Statement of Dena Mendelsohn

Senior Attorney

Consumers Union

to the

Department of Managed Health Care

on the

Proposed Acquisition of Aetna, Inc. by CVS Health Corporation

May 7, 2018

Consumers Union, the advocacy division of Consumer Reports,[1] offers this testimony on the proposed acquisition of Aetna, Inc. ("Aetna") by CVS Health Corporation ("CVS"). From its founding over 80 years ago, Consumer Reports has worked for a fair, just, and safe marketplace for all consumers, and to empower consumers to protect themselves. One of our top priorities has always been to make high quality healthcare available and affordable for all Americans. One key to empowering consumers to protect themselves is ensuring meaningful consumer choice, through effective competition.

Meaningful choice can only exist when consumers have access to the information they need to understand and compare the options available to them. Further, when consumers have meaningful choice, businesses are motivated to provide more affordability, better quality, and new thinking, in response to consumers' wants and needs.

Consumers ultimately benefit from competitive marketplaces and meaningful choice, in all parts and all levels of the healthcare marketplace, including where health insurance is sold. The past few years are characterized by a notable increase in health plan and insurer merger filings. We have, as an organization, spoken out when a merger posed particular concern for consumers. In California, we urged our insurance and health plan regulators to oppose mergers that would harm consumers and, if such a merger was finalized anyway, to institute robust contractual undertakings to safeguard the public interest. Nationally, we have supported active antitrust enforcement to promote and preserve competition in all parts of the healthcare marketplace. We have supported antitrust enforcement actions against mergers involving hospitals, medical practices, health insurers, and pharmaceutical manufacturers. And we testified before a Congressional committee on this proposed merger in particular.[2]

[1] Consumers Union is the advocacy division of Consumer Reports, an expert, independent, non-profit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. Consumers Union works for pro-consumer policies in the areas of antitrust and competition policy, healthcare, food and product safety, transportation, financial services, telecommunications and technology, privacy and data security, and other consumer issues, in Washington, D.C., in the states, and in the marketplace. Consumer Reports is the world's largest independent product-testing organization, using its dozens of labs, auto test center, and survey research department to rate thousands of products and services annually. Founded in 1936, Consumer Reports has over 7 million subscribers to its magazine, website, and other publications.

[2] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018 (Testimony of George Slover).

In our written testimony below, we call to the attention of the Department: (I) that being a vertical merger does not eliminate competition concerns; (II) that consolidation may benefit the merging parties but the value for consumers is unclear; (III) that a merged health plan, pharmacy, and retail establishment may mean worse care for patients and may raise privacy concerns. We close with recommended undertakings to ensure that any proposed merger will not be approved unless it is in the best interests of consumers.

I. Being a vertical merger does not eliminate competition concerns

The merger of two corporations such as Aetna and CVS is often referred to as a vertical merger, because, for the most part, CVS and Aetna do business with each other rather than compete with each other. CVS is the second largest retail pharmacy chain, with over 20 percent market share, and almost 10,000 retail locations. It has the largest Pharmacy Benefit Manager (PBM), CVS Caremark, with over 25 percent market share. It also runs more than 1000 MinuteClinics nationwide. It earned $177 billion in revenues last year.

Aetna is the third largest health insurer, by some measures, with over 23 million subscribers in 2016. It deals directly with hospitals, medical practices, and pharmacies from coast to coast. It earned $63 billion in revenues last year. CVS is paying almost $70 billion to buy it. Aetna has a smaller foothold in California than do some other health plans,[3] but it is a non-negligible presence in the state, and one that could very well grow.

Some claim that vertical mergers rarely, if ever, raise competition concerns, citing horizontal mergers as the threat to consumers. In his testimony before Congress, the Executive Vice President and General Counsel of Aetna reminded the committee of the fact that this is a vertical transaction[4] as if that were *prima facie* a reason for less rigorous review of the transaction. Vertical integration may not always trigger alarm to the same extent as the proposed horizontal merger of Aetna and Humana a few years back. As an expert testifying before Congress stated, "the theory and empirical evidence regarding the positive or negative effects of such mergers on social welfare is ambiguous."[5] In the presence of such ambiguity, it is important that our regulators be vigilant to potential threats to the interest of the public.

