Committee, have supported efforts to bring provider status into Medicare to acknowledge the significant role that pharmacists can play in lowering total healthcare costs by beyond just simply prescribing, but working directly with patients. And we applaud the Members who support that. And we need to continue to make that happen.

Mr. MARINO. I think pharmacists are one of the most important tools that we have to address this opioid epidemic. Not the only tool, I mean, we have to talk about physicians; we have to talk about manufacturers, distributors, education, the whole nine yards. But, I am very pleased with what you have to say, and my time

has run out. And I yield to the Ranking Member of the Subcommittee, Mr. Cicilline from Rhode Island.

Mr. CICILLINE. Thank you, Mr. Chairman. Thank you again to our witnesses. First, I would like to ask the witnesses, and we will begin with Mr. Moriarty, I think everyone recognizes that access to preventative care is really essential in terms of a restructuring of our healthcare delivery system.

I wonder if you would just speak a little bit on what this transaction might mean in terms of—and Mr. Sabatino, as well—what it might mean in terms of access to preventative care; how it may be enhanced by this proposed merger.

Mr. MORIARTY. Certainly, sir. I think, you know, just high level, statistically, 62 million Americans do not have access to adequate primary care. We have our MinuteClinic business, we know that 50 percent of folks who visit MinuteClinics do not have a primary care physician. One of the things that we do, is we go into the primary care community in which we are placing a MinuteClinic and ask if they are taking referrals; doctors are taking referrals, and if they are, we put them on a list. So, if a patient comes into MinuteClinic says I do not have a primary care physician, we emphasize the need to have one, and actually connect them with that primary care physician.

The other thing we know is, primary care, a lot of times, is being sought out when it is not available in regular business hours; 50 percent of the visits at MinuteClinic are nights and weekends when core primary care is not available. The ability to extend out and have available primary care at off-hours, at times when it may not otherwise be available, that is clearly something we can build out even more so with Aetna. And we, once we develop those solutions, can make them available more broadly into the marketplace as Aetna actually implements those with other providers outside of CVS.

Mr. CICILLINE. And, I take it, Mr. Moriarty, that the model provides some of the efficiencies and cost savings that are worked out in that relationship to be passed on to the consumer?

Mr. MORIARTY. Absolutely, because if you look, Congressman, roughly one-third of emergency room visits are unnecessary; the emergency room visit for that individual, who has to pay out of pocket for it, is huge. The average MinuteClinic visit is roughly $75 to $80 versus $600 to $800 for the patient.

Mr. CICILLINE. Thank you. Mr. Sabatino.

Mr. SABATINO. Yes, and I would agree with my colleague, and just add a couple of additional points. From Aetna's perspective, the exciting aspect of this combination is that we have a small presence in the community but working with CVS we will now have a much larger presence. The social and environmental determents of health are impacting health in ways that we are just beginning to understand. And so, we need to get to the local communities and interact with the individuals. And we can do that best through the doorway that CVS provides.

We also need to go beyond that; and we will go beyond that by going to the home. And so, we have a pilot program with Meals on Wheels, where we have trained Meals on Wheels volunteers, when they go in the home, to look for other determents of issues. Like,

do they have food in the refrigerator, is the heat on, and those sorts of things, so they can report them back and we can then have an intervention to make sure people stay healthy. As Mr. Moriarty mentioned, keeping people healthy is the best way to save the healthcare system money and to make people happier and have a longer life.

Mr. CICILLINE. Thank you. And, Mr. Moriarty, some have raised concerns that if this transaction is approved, it may increase the incentives and ability of CVS to foreclose rivals or steer consumers such as Aetna enrollees to CVS pharmacies, and you and I spoke about that. Maybe you could explain how that will be operationalized or prevented.

Mr. MORIARTY. Sure, so a few points, Congressman, on that. First off, if you look Aetna today, because we are the service provider to Aetna, represents roughly 11 to 12 percent of CVS' revenue. The other 89/88 percent sits with other health plans; other employer groups, et cetera. If we sought in any way to foreclose, availability to all the services and creations that we are going to make here as part of this to the rest of the market, we would have so much more to lose than we would to gain in that regard.

The other thing I can give you is one very tangible example in Medicare Part D. CVS has their own Part D Plan SilverScript. We have innovated, we have invested very heavily in that, and we have provided great member satisfaction for that. But at the same time, we are the service provider to some 43 other Part D plans run by other health plans.

And we have made available all of the innovation and SilverScript to those plans and 83 of the plans that we service outside of SilverScript have a four or five star rating, which are the highest ratings CMS will give to a health plan associated with quality of service, adherence, member satisfaction, and the like.

So if you look at just simply the SilverScript example as one and then others across our business, the risk of foreclosure, we feel really does not exist and in fact the economic interest would argue very strongly that it simply cannot happen.

Mr. CICILLINE. Thank you. With that, I yield back Mr. Chairman.

Mr. MARINO. The Chair recognizes Congressman Issa, from California.

Mr. ISSA. Thank you, Mr. Chairman. Mr. Moriarty, beforehand I walked up to you before this started and said, "How is this trust going to work?" And I did so because clearly this is a vertical integration.

But what I find interesting and I just want to go through it quickly and then ask a couple of questions is, it is a pretty inaccurate vertical integration. You are buying a convenience store with a pharmacy hooked to it. Your 11 percent relationship between CVS and Aetna is certainly not all the ore of the northeast, or the central area being brought up for a given group of steel mills.

So, the synergies are pretty imperfect in the sense that these are not, you know, 88 percent, and you are bringing it together. And it reminds me of the United Airlines buying the Weston hotels. And everyone was doing it for a while. It was called synergies.

Now, it is your company's decision and your stockholder's decision about whether this is a good decision or not. But would it not be fair to say that this is at least an experiment in whether or not you can use the synergies in a way that not only give you efficiencies with this 11 or 12 percent, but then can turn into novel ideas to work with other groups?

Mr. MORIARTY. It is a transaction, Congressman, that we feel is based on some known facts in terms of our own experience to date. So, for example, we know that transitions in care from a hospital to home, and the lack of the proper coordination of pharmacy associated with that is one of the single biggest indicators of readmissions back into the hospital.

Roughly 70 percent of all readmissions is associated with essentially bad pharmacy management in that. We have a business that has home infusion, so it is infusions and therapies are moved from hospital, where they cost roughly $340,000 a year, to a lower cost home settings.

We have been able to work on those transitions, make sure the medications are correct, and we have reduced hospitalizations by some 24 percent in that instance. So, that gives us a value proposition that we think that we can scale with Aetna, create an even more marketable product, and sell more broadly beyond simply Aetna and to other health plans and other providers.

Mr. ISSA. Now, a question for you is if Aetna were to decide that you were going to be their exclusive vendor in every through put servicer in every possible area where CVS has the infrastructure to do so, then what portion would you get that you are not currently getting from Aetna? Just ballpark number: I am sure the figure has been run.

Mr. MORIARTY. You know, I do not know it off hand. But I think it would be a very small percentage. And the risk of loss of so much other business would greatly outweigh any smaller benefit that comes——

Mr. ISSA. Well, Mr. Sabatino? If Walmart came to you the day after this merger and said, "You know what, we are going to set up our little mini-urgent care centers to meet or exceed what they are doing over there at CVS," and Walgreens did the same thing, Rite Aid, you know, a list of names. After the merger what would be your position if in fact they had the same value proposition at additional storefronts? How would that be affected by this integration?

Mr. SABATINO. Well, I think we would have to look at any opportunity that we have to lower the cost of healthcare. We service people around the country, and we need to find every opportunity. We intend to have an open system that allows all to participate in it. Because the ultimate goal is to find the ways to get our members to find the right healthcare. And so, the system needs to be open. It will not work otherwise. And we will not be able to compete effectively against the other managed care organizations.

Mr. ISSA. Now, I am going to act as though there are no insurers here for a moment and go back to Mr. Moriarty. In a perfect world, would CVS become the household word for the principal alternative, to emergency room? The place the people who do not have a primary care physician that they can just call in a concierge's

type way that will see them. Would you envision that that is your goal? Is to be the go to so that never again does somebody run to the emergency room, because they do not know where else to go?

Mr. MORIARTY. Well, the foundational elements of not only MinuteClinic, but what we have done with primary care providers, as well as the health systems is that it is not replacement. It is a complement. We cannot address every condition in a MinuteClinic that needs to be addressed in the emergency room. What we can do is do it——

Mr. ISSA. But tens of thousands of flu cases you could?

