

CVS-Aetna Merger: Benefitting Consumers' Health, If Not Their Pocketbooks

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In October 2018, the Justice Department gave preliminary approval for the merger of CVS Health, a multi-billion dollar pharmacy company, and Aetna, one of the nation's largest health insurers, two giants in a field that is rapidly consolidating [5]. Both companies maintain that the merger will reduce costs and inefficiencies, but outside groups have concerns about its anticompetitive nature: the Justice Department went so far as to require that Aetna divest all of its Medicare Part D (prescription drug) plans before it would approve the merger [5]. What does this mean for us, as health care consumers? The merger does align the objectives of CVS Health and Aetna with increasing patient health, most notably in creating incentives to reach Aetna customers before their health necessitates a visit to the hospital or another high cost site of care. However, the increased concentration in the pharmacy benefit management (PBM) industry and the anticompetitive effects of vertical integration in the health care industry could wipe out any cost savings for Aetna customers, and could even increase health care spending for consumers as a whole. So, even though the merger could actually

benefit Aetna customers' health, our pocketbooks might not appreciate it.

CVS-Aetna's desire to keep consumers out of high cost sites of care incentivizes providing pharmaceutical and low level care that is both affordable and easily accessible.

Empirical evidence from research comparing Medicare advantage Part D combined and standalone plans shows that the combined plans are more likely to be designed to keep patients out of hospitals, which suggests that a merged CVS-Aetna would be likely to do the same [10, pg. 13]. For example, it's estimated that 67% of patients who put their health—and insurers' bottom lines—at risk by not filling a prescription (in June 2017) did so because of cost [4]. After the merger, CVS Health's pharmacy will have an incentive to keep drugs affordable for consumers and tie drug prices more closely to their efficacy, all in an effort to help patients stick to effective medication regimens and stay healthy.

But cost isn't the only barrier to drug regimen compliance and other aspects of maintaining overall health, and CVS is

uniquely prepared to supply the infrastructure to overcome such obstacles by providing more integrated and supportive pharmaceutical and clinical care. In its investor report, CVS Health outlined a vision of its clinics and pharmacies as community-based sites of care, where patients would be able to visit at a time and location that is most convenient for them, supported by a team of pharmacists, nurses, nutritionists, and other health care providers [2]. Not only would the clinic be a more logistically accessible site of care, but that accessibility would also enable the success of care management programs like medication therapy management [3], which helps patients stick to complicated or difficult medication regimes but requires lots of face-to-face time with a patient [1, pg. 19]. Other kinds of preventative care, like vaccines or blood pressure and heart rate monitoring, could also be taken advantage of with the greater accessibility afforded by the clinic, along with other wellness programs focused on, say, reducing obesity [1, pg. 9]. This kind of convenient and continuous access to care and support is also ideal for managing chronic conditions, whose mismanagement is a major driver of both cost and poor health. In addition, the promised coordination of this new preventative and pharmaceutical care with the rest of a patient's care neighborhood, while logistically difficult, would help ensure that patients have the support they need to maintain or improve their health [1, pg. 9]. However, any possible immediate health benefit of the merger would most likely impact only consumers covered by Aetna; any benefit to the rest of the population will depend on whether or not

other insurers and pharmacies eventually adopt a similar business model.

Cost savings from increased utilization of lower-cost sites of care may not materialize

One way Aetna and CVS Health have claimed their merger will reduce cost is through increased utilization of lower-cost sites of care, such as retail clinics, instead of higher-cost sites of care, like a doctor's office or hospital [2]. In theory, this replacement sounds like a good idea: instead of trying to see an expensive and possibly unavailable primary care physician every time they have the flu, a patient could visit a nearby clinic and receive similar care at a greatly reduced cost. However, recent research suggests that, rather than just substituting for higher cost sites of care, retail clinics actually add to patient demand as consumers seek out care they might have otherwise forgone because of cost [3, pg. 21]. This increased utilization of care may improve patients' health, but will also increase total spending on health care [3, pg. 21].