Vertical mergers are not always inherently harmful to consumers, but they are also neither innocuous nor *de facto* likely to create social value. As I discuss in greater detail below, a company operating at two levels in the supply and marketing chain, if it has enough market power at one level, can arrange its dealings with the other level in that chain to favor itself at that other level – such as, for example, if Aetna were to self-refer to a CVS MinuteClinic. If rivals outside the CVS-Aetna family cannot get favored referrals, or if cost-sharing is structured to disadvantage those rival providers, there will be fewer choice at all levels up and down the chain – including, ultimately, less choice for consumers.

Finally, despite immediate appearances to the contrary, there is also a horizontal dimension to this merger investigation. One of the attractions of this merger to Aetna is that it would have access to its own in-house PBM, in CVS Caremark. But it doesn't need a merger to get one. Indeed, in choosing to integrate Aetna into

---

[3] According to data available via the California Health Care Foundation, in 2016, Aetna had about 680,000 Administrative Services Only enrollees, roughly 140,000 small group enrollees and about 430,000 large group enrollees. California Health Care Foundation, *California Health Insurance Enrollment, 2016*, (February 12, 2018).

[4] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018, (Testimony of Thomas Sabatino, Jr.) at p.6.

[5] *Id*. at p.3.

its portfolio, CVS is choosing against going to the market for the services Aetna provides. Similarly, in agreeing to be acquired, Aetna is opting to use an internal supplier rather than to continue its relationship with other established PBMs or to establish a new relationship with similar services – one of which could be CVS Caremark itself. In the alternative, if this merger is challenged and doesn't go through, Aetna is also in a very good position to establish its own in-house PBM, which would add some much-needed competition to this highly concentrated market sector.

We thank the Department for holding a public meeting and accepting written testimony. We urge the Department to put the full weight of its authority into this regulatory review. If the merger is ultimately approved, undertakings must be carefully crafted to sufficiently compel the merged corporation to act in the interest of its customers.

II. Consolidation benefits the merging parties but the value for consumers is unclear

Some say that mergers within the healthcare system are a necessary response to increased concentration in provider markets, and to conflict and lack of coordination among parts of the system.[6] However, we are not convinced that a mergers arms race is the proper solution, and we are concerned that consumers could ultimately bear the brunt of collateral damage.

Corporate savings from consolidation does not necessarily translate into savings for consumers

While corporations seeking to merge trot out a variety of justifications, a common one is that merging will lead to "efficiencies," with money saved for all. However, we agree with a leading health antitrust scholar that there is "little incentive [for an insurer] to pass along the savings to its policyholders."[7] Furthermore, although it is plausible that stronger market power will strengthen a health plan's negotiating position with providers and pharmaceutical companies, it is also likely that a health plan with control over clinics, pharmacy, and retail space could exercise undue control over the care its members receive, leading to fewer choices and higher prices for that care.

Beyond the prospect of stronger negotiating leverage, the promise of cost-savings being passed along to consumers is not supported by empirical research. We are, therefore, skeptical of the recent statement by CVS's Executive Vice President/Chief Policy and External Affairs Officer/General Counsel, who claimed that this merger would "enhance[the] consumer experience" and "result in cost savings of $6 for every $1 invested."[8] It may be that plans do cut costs by combining some aspects of their operations and by launching new programs. However, evidence suggests that savings from these programs will be limited to small pockets of efficiency. Beyond that, the savings of "more affordable" products could be attributable to lesser quality, reductions in customer service, or excessively narrow provider networks.

---

[6] Indeed, in our work on health insurance rate review, we witness a growing chasm between rate increases for northern California versus rate change in southern California,[#] due at least in part to the consolidation of providers in northern California. For the 2016 plan year, for example, Covered California reported that the "weighted average increase for Southern California consumers who stay in their current plan is … 1.8 percent, while for consumers in Northern California it is 7 percent. Consumers in Southern California can save an average of nearly 10 percent by moving to a lower-cost plan in the same metal tier, while consumers in Northern California would potentially be able to limit their rate increase to an average of 1 percent if they did the same." Covered California press release, 27 July 2015, available at http://news.coveredca.com/2015/07/covered-california-holds-rate-increases_27.html.

[7] Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affairs, 16 July 2015.

[8] Witness statement of Thomas M. Moriary, *infra*, at pp. 4-5.