Mr. MORIARTY. Well, those acuity issues——

Mr. ISSA. Yes.

Mr. MORIARTY. Yes, we certainly can.

Mr. ISSA. And finally, Kaiser, decades ago, integrated much more than most insurance companies do today. Could one of you contrast your proposal to theirs since it obviously did not disrupt the market?

Mr. MORIARTY. I will start, and Mr. Sabatino can add to it. But I think more than anything, what is being built out here is going to be an open source model. It will be made available not just to Aetna members, but other health plan members, as well as, to other pharmacies across—there are some 70,000 pharmacies in this country. CVS has 9,700, which is a lot. But it represents a very small percentage of all that. The coverage that is needed to cover all of America sits with those other pharmacies. That has to be addressed as part of this as well.

Mr. SABATINO. And I would add that I think, obviously, the Kaiser system is a closed system. Our system is an open system and will remain open. And I think it demonstrates the fact that our healthcare system is complex. And we need different models, in different places, in order to attack the issues that we are trying to address.

So I think there is a place for a Kaiser system in the environment in which Kaiser operates. And there is the place in the other systems like ours with CVS in order to address this issue.

Mr. ISSA. Thank you, Mr. Chairman.

Mr. MARINO. The Chair recognizes Congressman Nadler, the Ranking Member with the full Committee from New York.

Mr. NADLER. Thank you, Mr. Chairman. Mr. Moriarty, in your written statement, you argue that the proposed transaction will benefit consumers and lower healthcare costs through greater deployment of community-based care via the CVS health's MinuteClinic services, and you talked about that. Will these efficiencies achieved by the transaction be passed on to consumers in the form of lower prices for healthcare services or prescription drugs? And how do we know that?

Mr. MORIARTY. Well, the answer is yes, sir. And the way it will be, is as we can lower the total cost of care it will be reflected—and Mr. Sabatino can comment on this better, he is more the expert—ultimately in lower premiums. What we can do as well, whether it is MinuteClinic or what we do today in our core pharmacy business, is the better use and better efficient use of generics over branded pharmaceutical products. Lower copays associated with that.

At CVS as an employer, in our plan design we saw the impact of higher cost drugs on our employees. We saw utilization of in key categories of diabetes, cardiovascular, the utilization, use of those by our employees go down. We decided to do, implement a plan design of zero copay associated with generics, but also branded products in those key categories like diabetes and otherwise, because we know that the use of pharmacy adherence to pharmacy is critical to longer term healthcare.

And what we have seen as a result of that, is actually better utilization on our employee base and a healthier population as a result. And that gives us a lot of comfort and a lot of instruction as we go forward working with Aetna as we put this combination together.

Mr. NADLER. I am not sure I understood your answer. You have done a lot of nice things. But how do those lead to the conclusion that the efficiencies achieved by the transaction would be passed on to the consumers?

Mr. MORIARTY. It, ultimately, in the sense of what the consumer will pay can be reflected either in the form of a lower premium for the insurance that they are buying or, ultimately, for what they are paying at the pharmacy counter.

Mr. NADLER. And how do we know that it would be?

Mr. MORIARTY. I am sorry, sir?

Mr. NADLER. You said, "can be." How do we know that it would be?

Mr. MORIARTY. Well, that is what we will deliver as part of this. If we can lower cost, maybe Mr. Sabatino can comment on how the model works?

Mr. SABATINO. Yes.

Mr. NADLER. I have got questions for him. So, let me travel on to that. I will ask this of Mr. Sabatino, Mr. Moriarty may also want to comment. Professor Lamar Daphne, a leading healthcare economist recently argued that in the absence of this transaction, Aetna could have been a potential entrant in some business segments in which CVS currently operates such as entering the market for pharmacy benefit management. How would you respond to that?

Mr. SABATINO. Thank you for the question. We have gone through an analysis. We went through analysis several years ago looking at how we would have our PPM services, for example. Should we create our own PPM company or do other things? In the course of that we looked at all options and we came to the conclusion that the best solution for us, given our skill sets, was to contract with CVS for those PPM services because they were an efficient and effective provider of those services.

In the meantime, we focused on the things we can do more effectively around managing medical costs and driving down the total cost of care. And, in terms of the drug issue, just to address that very quickly, you know, we have a shared goal in keeping drug costs down. We benefit our members by keeping our costs down. Those are passed on in premium reductions and increasing benefits for the members. That is how we operate our business. When we are able to save costs, they get passed on, and we are able to lower the cost of care.

Mr. NADLER. Okay, and Mr. Slover is going to testify on the second panel, argues in his written testimony that there is a horizontal dimension of the proposed transaction which is that Aetna would essentially, "get its own in-house PBM," and outcome it could also achieve is a potential competitor in the PBM market. How do you respond to concerns that the proposed transaction harms potential competition in the PPM market?

Mr. MORIARTY. I can start and then Sabatino can add to it. Congressman, no player is leaving the field here. In the sense of there is no PBM competition. We are the service provider today for Aetna from a pharmacy benefit management prospective. And so, there will be no consolidation at the PBM level. There is a ripe competition today. We have anywhere from eight to 15 substantial players in the PBM market. We see a robust, competitive environment in that regard. So, I do not see how this combination impacts competition in the PBM space.

Mr. NADLER. Thank you. In the 17 seconds I have left, let me ask for a brief answer to one final question. This is for Mr. Sabatino. What assurances can you give this transaction is approved that CVS will not provide favorable treatment to Aetna over rival insurance companies? Maybe it should be Mr. Moriarty, whoever.

Mr. SABATINO. Because we need to stay competitive. We have a very competitive market place. We have other competitors in this space that are also looking to manage their costs down and we will have to do that in order to be a viable player in this industry.

Mr. NADLER. Thank you, my time has expired. So, I yield back.

Mr. MARINO. The Chair now recognizes Congresswoman Handel from Georgia.

Mrs. HANDEL. Thank you, Mr. Chairman, and thank you both for being here today. For Mr. Moriarty, could you give us just a more detailed example or detailed vision of what sort of the post-merger MinuteClinics are going to look like with the expanded services that you will offer there?

Mr. MORIARTY. Certainly, Congresswoman. I think if you look what we will be looking at doing is expanding the scope of services, consistent and better complimenting the primary care within the communities we serve. So, there will be gaps, potentially in primary care, in certain communities that do not exist elsewhere. We can actually modify the services provided at MinuteClinic to help fill those gaps. We will have much better coordination and further investments and coordination with those primary care physicians.

So, for example, we have made a very significant investment in Epic which is an electronic medical record system that will allow each of the visits that folks seen at MinuteClinic to go back to their primary care physician or to the health system in which that patient is associated. So, we avoid fragmentation in care. You will see a much more clinic approach to MinuteClinics as we go forward as well. And I think those are probably the highlights of how we will move forward in that area.

Mrs. HANDEL. If I can just follow up on that. You keep saying, "expanding services." And so, I am looking for specifically——

Mr. MORIARTY. Sure.

Mrs. HANDEL [continuing]. Is it going to be more of a full scale, the way the neighborhood sort of urgent care clinics work? Which

are not really urgent care anymore. They are, just they are open late, and we can go there, like that? Or, something scaled down?

Mr. MORIARTY. For example, so today, Congresswoman, the MinuteClinics address roughly 40 to 45 percent of what can be done at primary care. We envision over the next year or so that we can expand that to about 90 percent. It will not involve having X-rays or the ability to fix broken bones or things along those lines. But it will be much more the acute conditions that you will see; the ear infections, eye infections, skin abrasions, other things, flu.

And perhaps more importantly, chronic care management. As diabetes becomes more and more of an issue, the ability to interface with patients on a much more regular basis to ensure they are compliant with their A1C testing, taking their medications. That chronic care counseling will become a very big part of what we do going forward.

Mrs. HANDEL. Okay, great. Thank you. I wanted to talk a little bit about lower prices. There were some recent media reports suggesting that Caremark had recently slashed reimbursements for generic prescriptions to the independent pharmacies. My question is less about that, and more about were those lower prices passed on to consumers in keeping with Mr. Sabatino's comments about passing along cost savings to consumers? How is that going to work so that consumers really do see a competitive lower cost outcome from this?