In addition, some experts have pointed out a mismatch in between CVS Health's pharmacy and clinical capacities, with only 11% of CVS pharmacies containing a Minute Clinic, CVS' retail clinic [1, pg. 21]. In order for Aetna to reap any benefits (economic or other) of driving people towards retail clinics, the clinics need to be accessible to most plan holders, which would necessitate a major expansion of CVS's clinical capacity. However, Minute Clinic growth is slow due to the business' high fixed costs and low profitability, suggesting that such a major expansion of CVS's clinical capacity might not be

economically viable [1, pg. 9]. Given both of these barriers to realizing cost savings from increased utilization of Minute Clinics, it seems unlikely that the merger will significantly reduce costs by substituting low cost sites of care for higher cost ones.

Increased market concentration incentivizes disadvantaging other insurers and pharmacies and discourages the passing of cost savings to consumers

Aetna and CVS Health are both major players in the pharmacy benefit manager business—which includes administering prescription drug plans and negotiating prices from drug manufacturers—so the merger increases concentration in the PBM market. Given that the PBM market is already highly concentrated by nature [6, pg. 10] and both of the other major PBMs have been acquired by or are part of other insurance agencies [1, pg. 6], competition is low and likely to remain low because entry to the market would now require two-level entry [6, pg. 15]. Without sufficient competition, CVS-Aetna would be incentivized to increase in the cost of PBM services for insurers other than Aetna, which could increase the total cost of health care. In addition, the merger provides the conditions for vertical foreclosure, where CVS could raise pharmacy prices for consumers covered by insurers other than Aetna, which would also increase health care spending. This scenario is particularly likely because each insurance customer is 9 times more valuable than a pharmacy customer, so, to gain insurance customers, CVS could disadvantage competing health plans even if it risks losing pharmacy customers [9, pg. 12]. Increased market concentration also de-incentivizes the

passing on of any cost savings or revenue increases to consumers [9, pg. 12]. So, even if the CVS-Aetna merger were to reduce the companies' total spending, it seems unlikely that their customers would see much of that reduction in their own healthcare costs; patients not covered by Aetna could even see them increase.

In order to prevent this possible escalation of costs for consumers, the government could have considered restrictions on CVS-Aetna's profits, as the Affordable Care Act did for insurers. The so-called 80/20 rule in the ACA stipulates that at least 80% of the money insurers take in from premiums must go towards health care costs or activities that improve the quality of care; if that ratio is not met, then customers receive a rebate of part of the premium they paid [8]. If something similar had been done in the Aetna-CVS merger—say, where a certain minimum percentage of profit from pharmaceutical sales must be used to subsidize copays for generic drugs—the company would be limited in its ability to raise prices without at least some benefit to consumers. But, without further regulation by the government, the merger, while showing some promise in its integration of low cost sites of care into a patient's care neighborhood, seems likely to increase spending rather than stabilize it.

Conclusions

Given the possible increase in spending, along with the likelihood that the proposed benefits of the merger would only impact Aetna customers, it seems like the CVS-Aetna merger might hurt the average healthcare consumer. However, most of the proposed benefits of the merger stem from a shift from volume based care, like fee-for-

service, to more value based care: as CVS picks up the tab for later treatment costs, it is incentivized to provide valuable early pharmaceutical and clinical care that is more costly in the short term, but cheaper in the long term. This shift towards value-based care, touted as the future of healthcare, is happening all over the industry—from Medicare, to private insurers like Aetna and Blue Cross Blue Shield, to providers like Partners HealthCare and Trinity Health—and the CVS-Aetna merger will only accelerate it [7]. So, even though the CVS-Aetna merger increases market concentration and raises the specter of inflated prices, we should watch how the innovations that arise from a more value-based care model might change the health care industry in the future.

About the Author

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