In fact, it is by no means certain that any savings would be passed along. To start with, the opaque nature of the healthcare marketplace makes it unlikely that there would be adequate transparency and competition. Without these key ingredients, it would be difficult, if not impossible, for consumers to both be aware of the upstream savings, and to be able to insist on a share or else take their business elsewhere. As Professor Garthwaite, an expert in the economics of strategy and healthcare strategy at Kellogg School of Management, explained, "without a competitive market for health insurance, there will be no incentive for the newly merged firm to transfer value to consumers in the form of lower prices."[9]

Furthermore, efficiencies – which companies proposing to merge will always claim – often ultimately are shown, on further examination, to be unsubstantiated or exaggerated. And importantly for a merger investigation, even the genuine efficiencies can very often be achieved by other means without merging, through arm's-length contract arrangements. In the earlier CVS MinuteClinic example, why does Aetna need a merger to encourage its policyholders, in appropriate cases, to go to an alternative care setting such as a retail clinic, instead of to a hospital emergency room? Benefit design with differential cost-sharing and consumer education could accomplish the same purpose.

Moreover, sometimes what are loosely described as efficiencies are revealed, on closer inspection, to involve reducing competition in ways that harm consumer choice and harm quality. For example, CVS-Aetna might decide to tell Aetna policyholders that their coverage only applies if they go to a CVS MinuteClinic, not to a perhaps better, equally or more affordable, and more conveniently located walk-in clinic run by another entity. Or CVS-Aetna might decide to tell Aetna policyholders that they get full coverage only for the MinuteClinic, because it's "in-network," with in-network now meaning it has to be under common ownership. Or CVS-Aetna might decide to tell independent clinics who want to also be in the CVS-Aetna "network" that they must kick back profits, or cut corners on quality of service, in order to meet new "guidelines."

Similarly, CVS-Aetna might now find it to its advantage to steer as many Aetna policyholders as it can into using CVS to fill their prescriptions. Or to steer them into using CVS MinuteClinics for more of their medical needs, and away from their own primary care physicians – even though the primary care physicians have established relationships with the policyholders and can provide better continuity of care.

Or CVS-Aetna might find it to its advantage for CVS Caremark to negotiate different, better deals on prescription drugs only for those who pay with Aetna insurance, or only for those who fill their prescriptions at CVS. Because of the black box surrounding PBM rebates and side agreements, this area is particularly vulnerable to anticompetitive abuse.

We therefore urge DMHC, in the event this merger is approved by antitrust enforcers, to craft undertakings that ensure not only that the asserted "efficiencies" are passed to consumers, but also that any cost savings will not be achieved via reductions in the availability or quality of services.

<u>The unfounded linkage of consolidation and innovation</u>

In our mission to improve affordability and access to healthcare, including high-priced prescription drugs on which more and more consumers rely, we are familiar with the impact of high-cost specialty drugs on

[9] Garthwaite testimony, *supra*, at pp.17-18.

consumers. We are also familiar with, and in support of, new ways of paying for care that prioritize quality over quantity. We therefore welcome Aetna's commitment to "advancing a value-based framework to continue addressing" the important issue of drug costs. However, we question the notion that this insurer must merge with a PBM and retail operator in order to do so. Rather, as with our skepticism that these corporations could achieve efficiencies only after a merger, we also question why a merger is a necessary component to a major health plan giving its members value from their prescriptions. We support innovation that makes high quality products more affordable, improves health outcomes, and makes significant inroads in reducing racial and ethnic disparities. Health plans must be held accountable for assurances such as these so that they are not merely empty, self-interested promises.

Along the same vein, we are skeptical of CVS's assurances that this merger would strengthen "the relationship between the physician and his or her patients."[10] As consumer advocates, we know that a strong doctor-patient relationship is the backbone to high quality care. We do not know, however, why it would take an external PBM and retail business to make that improvement. We also question whether this promise extends to the physician-patient relationship that could exist extramural to a merged CVS-Aetna. And while some of the examples that CVS provided in its testimony to Congress[11] were admirable, it is not clear that CVS intends to offer patients any services that are not already in practice, or why their pharmacists will be better able to "give patients tools to more effectively manage their health"[12] compared to the provider a patient will have already seen before venturing to the pharmacy.

In its review of this proposed merger, we urge the Department to inquire:

- Whether CVS has a detailed plan to achieve an improved doctor-patient relationship;
- Why CVS cannot achieve the same result independent of acquiring the health plan;
- Whether its commitment would remain the same for all its clinic patients and pharmacy customers irrespective of their insurance enrollment and how it will ensure consumers are not unfairly disadvantaged if they are not Aetna enrollees.