Mr. MORIARTY. That is a great question, Congressman. Let me start to take a step back, because I think if we look at reimbursement at the retail pharmacy level, there is incredible pressure there for a lot of different reasons. I think one of the single biggest things that is happened over the last two years is the changes in reimbursement for Medicaid.

So, changes were made roughly in 2016 and have taken some $600 million in reimbursement from retail pharmacies out of Medicaid. Savings to CMS, savings to the Medicaid program. Those are significant cost impacts and headwinds that retail pharmacy is bumping up against. That has had a natural drag on pressure in the commercial world as folks have seen those rates, there is been a lot of pressure from our employer, clients, and others who are looking to save money.

I feel very strongly that we solve for this longer term, is we have a new model for pharmacists where much more of the professional skills they bring in terms of the ability to counsel patients, work with patients on chronic conditions and otherwise is acknowledged and reimbursed, not only by the Federal Government, but also by commercial payers. And we fundamentally believe as we put these models together, we can see the value of that showing up in medical costs. We can create new reimbursement models for pharmacists as we go forward.

Mrs. HANDEL. And has the response or the input from the pharmacists, what has that been? Pro? Con? In between? Wait and see?

Mr. MORIARTY. Well, actually interesting, today the National Community Pharmacy Association which represents the independent pharmacist stated that they had no position on the merger.

Mrs. HANDEL. That is interesting. Okay. Thank you so much. I appreciate it. Mr. Chairman, I yield back.

Mr. MARINO. The Chair recognizes Val Demings from Florida. The newest Member of our Judiciary Committee and our Subcommittee. And we look forward to your input. So, welcome.

Ms. DEMINGS. Thank you so much, Mr. Chairman, and thank you to both of you for being here with us today. I think you have both said that healthcare is complicated and that is an understatement. Certainly, we need to expand care and lower cost. Could each of you please tell me how the proposed transaction will benefit more underserved communities?

Mr. MORIARTY. Yes. I can start. I think, Congresswoman, as you look first and foremost it will take the form of what we can offer within not just our pharmacies, but how we can extend that to other pharmacies. We know in certain areas that, from a behavioral standpoint and from just social determinants, that where you live has as much to do with your healthcare and your health outcomes as any other factor.

We can extend and push care, not just physically, but also through telemedicine and other related capabilities that we will be able to invest in as part of this transaction. Those are things we are doing today. Those are things we will accelerate as we go forward with Aetna.

Mr. SABATINO. Yes, and let me start by saying that I think we all recognize that not only is healthcare complicated, but the status quo is unacceptable. We are not able to provide healthcare to everyone in an effective way and we are working to do that. We believe that by getting to our communities, by becoming much more locally focused on people and their issues, we can get at those social determinates of health that are affecting it.

Mr. Moriarty alluded to this. Our CEO is famous for saying—not famous. I do not know if he is famous or not. But he will say, “That today we now recognize that our zip code matters more than our genetic code” in terms of whether or not our health outcomes. So, we need to get into those communities. This transaction allows us that opportunity to do that. It allows us to get where the people are in every community in which we operate. And so, we think that is the best way to get at increasing the health of individuals and reducing the costs.

Ms. DEMINGS. And some antitrust experts express skepticism about the merger being necessary to expand services. Could you tell me why this merger is necessary as opposed to a contractual relationship?

Mr. MORIARTY. Again, I can start, and Sabatino can add to it. We start with the very proposition of we have a $3.2 trillion healthcare budget in this country. We know the data suggests that one-third is not being spent appropriately, may even being wasted.

So looking at solutions as to how we get at that. Whether it is unnecessary emergency room visits, lack of compliance, lack of people taking their medications as prescribed by the doctors costs $300 billion each year. There is a fragmentation in the system today where the primary care doctor will recommend that you do X, Y, and Z and that is not being followed through on.

Our ability to integrate the data that Aetna has in terms of it is medical records, with our touch points at the pharmacists can lead to a much more connected care management system that we think will make a real difference.

It will also allow us to extend things like we are doing today with the Veteran's Administration in Phoenix. As we have looked at what is happening at the VA, we have been able to extend MinuteClinic services to those veterans to triage conditions that can be seen at MinuteClinic. Reduce the back log at the hospitals that are in the VA systems, get the veterans the care they need for what we can take care of, and only those who truly need to be back in the VA system actually go there. These are all examples of things that we can extend and accelerate when we put the combination together.

Ms. DEMINGS. Thank you.

Mr. SABATINO. And I would just add that from Aetna's prospective, CVS has the doorways that we need to go to. We do not have those doorways today. We have the analytics. We have the medical professional network that we can link in with the system, and we cannot fully integrate those unless we are actually one part, part of one combined company. Our data analytics will fuel that, but it needs to be as part of a single entity for us to really get to the true value that is able to be captured.

Ms. DEMINGS. And finally, could you talk just a little more about, kind of, the guarantee that you will not force your consumers to use one or the other because you need to remain competitive. Could you just talk a little bit more about how that makes you more competitive?

Mr. MORIARTY. Sure, I can do that.

Ms. DEMINGS. Allows you to be more competitive than the other way.

Mr. MORIARTY. That is right. And, ultimately the model is we will want them to come. We cannot force them to come. And, in fact, if we look at our broad customer base at CVS and the number of companies we provide services for, if we try to restrict these only to Aetna, we would lose so much other business that we are just simply cannot do that as part of our model. So, what we have built today, and we will continue doing is offering and developing services made available across the healthcare spectrum. Not limited to any one company or to only one group.

Mr. SABATINO. And I would just simply add that for us to continue to serve our customers, school, unions, corporations, we need to be able to provide access to a retail pharmacy wherever they may be and a large number of those. So, it is imperative that we keep our network wide and broad in order to continue to provide those services.

Ms. DEMINGS. Thank you so much to both of you. Mr. Chairman, I yield back.

Mr. MARINO. Thank you. Seeing no other Members on the dais for questions, this concludes the first panel of our hearing. I want to thank our witnesses. Gentleman, your testimony has been very encouraging. I think I speak on behalf of Mr. Cicilline, particularly pursuant to some of the legislation and issues on which we are working, thank you very much. You are excused.

Mr. MORIARTY. Thank you for the opportunity.

Mr. MARINO. And it is time now we will call the second panel for today's hearing. I will begin by swearing in our witnesses before we introduce them. So would you please stand and raise your right hand? Do you swear that the testimony that you are about to give before this Committee is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record reflect that the witnesses have confirmed in the affirmative and may be seated.

I will now introduce all of the witnesses before we go into your individual statements. And if I mispronounce your name, let me know.

Dr. Craig Garthwaite is the Herman R. Smith research professor in hospital and health services management and the Director of the Health Enterprise Management Program at Northwestern University, Kellogg School of Management. His research focuses on a variety of issues related to the pricing and development of pharmaceutical products and the effects of the changing healthcare market on the operations of hospitals and other healthcare providers. Dr. Garthwaite has a bachelors and master's degree from the University of Michigan and a Ph.D. in economics from the University of Maryland. Doctor, welcome.

Dr. Lawrence Wu is an economist and president of NERA Economic Consulting. A global firm of experts in economics, finance, and statistics. Dr. Wu specializes in health economics and antitrust. And over the past 25 years he has analyzed the competitive impact of scores of mergers across the healthcare industry.

From 2011 to 2015, he was a visiting scholar at the Stanford Institute for Economic Policy Research at Stanford University. From 1992 to 1996, before he joined NERA, he was a staff economist in the Bureau of Economics of the Federal Trade Commission. Doctor, welcome.

Mr. George Slover is a senior policy counsel at Consumers Union, the advocacy division of Consumer Reports, where he works on competition policy, regulatory policy, and other consumer protection policy issues. He has authored numerous comments on agency rulemakings, has testified before Congress on several antitrust and competition policy matters, and has assisted with the drafting of a number of bills. Before going to Consumers Union, he worked in the legal policy section of the Justice Department's Antitrust Division, as well as at the House Judiciary Committee, where he was again focused on antitrust issues. He holds a JD from the University of Texas Law School and a Master of Public Affairs from the LBJ School. Counselor, welcome.

Mr. Geoffrey Manne is the founder and Executive Director of the International Center for Law and Economics. A nonprofit research center based in Portland Oregon. He is an expert in law and economics with two degrees from the University of Chicago; a BA in economics and political theory and a JD. And he is the son of Henry Manne, one of the founders of Law and Economics and former dean of George Mason Law School.