<u>The risk that a merged corporation could avoid profit regulations</u>

The Patient Protection and Affordable Care Act (ACA) instituted what is known as the medical loss ratio (MLR) requirements. These regulations require health insurance carriers and plans to spend at least 80% of their premium revenue on medical services of enrollees in the case of individual and small group plans, and 85% in the case of large group plans. Failure to meet or exceed that ratio triggers a mandatory rebate to consumers of the difference. In instituting the MLR, the goal was to rein in insurance and health plan business practices that put profits before patient care.

While MLRs serve as a check on excessive profit-taking, they may be subject to manipulation. As highlighted by Professor Garthwaite before Congress, "there are reasonable concerns that even these MLR ratios serve as ineffective limit on the profits of firms. This is particularly true in markets where insurers and providers

[10] *Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna*, House Judiciary Committee on Regulatory Reform, Commercial and Antitrust Law, 27 February 2018, (Testimony of Thomas M. Moriarty) at p.4.
[11] Witness statement of Thomas M. Moriary, *infra*, at pp. 5-6.
[12] *Id.*, at 5.

are owned by the same firm."[13] Specifically, the concern is that, in a scenario where the health plan (Aetna) and the provider (MinuteClinic) are one and the same, Aetna could raise its premiums as well as its MinuteClinic prices, and in so doing, keep its MLR ratio stable while actually increasing profits, with the cost borne by policyholders.

III. Merged health plan, pharmacy, and retail establishments may mean worse care for patients as well as privacy concerns

A merger between CVS and Aetna would have a significant impact in every part of the healthcare marketplace, combining a major PBM, leading retail and pharmacy chain, and a national health plan into a new type of healthcare entity the likes of which we have not experienced.

Importantly, this merger would combine these entities into a new corporate structure, straddling more market sectors and creating new and potentially far-reaching profit-maximizing incentives, so that what before did not make business sense for each entity separately, now does make sense for them as a combined enterprise. To the extent those new incentives drive the combined company to integrate its resources in new ways to bring costs down and improve the quality of services – what antitrust refers to as "efficiencies" – that can be good for consumers, and good for the overall economy. However, while it is conceivable that some of that picture may prove accurate, it is unlikely that it will be the full scope of changes to how these separate businesses currently operate once the merger alters their incentives. Sitting before Congress, Aetna only offered the hedged assurance that "[o]ur products and services will not initially change."[14] To be sure, it would be surprising for these corporations to merge and make no changes, but we should go into this agreement with our eyes wide open, and without undue reliance on assurances from the parties seeking to merge that doing so will be in the interest of consumers.

As detailed throughout this section, the merger of a pharmacy retailer that regularly tops the list as the most expensive place to fill some prescriptions, a PBM that is known for aggressive practices, and a health plan that in the past has implemented rates found unreasonable or unjustified by the Department, and both of which having recent consumer privacy violations, demands the utmost of regulatory review and begs for undertakings with high benchmarks to ensure the merging corporations do not profit on the backs of consumers.

<u>Vertical integration may limit consumer choice</u>

CVS and Aetna insist that their goals will always be focused on serving as many as they can, as well as they can, as often as they can. However, consideration of whether to allow this merger to occur should not be limited to these corporations' present intentions alone. This review should also be about how their incentives and capabilities would be altered by the new market-straddling corporate structure that the merger would create, and whether this would lead to improved products and services, or would lead to restricted competition and choice, and to poorer products and services.

For example, an independent Aetna would want to encourage its policyholders to use a MinuteClinic in an appropriate case instead of a more expensive emergency room, naturally. But it would also be fine with its

[13] Garthwaite testimony, *infra*, at p.19.
[14] Sabatino testimony, *infra,* at p.6.

policyholders choosing an equally affordable walk-in clinic run by another entity. In fact, that other clinic might be more convenient and familiar to the policyholder, and therefore more likely to be used when appropriate.

But an Aetna merged with CVS could see a trade-off. Every Aetna policyholder who comes to the MinuteClinic brings profits to the merged company. Every Aetna policyholder who goes somewhere else means profits forgone. For the Aetna with no MinuteClinic affiliate, the incentive to discriminate among equivalent clinics is zero. For the Aetna joined with MinuteClinic, the incentive is higher. CVS-Aetna may still be willing to do business with those other clinics, but the terms it wants will change. The line as to where CVS-Aetna can take optimum profit-maximizing advantage will shift. And consumers could find that these other, more convenient and familiar clinics are off-limits, or that they will have to pay more to use them.

Given that Aetna is currently under investigation by the California Department of Insurance for how it makes decisions to deny or cover care,[15] it makes sense to question whether the health plan would use this merger as an opportunity to improve care for consumers or to further limit consumers' access to care.

Exactly how that line would shift requires investigation and rigorous review by regulators such as the DMHC, as well as the Department of Justice under its antitrust authority. We urge this Department to investigate:

- Where all the clinics are, and where the medical practices are, and the hospital emergency rooms, and other facilities, that consumers might want and need as choices, and whether and the extent to which consumers' access and/or choices of provider might be reduced to maximize the merging company's profits.
- How CVS interacts with all of the health plans, not just Aetna but also the ones that compete with Aetna, and how it interacts with pharmacies other than CVS. This includes the rebates and side agreements CVS Caremark has negotiated with the pharmaceutical companies.
- All factors that play into the effects on competition and choice, as those effects vary with the particulars of each affected location.

<u>The risk of costly prescription drugs becoming even more expensive</u>

In the course of our work identifying the lowest cost prescription drug options for consumers, Consumer Reports conducts an annual secret shopper survey of 150 pharmacies in six metropolitan areas nationwide. In our most recent survey, we found that the cost of a standard "market basket" of five commonly prescribed drugs was the highest at CVS and Rite Aid, totalling about $900 for the five drugs as opposed to $66 at an online pharmacy, $105 at Costco, and $107 at individual independent pharmacies.[16] As CVS expands into more neighborhoods and communities, independent pharmacies could be pushed out, either because they are unable to obtain the same arrangements with pharmaceutical manufacturers and PBMs, including CVS Caremark itself, or because they are bought out by the pharmacy retail and PBM giant that is CVS. Although CVS in some locations was able to offer discounts that lowered our shopper's costs – when specifically requested by our shopper – that experience was uneven and unpredictable across multiple

[15] California Department of Insurance, *Press Release: Insurance Commissioner Dave Jones Issues Statement Confirming Aetna Investigation*, (February 12, 2018).
[16] Consumer Reports, *Shop Around for Lower Drug Prices*, (April 5, 2018).

locations. This finding is not reassuring for consumers who would be required by the merged CVS-Aetna to shop for the lowest cost within a single retail chain.

There is no clear reason why standard prescription drugs should cost so much more at CVS than at other retailers, and no reason to believe that CVS would lower the price it charges if it were to enjoy the advantage of a larger market share. Although the Aetna Executive Vice President/General Counsel assured a Congressional committee of Aetna's commitment to "advanc[e] a value-based framework to continue addressing [the] important issue" of high prescription drug costs,[17] that assurance seems less reliable in light of Aetna's proposed partner's current pharmaceutical pricing practices. Furthermore, due to the potential perverse incentives detailed in *The Risk that a Merged Corporation Could Avoid Profit Regulations* section of this testimony, at p.5. *supra*, we are concerned that a merged CVS-Aetna may actually be incentivized to keep its prices high or even raise them, thereby leading to higher health plan premiums, increasing out-of-pocket costs for consumers, and further inflating the cost of care at a macroeconomic level.

Finally, over the years, Consumers Union has called for greater transparency from PBMs – a highly concentrated sector – in their dealings with health plans and pharmacies, as to their true costs and markups, including the rebates and other side agreements they have negotiated on the back end with drug makers. We have endorsed numerous bills designed to rein in the ability of PBMs to increase their own profits by restricting pharmacists from helping consumers find the lowest cost option to fill their prescription. We have reason to believe CVS Caremark engages in this anti-consumer practice. We are also aware of accusations that CVS uses its PBM to undermine independent mom-and-pop pharmacies, a practice that puts CVS pharmacies at a competitive advantage but takes away a vital community asset. Each of these raises concerns for us that an even stronger CVS could be further disadvantageous to consumers.