He was a law professor at Lewis and Clark Law School in Portland, a lecturer in law at the University of Chicago and the University of Virginia and worked as a research assistant for Judge Rich-

ard Posner. Jeff has written extensively on antitrust law and economics, particularly on vertical mergers and on merger issues in the healthcare and health insurance industries. Welcome, Counselor.

Each of the witnesses' written statements will be entered into the record in its entirety. And again, I ask that when you make your statements, please try to keep them within 5 minutes. And as you heard, you will see that there is a timing light. And when the green light goes to yellow, you have 1 minute, and when it goes to red, your time has run out.

And as I say, I will be very polite and diplomatic. If you excessively run over, I will just raise the hammer a little bit to give you an idea that it is time to wrap up. So, with that in mind, Dr. Garthwaite, would you like to make your opening statement?

STATEMENTS OF CRAIG GARTHWAITE, ASSOCIATE PROFESSOR OF STRATEGY, DIRECTOR, HEALTH ENTERPRISE MANAGEMENT PROGRAM, KELLOGG SCHOOL OF MANAGEMENT, NORTHWESTERN UNIVERSITY; LAWRENCE WU, PRESIDENT, NERA ECONOMIC CONSULTING; GEORGE SLOVER, SENIOR POLICY COUNSEL, CONSUMER UNION; AND GEOFFREY MANNE, EXECUTIVE DIRECTOR, INTERNATIONAL CENTER FOR LAW AND ECONOMICS

STATEMENT OF CRAIG GARTHWAITE

Mr. GARTHWAITE. Chairman Marino, Ranking Member Cicilline, Ranking Member Nadler, and Members of the Subcommittee, thank you for holding a hearing examining the merger between CVS Health and Aetna and the potential implications of vertical mergers of this nature. As you have said, I have prepared a written statement for the record that I will briefly summarize here today.

First, I would like to clarify for the Committee that I have not been in contact with any representatives of either of the organizations, nor do I have access to any propriety documents relevant to the merger. Therefore, my testimony is primarily intended to highlight the broad economic incentives involved with a merger of this nature. As such, it is also generally relevant to other similar combinations of assets we see in the market, such as those with United Health Group with its United Healthcare and Optum divisions.

The proposed merger, as you mentioned, is primarily a case of vertical integration, a situation where a firm and either its customer or supplier attempt to organize into a single entity. Such strategies involve effectively abandoning the broader supplier market in favor of an internal supplier, and they are often met by with skepticism by economists and strategy professionals, a skepticism that stems from our knowledge that well-functioning economic markets allow firms such as Aetna and CVS to obtain the best price quality combination for various inputs and services.

That said, we also know that firms often do not face the well-functioning and efficient markets that inhabit many economic textbooks. In fact, features such as the presence of incomplete information, uncertainty, meaningful transaction costs, decreased market efficiency, and facing those imperfect markets, strategic vertical integration can increase social welfare.

And concerning the merger of CVS Health and Aetna, I can identify three primary rationales for how vertical integration could increase social welfare in this context. First, the proposed merger may allow a better coordination of the various components of the health insurance benefit. Often, medical and pharmacy insurance benefits that we receive are provided by different firms, each of which is naturally focused on maximizing its own profits. For example, a PBM rarely bears risk for medical spending, and thus primarily focuses on how its decisions on copays and which drugs to cover affect drug spending rather than total health spending.

The potential inefficiency is easiest to consider for something like the treatment of diabetes, where a PBM aims to minimize drug spending, while a firm responsible for total health spending realizes that diabetics who were not adherent to their medications result in future inpatient hospitalizations that are costly for society.

A merged CVS-Aetna would have both the incentives and the information to offer this more coordinated benefit that considers these spillovers. That would be good for consumers, because such a benefit both increases health and lower healthcare spending.

A second potential source of value creation is addressing inefficiencies in the existing PBM market. While there are many complexities to drug pricing, at a high level, payors such as an employer pay a publicly available list price to a pharmaceutical firm. They then hire PBMs to do, among other things, negotiate rebates from that list price, and then those rebates are shared to the firm and the PBM keeps some portion of it as well.

In a well-functioning supplier market, PBMs would compete for a payer's business until the appropriate amount of the rebate was transferred. But the PBM market does not appear to be as competitive as we would like, and is, in fact, quite concentrated. As a result, PBMs and pharmaceutical firms have an incentive to increase list prices and the size of the rebate in an attempt to capture value for themselves.

My research suggests that in the current PBM market, both of these firms are benefitting from higher drug prices. This increases premiums and forces customers to pay directly higher prices at the pharmaceutical counter. But a merged CVS-Aetna would not have a similar incentive to raise these list prices for its insurance customers, since this would decrease the profitability of the merged firm's insurance product.

And a final source of potential value creation stems from the provision of medical services in new lower cost settings. And we heard both of the general counsels talk a lot about that. A merged CVS-Aetna could provide the appropriate incentives for more care to be provided at low cost locations such as CVS's chain of MinuteClinics.

Currently, when CVS picks the services they offer at those clinics, they focus on maximizing retail revenue. They do not focus on services such as chronic disease management for diabetes, and COPD, and other conditions. That would benefit customers and society through a reduced future health expenditure but would not be directly profitable for CVS as a standalone pharmacy.

CVS does not invest in those services because it is worried its investments will be captured by another firm such as a health in-

surer, an economic concept we refer to as "hold up." However, a merged CVS-Aetna would make those investments, because it would know that some portion of the merged firm, either the insurance arm or the pharmacy arm, would benefit from the future reduced savings and the increased rates of revenue. It would be beneficial both for consumers and for society.

Despite the potential for value creation, it is still possible the value will ultimately be kept by CVS-Aetna rather than the consumers. How the value is ultimately distributed hinges on whether there is sufficient competition in the health insurance market. Without competition, the merged firm has little incentive to return the value it generates back to consumers in the form of lower premiums.

However, if there is not sufficient competition in insurance markets, policymakers have tools to regulate the future profits of the firms. Note that this is not an option if the value creating activities from the merger never occurs in the first place.

Overall, there are many potential economic avenues whereby this merger would increase value. At a minimum, we know the healthcare market is evolving. Given this fact, we should not imagine that the existing firms have the right combinations of assets and activities to succeed for this newly emerging market. And this merger appears to be one attempt of an example of two firms that are undertaking to address this fundamental reorganization of healthcare. I thank the Committee for having me here today, and I welcome any questions you may have.

Mr. Garthwaite's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-GarthwaiteC-20180227.pdf.

Mr. MARINO. Thank you, Doctor. Dr. Wu.

STATEMENT OF LAWRENCE WU

Mr. WU. Chairman Marino, Ranking Member Cicilline and Members of the Subcommittee, I am pleased to appear before you today to share with you a few observations on the proposed merger, given my experience as an economist who has specialized in healthcare antitrust.

I am Lawrence Wu. I am president of NERA Economic Consulting. For over 25 years, I have had the opportunity to analyze mergers and acquisitions across the spectrum of healthcare services. I am proud to be affiliated with NERA, but the views and opinions I express today are entirely my own. I have not been retained by any party to evaluate the proposed transaction.

Before I share my thoughts with you, let me tell you how I approach transactions like the one we are discussing today. I always start by asking how a proposed transaction is going to improve consumer welfare. In the context of a healthcare merger, this means I focus on whether the transaction is likely to result in lower prices, an improvement in the quality of healthcare provided to consumers, increased access to care, and/or more innovation.

Transactions that lead to such benefits would be called, "procompetitive." Transactions that lead to the opposite outcome would be called, "anticompetitive." This is the same approach that the anti-

trust agencies take as well. So, with that, here are three observations on the proposed transaction.

First, an important characteristic of this transaction is that with the exception of Medicare Part D, prescription drug benefits, the merger combines companies that operate at different points along the pharmaceutical supply chain. This is why many describe the transaction as a vertical merger as opposed to a horizontal merger, which would be a transaction that combines companies that compete in the same market.

This is important, because while vertical mergers can sometimes raise competitive concerns, they also have the potential to reduce costs and inefficiencies along the supply chain, with the result being lower prices.

Second, the importance of MinuteClinics is in their ability to deliver to patients the care they need in a more cost-effective setting. Getting patients to the right place at the right time is currently a major challenge in this country. To give you an example, half of all U.S. hospital admissions come through the emergency department, which is an expensive place for doctors to figure out whether a patient needs to be hospitalized or not.

This is a problem that insurers and providers and healthcare systems have been trying to address for a long time. If the proposed transaction can increase the use of low-cost clinics for diagnostic care, or if it can facilitate the expansion of these clinics, especially in areas where access to outpatient care clinics or urgent care centers is limited, then the proposed transaction is a big step forward.

Third, and my last observation, is based on my experience seeing providers and insurers adapt and try new business models in response to market changes in an industry that is highly dynamic and innovative. Mergers and acquisitions have played an important role in achieving these goals. The proposed transaction is another example of innovation in action.

Clearly, there are many ways for insurers to get cost-effective PBM services and ensure that their subscribers get their medications at a low cost. And there are many ways that providers can encourage patients to use low-cost clinics. Will the merged entity be successful in accomplishing these goals? Well, time will tell, and only time will tell whether the combined firm will pass the market test.

The transaction has the potential to benefit consumers. I am confident that the talented attorneys and economists at the Antitrust Division are working hard to ensure that any potential for competitive harm that they foresee is minimized. If the Antitrust Division finds that the proposed transaction has a low risk of competitive harm, then let's see what innovation flows from the transaction and let the experiment happen. Thank you for convening this hearing. I look forward to answering any questions that you might have.

Mr. Wu's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-WuL-20180227.pdf.

Mr. MARINO. Thank you. Attorney Slover.

STATEMENT OF GEORGE SLOVER

Mr. SLOVER. Thank you. We have been working since our founding in 1936 for a healthcare marketplace that brings quality affordable care to all Americans. One key to making the marketplace work for consumers is meaningful choice, from effective competition, so consumers can shop around. That motivates businesses to respond to consumers' wants and needs with more affordability and better quality, lest consumers go elsewhere.

The healthcare marketplace is complex. Most costs are not directly paid by the consumer, and the ways costs are negotiated and shifted among various commercial actors are often obscured. Active antitrust enforcement can help foster competitive market forces in all parts of this marketplace, from hospitals and medical practices to health insurers, to drug makers, pharmacies, and pharmacy benefit managers.

The CVS-Aetna merger would combine two giants into a new corporate structure, straddling more market sectors and creating new, far-reaching profit-maximizing incentives, impacting all those parts. If CVS-Aetna finds it has new ways to bring down costs and improve quality, what antitrust calls "efficiencies," that can be good for consumers and the economy. We have heard those explained today, and that is the picture CVS and Aetna are painting. Some, or even most, of that picture might prove to be accurate.

For example, encouraging Aetna policyholders to use a CVS MinuteClinic for simple, routine care instead of a hospital emergency room will cut expenses for Aetna. That might be passed along in lower costs or improved service—might. It is far from certain. For one thing, we would need transparency in competition, so those on the receiving end are aware of the savings upstream, and able to insist on a fair share or to go elsewhere. Unlikely in our current healthcare marketplace.

What is more, efficiencies often turn out to be illusory or exaggerated. And when they are real, they can often be achieved without merging. Why does Aetna need a merger to encourage policyholders to visit MinuteClinic instead of an ER? And we could instead see reduced competition, which brings no benefit except to CVS-Aetna.

For example, as we have heard today, CVS-Aetna might tell Aetna policyholders they can go only to MinuteClinic, not to a conveniently located walk-in clinic run by someone else, or might direct them to fill prescriptions only at CVS; or to use MinuteClinic for an expanded set of medical needs instead of seeing their own doctor. Or CVS Caremark might negotiate different, better prescription drug deals only for Aetna insurance, or only for purchases at CVS. The black box surrounding PBM back-end rebates and side agreements makes this area particularly open to anticompetitive abuse.

CVS and Aetna said they would never do any of that. Maybe. But this is not about what present intentions might be, or what is happening now in the marketplace. It is about how incentives and capabilities would be altered by the new, market-straddling corporate structure.

Solo Aetna would encourage policyholders to use MinuteClinics, but would also be fine with them choosing other walk-in clinics.

CVS-Aetna would see a trade-off—MinuteClinic visit adds to profits; going elsewhere means profits forgone. CVS-Aetna would probably still want to do business with those other clinics, but the terms would be more restrictive.

This kind of merger is called "vertical," because CVS and Aetna do not compete with each other, they deal with each other. We have heard about the differences in how you analyze competition issues with these kinds of mergers. It has sometimes been said, though, that vertical mergers cannot harm competition. This is not accurate. The concerns I am describing are squarely within established antitrust law. Forty years ago, they were often being cavalierly dismissed in the so-called "new thinking." But our understanding has evolved and deepened.

The Justice Department is challenging the proposed AT&T-Time Warner merger based on very similar kinds of concerns.

We do not prejudge the outcome of the investigation, but we expect it to be thorough. And for the Department to take action as needed to protect competition.

Genuine risks to competition will not be fixed by pledges of good behavior. As Assistant AG Delrahim recently noted, that unrealistically asks the merged company to make daily business decisions that run counter to its profit-maximizing incentives.

Given the stakes, if the Department takes no action, we will want to know why. Of course, if the Department takes action, we will see a full explanation in the court filings. Thank you.

Mr. Slover's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-SloverG-20180227.pdf.

Mr. MARINO. Thank you. Attorney Manne.

STATEMENT OF GEOFFREY MANNE

Mr. MANNE. Thank you, Chairman Marino, Ranking Member Cicilline, and Ranking Member Nadler, Members of the Subcommittee. Thank you for allowing me to testify before you today. The overriding theme of my testimony is that the proposed merger is a commendable effort by two industry leaders to experiment with substantial reform of what, we can all agree, is a beleaguered healthcare system.

I think it was interesting; one analyst talked about the thinking behind the deal and said, "What if an entire array of services was available at the pharmacy. Better yet, what if it would cost less?"

The advantage is clear. Send the patients to the pharmacy and free up the doctors for more pressing needs. Everyone recognizes the urgent need to realign the healthcare industry. But the extent of agreement that something should be done is exceeded only by the extent of disagreement over what exactly should be done. And I think it is difficult to overstate the singular importance of private sector efforts to try new things in the healthcare industry.

So, in that light, I look at this merger as not as a combination tending to increase or concentrate economic power in the existing industry structure, but as a step toward reorganization of that structure itself in which we do not know where the economic power will lie.

Amidst the typical antitrust concerns about industry concentration or foreclosure, it is often missed, I think, that changes in technology, changes in demand, experimentation with new ways of doing business, virtually always lead to changes in industry structure. Restructuring that may, in the abstract, seem troublesome, is often easily understood as a response to changing market conditions.

Absent overwhelming evidence that the merger would create unacceptable risks of harm, this partnership and some others that I will talk about in second, that try to break down the old paradigms and fundamentally rethink traditional industry models should be welcomed by consumers and lauded by regulators.

It is important that the relevant standard here is not that they demonstrate that they can increase efficiency and pass it all on. The real relevant standard here is that they can demonstrate that they are trying something. They are experimenting. They are doing something new, but most importantly, that they are not harming consumers. Those are very different.

As I said, the importance behind this merger, I think, is a change in the industry. It is a technological evolution particularly with respect to data and data processing abilities and the growing movement away from fee for service care toward value-based care. Taking advantage of these, though, requires large investments in technology, comprehensive tracking of preventive care activities, and health outcomes, and more holistic supervision of patient care. And arguably, all of this may be accomplished more efficiently and effectively by larger, better-integrated firms.

The idea that this kind of combination of diverse aspects of the current healthcare industry might better serve the direction that healthcare is going also comes from the fact that there is a veritable wave of these sort of interesting vertical mergers going on right now. There are a lot of examples, but I want to just draw your attention to two of them that I think are particularly interesting.

So Walmart recently announced a deal with Quest Diagnostics to offer diagnostic testing services and potentially other basic healthcare services inside of some Walmart stores. Now, what is interesting about this arrangement that while it does not necessarily do this right out of the gate, it does portend the possibility of an expansion of the use of patient-initiated as opposed to doctor-authorized tested in States that allow it.

Very much consistent with the direction, I think, of the sort of consumer-centric, outcome-based healthcare and potentially remarkably cost saving. It is something that I do not think Quest would really necessarily be able to accomplish on its own. But in partnership with Walmart, one can easily imagine that happening.

And maybe even more interesting, is the pharmaceutical company Roche announced this month that it would buy cancer data company Flatiron Health, and as it said, "to speed development of cancer medicines," and this is the interesting part, "and help price them based on how well they work."