Potential risks to patient privacy and health data security

Consumers have long been protective of their personal health information. And to safeguard the very personal information that each of us accumulates, laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, in California, the Confidential Medical Information Act (CMIA) are in place. Yet, even with these protections, there are lapses where compliance and/or oversight fall short, or where the laws and regulations fail to completely protect consumers. We believe consumers have reason to be wary of the privacy implications of a merger between Aetna and CVS.

One need look no further than this past year to find a striking example of where both CVS and Aetna carelessly exposed sensitive personal information, violating consumers' privacy. In July 2017, Aetna used window envelopes to mail information on filling prescriptions for HIV medication to approximately 12,000 customers, which in some cases was visible through the window opening.[18] Shortly thereafter, and in a completely separate incident, CVS Caremark mailed pharmacy benefit information in window envelopes to approximately 4,000 customers, with a program code that included "HIV" visible for some through the window.[19] These shocking examples of privacy violations clearly failed to meet already-existing privacy

[17] Sabatino testimony, *infra*, at pp. 5-6.

[18] AIDS Law Project of Pennsylvania, *Federal Lawsuit: Aetna's Envelope Revealed HIV Information of 12,000 Customers in 23 States*, (August 28, 2017).

[19] Consumer Watchdog, *CVS Halts Patient Mailings that Revealed HIV Reference Through Envelope Window*, (September 1, 2017).

protections, and could have been avoided by the simple act of using an envelope without a window or, better yet, a security envelope. Yet both companies made the same mistake within a short timeframe. These easily-avoided incidents suggest a corporate culture where consumer privacy is not a priority.

In this age of vast digital collection of customer data, how data may be used, shared, and secured by a merged CVS-Aetna is another area that should be investigated by the Department. Certainly, it is foreseeable that consumers could benefit from having their information shared within a vertically integrated system rather than between separate organizations. At the same time, though, it must be noted that in combining systems, the newly formed corporation would have a potentially unprecedented understanding of each customer – for better or for worse – with a portfolio of data that comprises consumers' health claims, pharmacy purchases, and retail shopping habits. For consumers, consolidation of their data raises red flags, such as: the possibility that it could be used for unwelcome and potentially invasive targeted advertising or the possibility that it could be used to engage in price discrimination, such as by tailoring coupons offered through the CVS Rewards program. Finally, if all of this consumer data – including healthcare and financial information – is combined or digitally stored together, a breach would be all the more harmful.

We, therefore, strongly urge the Department to evaluate with a critical eye:

- How will policyholders' data be stored, and what security precautions will be taken?
- Will the retail shopping data, including CVS ExtraCare rewards program, be combined with other consumer health data? If so, how would the company safeguard personal health information (PHI) from being shared or sold with other less-regulated customer data?
- How could this comprehensive data set be used?

<u>A larger carrier may be less responsive to rate review</u>

Aetna has a notably poor track record when it comes to rate setting in California. In fewer than three years, DMHC deemed four Aetna rate requests unreasonable, unsubstantiated, and unjustified. In fact, in 2015, "[t]wo thirds of the Department's unreasonable premium rate findings have been for Aetna rate increases."[20] DMHC described Aetna's pattern of unreasonable increases as "price gouging in today's market."[21] Each request impacted over 75,000 members, for a total in excess of 300,000 affected consumers. Upon finding that rate request by Aetna unjustified, DMHC noted that the Plan "failed to provide the DMHC with timely and adequate documentation that would justify the rate increase."[22] Despite the Department's objections, Aetna proceeded with each of its unreasonable rate increases. Large rate increases by Aetna are not limited to its Knox-Keene products. According to a report issued by the California Healthcare Foundation, Aetna increased individual health insurance premiums for some of its California Department of Insurance (CDI) products at a rate higher than average in 2011, 2012, 2013.[23] With increased market power from a merger, it seems highly unlikely that the larger company would improve its responsiveness to regulators or sensitivity to consumer rate burdens.

---

[20] DMHC Press Release, *DMHC Declares Premium Rate Increase by Aetna Unreasonable*, (July 16, 2015).

[21] *Id*.

[22] *Id.*

[23] California HealthCare Foundation, *Individual Health Insurance Premium Growth in California*, (March 1, 2017). In the same timeframe, Aetna increased premiums at a rate below average for three of its smaller products.

We therefore urge the Department to pursue undertakings that hold Aetna accountable for any unjustified rate increases, and that compel Aetna to provide all the required documentation—as defined by state and federal rate review regulations—and to be responsive to regulators throughout the rate setting process.