Now, not only is the deal intended to improve Roche's drug development price pipeline, but it is also aimed at accommodating efforts by other players in the industry to shift the pricing of drugs

toward an outcome-based model. I think that is terrific, and I also think, again, it is driven largely by the technological ability that we have now with the integration of data and other sorts of practices. And as I said, as a part of this transformation in the industry, I think.

So, I think with respect to the Aetna-CVS merger in particular, as we heard this morning, there seem to be a lot of interesting opportunities. And again, I want to highlight just one, because sadly I do not even have time to do that, but I do not even have time to highlight more.

And in particular, I think we heard about the Meals on Wheels program that Aetna runs. Well, they run another program that involves community care managers who typically drive to subscribers' homes. They provide them with advice. They evaluate their needs. It acts on a very small scale, and it requires a lot of driving, it requires special meetings; it is probably not something that most subscribers see as something that sort of fits into the normal course of their day.

But now, imagine that something like, say, and I am making this up, a third of workers in every CVS retail store has specialized training. And these care managers are located in a dedicated space in the store. And they do not interact with just a few patients between scheduled drives, but with hundreds of patients as they pass through the stores. You can imagine something like concierge medicine for the masses. And I think this is the kind of opportunity that this merger presents and exactly what we need in the healthcare industry today.

Mr. Manne's written statement is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-ManneG-20180227.pdf.

Mr. MARINO. Thank you. We now will start with our 5 minutes of questioning, and I will recognize myself. And if I select someone for a question and anyone else wants to respond to it, go ahead, but just bear in mind we are talking about 5 minutes. Dr. Garthwaite, Americans pay some of the highest prices worldwide for prescription drugs. Do you see this merger helping to drive drug prices down?

Mr. GARTHWAITE. I think it is important to think about why we pay the highest prices for these prescription drugs. And I do not think it is a situation in which, you know, we should think about comparing the prices we pay here to the prices we pay in Europe. We should think about the value we get for the dollar in the United States.

I think that what you would see in terms of prices in the United States is that the primary effect here would be on list prices as opposed to the net prices being paid by just sort of rank order. And that is sort of the pre-rebate price that we face. A lot of times, we dismiss that as a fiction, right? No one ever pays that price, we all get discounts.

I would note, though, that increasingly consumers find themselves exposed to those list prices. And that is where, you probably heard a lot from your constituents in the sense that they are in their deductible, or they pay a percentage of the list price for their

coinsurance. I think that is where you would see some incentives to no longer play games to artificially inflate list prices to get high rebates. And you would see an effect there more than you would on sort of the aggregate spending on prescription drugs.

Mr. MARINO. Okay. Dr. Wu, would you care to respond?

Mr. WU. Well, I mean, drug pricing is a complicated topic. And this transaction does not cover all of those issues. But I think this transaction does represent an innovative way to tackle some hard issues that we face. And we need innovation. And this transaction is an example of that.

Mr. MARINO. Attorney Slover.

Mr. SLOVER. Yes, I think the merger is likely to lead to reduced costs within the CVS-Aetna corporate structure. The question is at what cost to the rest of the marketplace? And that is going to depend on other external factors, the competition that is available throughout the marketplace and the competition that remains after the merger and whether any of those costs get passed along to the rest of the market and ultimately to consumers. And that is, I think, going to require a careful look by the Justice Department.

Mr. MARINO. Thank you. Attorney Manne.

Mr. MANNE. I will just say very quickly; I think there are lots of opportunities in this merger to reduce double marginalization at various points in the pharmaceutical supply chain. And so, I think we can all agree that there are reasons to expect that the cost of delivering drugs to patients will go down.

To Mr. Slover's point, I do not see any reason to expect that the merger would portend higher prices for either the customers of Aetna's and CVS' customers or outside the firm elsewhere in the market. And as a result, even if the savings are not passed on, I cannot imagine a story that would explain why things would get worse with respect to drug prices following this merger. And I can certainly see some reasons why I might think they would get better.

Mr. MARINO. Okay. Dr. Wu, United and Humana are both health insurers that also have PBMs. Has there been any antitrust problems or consumer harm based on these companies being both insurers and PBMs that you are aware of? And, again, anyone else can comment on this too.

Mr. WU. I am not aware of any antitrust issues with the integration of PBMs and insurers. Again, this is the market experiment that is taking place. I do not think it is clear if there is one business model that will be more successful or less successful. The integrated model is the structure that CVS and Aetna want to move towards. This is an experiment. Will it work? Will it not work? You know, this is the market test.

Mr. GARTHWAITE. I would also note just broadly that this is also the model that Anthem is moving towards as well as CVS-Aetna. So, you have got all the major insurers looking to this integrated model at this point.

Mr. MARINO. Attorney Slover.

Mr. SLOVER. Yes. PBMs make a lot of their money by negotiating reductions on the price they pay for pharmaceutical drugs and not turning all of that money over to the health insurers. And so, there is definitely a competition issue there. The reason they turn over

what they do is because there are options for health insurance companies to go to a different PBM or to do that service themselves. To the extent that the new market structure and coupled with other consolidation taking place removes those options, it could definitely have an effect.

Mr. MARINO. Thank you. Attorney Manne.

Mr. MANNE. I do have thoughts, but I see the time is up.

Mr. MARINO. We are fine. Go ahead.

Mr. MANNE. Well in case you had another question I thought I would leave it for you. But that is fine. Not surprisingly, I agree with Dr. Wu. I think the most important thing here is once again, it is difficult to see why there would be problems arising from this. And the PBM market such as it is has been kind of in a state of disruption for about a decade now.

And I think it seems pretty clear, as Dr. Garthwaite said, what direction it seems to be heading. But it will not be inexorably in that direction. We will see some other changes happening, too. This seems like a perfect opportunity to try out this particular combination of companies around PBM market, see if it works, and if not, we will continue to try other things, too. I do not see any great problems in that market as it happens.

Mr. MARINO. All right, thank you. The Chair now recognizes the Congressman from New York, the Ranking Member of the full Committee, Congressman Nadler.

Mr. NADLER. Thank you, Mr. Chairman. Mr. Slover, a number of questions for you. The health insurance market is already highly concentrated. According to studies by the AMA, there has been a near total collapse of competition among health insurers. The cost of health insurance has also grown dramatically over the past 30 years. What effect does concentration in this market have on premium growth, worse customer service, or less choice for health insurance options?

Mr. SLOVER. Well, I think your question kind of contains the answer. The more——

Mr. NADLER. Best kind of question.

Mr. SLOVER. The more concentration there is, the fewer choices are available in all levels of the marketplace. And when there are fewer choices, the ones who are offering those choices do not have to try as hard to make those choices attractive.

Mr. NADLER. Thank you. Would the combination of Aetna, a dominant health insurer, with CVS Health, which is the largest pharmacy benefit manager and second larger retail pharmacy, create risks of anticompetitive conduct?

Mr. SLOVER. Yes. It certainly could in some of the ways that I have described. If there is a silo where it is favoring its in-house operations, the question is whether it still has the incentive to make those same offerings available to others and to what extent. I think they will try to have their cake and eat it, too. And so, how that changes will affect the quality of those choices that are still available.

Mr. NADLER. Now, I asked Mr. Moriarty and he says the following is not a concern for reasons you probably heard, but let me ask your opinion. Are you concerned that the proposed transaction would increase the risk of CVS Health steering Aetna enrollees to

its own pharmacies or creating disadvantageous conditions for rivals?

Mr. SLOVER. I do not envision something happening right away that suddenly the merge company wants to lock everybody else out, but it is a question over time. For examples one of the scenarios that was described is CVS taking its MinuteClinics into markets in rural areas or underserved areas where there are no primary care physicians. Well, if they are meeting a need that cannot be met some other way, I think that is an unmitigated good.

But why would CVS stop at that point and say we are only going to offer these profitable services in areas where there are not primary care physicians? They are going to say, "Well, look we have got it established, we will move into the other areas. We can take some of the business away from the primary care physicians." So, it is a continuum, and the question is where the line changes in terms of having your cake and eating it too.

Mr. NADLER. And there are studies that indicate that health insurance premiums and insurer profits tend to rise in the wake of health insurance mergers. Is this also true for vertical acquisitions effecting the availability of health insurance in your opinion?