Recommended steps to protect the interests of consumers should the merger be approved.

If this merger is finalized, consumers need assurances that the newly combined CVS-Aetna corporation will lift up consumer interests and improve their lot—on access, affordability, and quality—rather than leaving consumers carrying the weight of this deal. Undertakings Consumers Union recommends for your consideration include, but are not limited to:

- Health insurance rates: The merged company should agree to not move forward with rate increases in any market segment that DMHC deems unjustified or that contain inaccurate or incomplete information. Given the high risk that the bigger merged company will have higher premiums, it should agree to providing even greater detail, publicly available, to aid DMHC in especially close rate review, particularly during the first years after the merger, and perhaps beyond. Moreover, it should agree that proposed rate increases will be quantified based on Aetna's prior plan year rates, not as a new health plan altogether. CVS-Aetna must not be permitted to finalize proposed premium rate increases deemed unreasonable or unjustified by the Department, and instead should confer with regulators until a reasonable and justified rate is set. This should apply to all lines of business subject to rate review at the time the rate is filed.
- Upholding profit regulations: To safeguard against circumvention of the medical loss ratio, Aetna must commit to inspection by the Department of any potential relationship between how much it spends on enrollee healthcare claims and how it prices its healthcare services and prescription drugs. The Department should also consider whether it is appropriate to tailor a specialized medical loss ratio that would capture claims costs incurred as a result of one branch of the corporation raising healthcare costs on the health plan branch of the organization.
- Enhancing networks: The merged company should commit to improving the network of providers available to consumers, which could include CVS providers such as the MinuteClinics and pharmacy retail centers, but would not be limited to those providers.
- Quality improvement and cost containment initiatives: Existing state law requires that each plan's rate filing include "any cost containment and quality improvement efforts since the last filing for the same category of health benefits plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period".[24] That requirement is unfortunately often honored more in the breach than the observance. CVS-Aetna must be required not only to reinvest profits appropriately in quality improvement and cost containment initiatives, but also to provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each directly benefits policyholders.

[24] California Health and Safety Code Section 1385.03(c)(3).

- Improved quality and consumer satisfaction ratings: Achieving above-average quality ratings as measured by NCQA, Covered California, the Right Care Initiative, the Office of Patient Advocate Quality Report Card, and the Medi-Cal Managed Care Health Care Options Consumer Guide, by no later than the performance measurement period ending December 31, 2019, should be a required condition.
- Protecting consumer privacy: The merged company should commit to creating a corporate culture that values healthcare information privacy and keeps it top-of-mind, from major decisions down to selecting envelopes for mass mailings. Additionally, prior to merging, CVS and Aetna must design and legally bind themselves to undertake a healthcare data security plan that would, for example, require that the merged company store healthcare data separately from financial data, and not combine data from their retail data collection with data from their healthcare providers and health plan.
- Dedicated staffing for transition issues: Whether due to network shifts, information technology glitches or other operational issues, mergers inevitably have bumps in the road that will affect CVS-Aetna and the newly merged company's customers. Consumers Union recommends that DMHC require dedicated, increased staffing—in California and anywhere else trouble spots in the company may arise and need to be rectified—such as personnel to craft provider directories, provide customer service, and ensure that protected health information is continuously secured during the transition and thereafter.

Conclusion

Californians rely on their regulators to act in their best interest. After conducting a thorough investigation, the Department must take whatever enforcement action is warranted and available to the Department to ensure that consumers can benefit from a healthy dose of competition in the healthcare marketplace. If the merger is not blocked under the antitrust laws, we urge the Department to secure substantive undertakings with sufficient teeth to avert potential harms to competition and choice that could result. Genuine risks to competition cannot be contained with pledges of good behavior alone. Although we would be pleased to see the many promised benefits of this integration come to consumers, we are mindful that if they do not, and if this merger in fact erodes access to affordable high-quality care for Californians, that failure to hit the mark will be most keenly felt by consumers. To avoid such an outcome, we urge the Department to use its regulatory authority to positively reinforce, and enforce, any commitments that CVS-Aetna has made in the run-up to their proposed merger. Thank you again for the opportunity to submit in writing our analysis of the risks to consumers from this proposed merger.

Sincerely,

Dena B. Mendelsohn
Senior Attorney
Consumers Union