Mr. SLOVER. I think it is more complicated, as a lot of people have discussed here, how vertical mergers affect the marketplace. They generally do provide opportunities for cost cutting within the new merged entity. Then there is the question of whether those are going to get passed along to others. And then on the other side, there is the potential for foreclosure if it is profitable to the combined entity to freeze out others, or to disadvantage others, or to make life harder for others so that more business comes to it.

Mr. NADLER. And as you note the market for pharmacy benefit managers or PBMs is highly concentrated with just three PBMs accounting for 70 to 80 percent of the market. What effect with the proposed transaction have on competition on the PBM market? And do you believe that consumers would benefit from Aetna entrance into the PBM market through organic growth and competition rather than through this proposed transaction?

Mr. SLOVER. Well, we heard Aetna say that they had already looked at that a few years ago and decided that it did not make sense for them to go into that market themselves, and that they would have a contractual relationship with CVS. I think, absent the merger, they are going to take a fresh look at that.

And if they say, "You know what? It kind of makes sense for us to give this a try, because we really have decided now that we want our own in-house PBM," and they did enter, then it would provide another major competitor in the concentrated PBM marketplace.

Mr. NADLER. Thank you. I have one last question. There is general consensus as you note in your written testimony that behavioral remedies are not an effective tool to address harms to competition in merger enforcement. To the extent the Justice Department determines that there are anticompetitive harms of the proposed transaction, such as increasing the risk of vertical foreclosure or steering by the merging companies, how might they address these concerns? In other words, what mitigation or remedies might there be?

Mr. SLOVER. Well, in a vertical merger, it is very difficult to handle that with divestiture or partial structural remedies, you are really talking about deciding whether or not the merger should be blocked or not. The Department has decided to challenge the AT&T-Time Warner merger for that very kind of reason. If you do not do that, the behavioral remedies may be the only alternative. And so, they can be considered as a last resort but they are very time consuming, very problematic to enforce, and like I said in my written statement, they actually require the merged company to act against its interests——

Mr. NADLER. In other words, behavioral remedies are the only remedies and they do not work very well? Is that your testimony?

Mr. SLOVER. Well, the other remedy is to challenge the merger and say it should not go forward. And then there may be some others. I hope that the Justice Department will look at the full range of opportunities, and will do whatever it can to protect competition.

Mr. NADLER. Thank you. I yield back.

Mr. MARINO. The Chair recognizes Congresswoman Handel from Georgia.

Mrs. HANDEL. Thank you very much, Mr. Chairman. I appreciate it. Dr. Wu, in your opinion, how reliable are the economic techniques that the Department of Justice and FTC regulators use in predicting whether or not a proposed merger will have an anticompetitive impact?

Mr. WU. I am confident that the antitrust attorneys and economists at the Federal Trade Commission and Department of Justice have the tools and talent that they need to address these questions. They evaluate mergers before they happen, and they are also in a great position to evaluate mergers after they happen. And they should evaluate consummated mergers whenever they see problems arise.

Mrs. HANDEL. Great, thank you very much. Mr. Manne, do you have any specific concerns regarding anticompetitive effects from this merger in the insurance marketplace, pharmacy market, or PBM market?

Mr. MANNE. No. I can elaborate a little bit more. I think that some of the arguments that have been suggested, for example, with respect to the possibility that it is more difficult for other insurers to enter because they will not be able to compete unless they also have a PBM or some of the foreclosure arguments that Mr. Slover has suggested. I think all of those actually end up being examples of what they are actually saying this merger to the extent that it creates a more efficient arrangement, it makes it harder for other entities to compete. And that is not a bad thing. That is exactly what we want.

So, there are, you know, some arguments out there, and we do not have enough time to go into them in great detail. But I am not persuaded that any of them are particularly problematic.

Mrs. HANDEL. Okay. And one last question since there has been several references to the AT&T-Time Warner merger. Does the DOJ's challenge of AT&T-Time Warner merger suggest anything about this particular merger?

Mr. MANNE. Is that for me?

Mrs. HANDEL. Yes.

Mr. MANNE. I do not think so, no. I think that the challenge of that merger is absolutely a bucking the trend, and the precedent, and the economics on vertical mergers. I am quite confident that the DOJ will lose that as well which also will mean that there will be no lasting precedent from that challenge. It is a little hard to suss out exactly why they did bring that merger. And, of course, there have been some stories floating around. I do not really have any idea if they are accurate or not. But I actually think that part of the story turns on what AG Delrahim said about behavioral remedies. And it goes to some of what Mr. Slover said.

And I do have one important comment to make on that which is the real problem is not behavioral remedies. The problem is behavioral remedies that have nothing to do with the merger itself. And there are some terrible examples of the DOJ and other agencies engaging in those. Properly applied behavioral remedies are actually effectively just the same thing as saying the DOJ is going to continue to enforce the antitrust laws and make sure that no ongoing behavior causes anticompetitive problems.

For example, if they said, "It would be anticompetitive to engage in certain foreclosure activities, and we are going to apply a behavioral remedy that prevents that." That is no different than the world in which the DOJ has to monitor a company and make sure they do not engage in those allegedly anticompetitive problems.

So, I actually do not think there is any problem with a behavioral remedy here or anywhere else. And I just want to say, of course, that in that last discussion they left off one option which is approve the merger without any remedies at all, of course.

Mrs. HANDEL. All right, thank you very much. Mr. Chairman, I yield back.

Mr. SLOVER. If I could jump in really quick and——

Mrs. HANDEL. I am yielding my time back, sir. Thank you. Mr. Chairman, I yield back.

Mr. MARINO. Your testimony is very helpful. But I would like to ask Mr. Slover, you testified before on behalf of our CREATES Act.

Mr. SLOVER. That is correct.

Mr. MARINO. I remember that. Could you please comment on the CREATES Act? What you think about it? What benefits there are to it? Why if you believe we need it?

Mr. SLOVER. Well, one of the big insights that Congress had many years ago in enacting the Hatch-Waxman Act was that if an easier way could be found for generic alternatives to enter the market, they would be more affordable. Consumers would have greater choice; they would be able to get the drugs that they needed at a better cost. And since then, the brand name drugs have looked for ways to try and throw obstacles in the way of that happening.

And one of the ways that they had been doing that is to block access to the samples, because the generic drug makers need to have the samples to be able to test their drug alongside the brand name drug to show the FDA that they are bioequivalent. So, that is one of the ways that they have impeded the entry of competition for more affordable generics.

Another way has been that there are some drugs that have protocols. There are dangers that are significant enough in misuse or misprescription that they need to have a protocol established to

make sure that that is taken care of properly. And if those protocols are blocked, if the generics are denied access to those protocols, they can also be a hamper from entering the market.

So, the CREATES Act just takes care of those two specific problems. There are others too. But those are two very important ones to take care and so that is why we enthusiastically support that bill.

Mr. MARINO. The CREATES Act, I think you would agree with me, that this all takes place after the patent has expired. Correct?

Mr. SLOVER. A lot of times it is a challenge that is being brought by the generic to the patented drug, and they found a way to successfully challenge the patent.

Mr. MANNE. The access to the sample sometimes happen—that process can start, I believe, before the patent expires, right? I mean all of this is taking place generally at the end of the——

Mr. SLOVER. It is in anticipation of the patent expiring.

Mr. MARINO. You cannot infringe upon the patent.

Mr. MANNE. Right. Well, it would not be an infringement. That is right.

Mr. MARINO. Right. Yes, sir.

Mr. GARTHWAITE. I think you asked earlier about drug pricing as it encourages to the Committee focusing on this issue of generics. Because there are two sets of high drug prices in the United States. There is one for brand name drugs that we think provide this dynamic incentive to get better cures in the future.

And then to your last statement, there is these generic drugs where the patents expired. And we want to do everything we can to push things to marginal cost. And we see an incessant amount of gaming in that area that is causing high prices particularly from very valuable small market drugs.

And so, your ability to influence drug pricing there is going to have far more of an effect on consumer welfare and a far more unambiguous effect on consumer welfare then things on brand name medications.

Mr. MARINO. Manne.

Mr. MANNE. I had one quick comment which is just that as you may know I have written in support of the CREATES Act as well. I submitted some materials for the record. I think it is a great idea. I want to just flag one thing which is that the problems that it tries to solve are not necessarily endemic to the brand patent industry.

There are plenty of actors who are acting perfectly appropriately in that market. And in some ways, I think, it is a relatively small number of potentially bad actors who sort of have been consistently identified. Now, that does not mean that the other ones could not do it, but companies like Pfizer, for example, are not engaging in these practices.

And, so, it is important not to paint with too broad a brush and tar the whole industry when it is not the whole industry.

Mr. GARTHWAITE. These are often non-pharmaceutical companies that are doing this. These are private equity companies coming in. And this is a profitable trade like anything else. This is not large pharma engaging in these tactics.

Mr. MARINO. All right. It has been referred numerous times that this vertical merger is an experiment. And I kind of like that con-

cept. But I think generally speaking and I do not want the public to think that or my constituents to think that we do not know what is going to happen here in this experiment.

So, if you could comment on that, after I state that at any time if we see an antitrust issue particularly on this Committee, we can immediately address that. At any time, DOJ or the Federal Trade Commission can do the same thing. So, we will be watching this. I would not be supporting if this would not be a bipartisan matter, if we did not there was merit to this. There is no such thing as the perfect piece of legislation, but what I think the newer Members of Congress look at, it can always be tweaked.

Just to go along with that, before I went to college and law school I was in manufacturing. And I am a baker by trade actually. And we always tweaked a product to make it better. If one of my supervisor's that worked for me said to me, "We cannot be more efficient," I knew I did not need that supervisor.

And hospitals, the administrators, are constantly calling me about the cost of running an emergency room. And it should be this way, anyone who comes in, they really have to give them care, particularly if it is a life or death situation. But how are the hospitals—what do you think their position is going to be on these urgent cares or clinics, what impact is that going to have on the hospitals? Anyone.

Mr. GARTHWAITE. I think one interesting thing about this is that we have long thought that provider sponsored health plans were coming, and Attorney Manne had spoken about the idea that we are seeing a move away from fee-for-service medicine. What is unique about these mergers is that it is the insurance companies that are buying up providers both United Healthcare buying up ambulatory surgical centers, and CVS-Aetna. But they are not interested in purchasing the in-patient hospital, and that is because in many ways that business is not going to be a very good business to be in going forward. At least that appears the debt people are making.

That if we run these urgent care centers well, if we do a good job with the type of innovation these companies are looking at; we can cut in-patient volumes. And you are seeing declining in beds per capita. You are seeing utilization of the hospital go down.

And so, they are going to be upset in some way because you are taking away their business. But that is not necessarily bad for society. Because for society, it is better. I do not think any of us want to be in the hospital. And so, if you do this right and you reduce in-patient hospitalization, that is a positive from this merger, not a negative.

Mr. MANNE. I totally agree with that and I would just point out also lest we forget the in-patient hospital is itself a vertical and horizontally integrated entity. And there is every reason to expect exactly what I was saying before that when the market conditions change, those kinds of integrations change as well because whatever drove them before may not exist anymore, and vice versa.

And so, for example, the fact that insurers may not be interested in buying in-patient hospitals may indeed suggest that they think that the most efficient form of offering care in the future may change. That does not mean that they are against provider care.

That does not mean they are against anything that is done in the hospital. They may just think that that particular organization is not the most efficient way to do it. I do not know that that is true. But it may very well be the truth.

Mr. MARINO. Dr. Wu and then Attorney Slover.

Mr. WU. Chairman, you are absolutely right that the antitrust agencies are in a good position to resolve antitrust issues when they see it. There is innovation and tweaking on all sides.

For the antitrust agencies, for example, the Federal Trade Commission conducted a major hospital merger retrospective about 10 years ago. That was after the Federal Trade Commission and Department of Justice lost a number of merger cases at trial. They did a fantastic study. They learned what they were doing right. They learned what they were not doing. And it really strengthened their premerger investigations. That is tweaking on that side.

On the hospital side, this is called competition. I know we focused today on the competitive effects of the proposed transaction. But one thing we should keep in mind is the competitive response by rivals, and that includes hospitals who have emergency rooms. And emergency rooms are very important places, but it is not exactly the right place for a lot of the services that people go to. And they will have their challenges too, and I expect them to respond.

Mr. MARINO. I have two more brief questions. But if you are ready to catch a plane, I will conclude. Is everybody all right for now? How about explaining to the public, because I do it all the time in meetings that I have, the difference between the expense of running the hospital and, you know, emergent care? Because a lot of people do not realize the differences between that. I know it and you know it, but as far as the expense of running a whole hospital compared to an emergency room, an operating room, and everything else. So, could any of you shed some light on that?

Mr. SLOVER. Well, not as a healthcare expert but as someone who has had to use the emergency room services a couple of times recently on a doctor's recommendation, I might add, the emergency room is all hands on deck. And it has everything that you could possibly need. So, it is a very expensive proposition because they want to be able to provide anything in an emergency situation.

Mr. GARTHWAITE. I mean, I think hospitals get this wrong a lot when they talk about this as well, right? They did not think about the difference between their fixed and their marginal costs. It is clearly that the hospital is a higher fixed cost. And indeed because having all this all hands on deck side.

The other thing that is very different about the hospital emergency room that is important, and you referenced it earlier, are the regulatory structures that we put on them. In which they are required to treat and stabilize all comers, whereas an emergent care center that does not have an ER is not. And that changes the nature of the payer mix that you have, and your ability to serve the public.

So a well-run ER in a fairly wealthy area is a profit center for a hospital. Even well-run ER in downtown Chicago or on the Southside of Chicago is just a loss. It should not be surprising, right, when the University of Chicago built their new hospital recently and neglected to put an adult trauma center in because of

the negative payer mix that comes with that. So, I think that is a big issue. It is on the cost side, but also on the expected revenue side.

Mr. MARINO. Attorney Manne, you wrote about an ill-advised return to the biggest baddie antitrust of the 1960s and 1970s. Can you elaborate on the risk to consumer welfare from a reflexive opposition to corporate combinations?

Mr. MANNE. At great length, in fact. You know, I think it actually—it bears on a lot of the things we have been talking about. There are certainly circumstances in which, especially at a very horizontal level, an absence of competition can create problems for competitors. We all understand that perfectly well.

But we also understand, and we have heard a lot about—talking about this merger—how the fact that an entity may be somewhat larger than before especially if it grows through a vertical integration does not necessarily mean that its either in a position to, or has any intention of taking advantage of its consumers, or other consumers. And, in fact, those kinds of integrations, the particular agglomerations of skills and resources, and all sorts of other things are in most circumstances and especially when vertical lead to benefits for consumers.

So, of course, stopping that kind of thing simply because it is bigger than what we had before means that the consumers never receive the potential benefits of that. So, the harm to consumers is deterring the creation of what otherwise would be more efficient collections of capital, and of other resources. Because we simply say well, that is bigger, and so we do not like it.

Mr. SLOVER. I think we need to be careful not to create a straw man that is too easy to knock down. I think simply saying big is always bad, and we should always be opposed to any merger because it is always going to make something bigger than it was before the merger is different than saying that the bigger the size that you are looking at, and the bigger a chunk of the market that is going to be captured by that merger; the closer look it needs, because the bigger entity is going to have more ability to potentially cause harm to the marketplace.

If we were talking about a health insurer here that had 5 percent of the market, and PBM that was just a sliver of the market, and a pharmacy chain that was a sliver of the market, and they were all going to try to some new experiment; we would be looking at that much differently than if there was one PBM, one insurer, one pharmacy, and they were all going to unite.

So, somewhere in-between there are infinite shades of difference. And that is why we have an antitrust division taking a close look at this rather than just somebody making a snap judgement.

Mr. MARINO. Antitrust issues are some of the most complicated pieces of legislation to litigate. I clerked for a Federal judge as an intern, and when I was U.S. Attorney we had a civil division. This is just probably some of the most complex areas in the judicial system that there are. But we become smarter at it because of people like you.

And I want to thank you for being here, because I learn something every time I have a hearing. And today's hearing was exceptional with the gentlemen in the first panel, and you. And at the

risk of boring some people, I will not continue questioning because we could do this all night. But I want to thank you so much.

And for the record I do want to enter in two statements. The statement from the National Community Pharmacists Association, NCPA, and a statement from the American Medical Association. Is there any objection? And that is what is nice about being here alone, there is no objection. So these will be answered into the record.

This material is available at the Committee or on the Committee Repository at: https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-20180227-SD003.pdf.

Mr. MARINO. And this concludes our hearing. Again, thank you so much for attending, and you are excused.

[Whereupon, at 4:22 p.m., the Subcommittee was adjourned.]