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Association of American Physicians and Surgeons, Inc.
A Voice for Private Physicians Since 1943
*Omnia pro aegroto*

February 24, 2020

The Association of American Physicians and Surgeons (AAPS) submits the following comments on the "Draft Vertical Merger Guidelines" announced on January 10, 2020 by the Department of Justice and the Federal Trade Commission.

AAPS is a non-profit membership organization of physicians and surgeons who are mostly in small, independent practices. Founded in 1943 (and celebrating our 77th year), AAPS defends and promotes the practice of private, ethical medicine. AAPS has members in virtually every specialty and State, and AAPS speaks out frequently about issues concerning patients and medical practice.

Harm to patients has been the overwhelming result of vertical consolidation among insurers, pharmacy benefits managers (PBMs), and purveyors of medical care and prescriptions. We are hopeful that the release of the new guidelines signals increased scrutiny of not only future attempted mergers but greater examination of existing vertically combined entities as well.

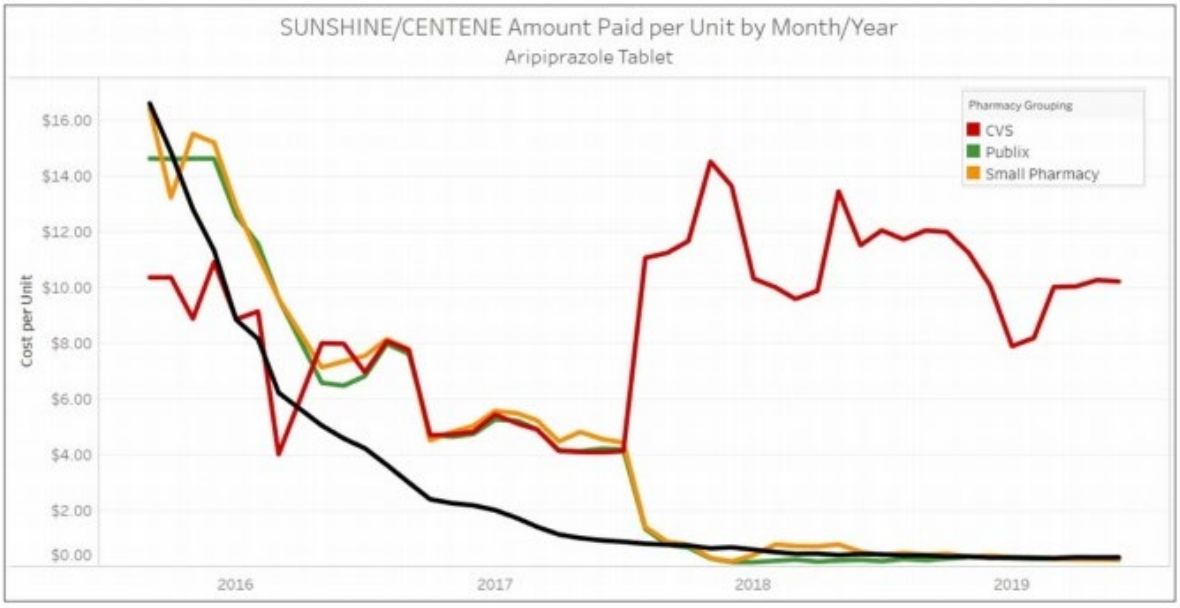
The list of examples of anti-competitive actions among vertically integrated medical industry actors is too long and growing by the day. We would like to use this opportunity to share some examples.

First we would like to offer a specific comment on the draft guidelines. The guidelines state that an activity of concern includes when "the merged firm may be able to raise its rivals' costs by charging a higher price for the related products." In the healthcare arena, when entities own both the health plan and the site of care, a variation of this activity is equally concerning. Here, insurers are reimbursing independently-owned physicians and pharmacies at lower rates than are paid to sites of care owned and operated by the insurance plan.

For example, in August 2017, when CVS Caremark became a Pharmacy Benefits Manager (PBM) responsible for managing drug benefits for Florida Medicaid beneficiaries, reimbursements for certain widely prescribed medications at CVS pharmacies shot up, while reimbursements at competing pharmacies "plummeted below" acquisition costs according to a report released in January 2020 titled, "Sunshine in the Black Box of Pharmacy Benefits Management." (see graph on page 2) https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

We ask the DOJ and FTC to consider adding to the guidelines a statement about this type of activity, i.e. where a vertical merger enables a combined entity to drive the prices obtained by a rival to a price-point below cost, while maintaining higher prices for itself. In situations like these, the patient often does not even directly benefit from the below market prices at the independent providers while taxpayers, employers, and patients shoulder a large portion of higher prices charged by the insurer-owned sites-of-care.

**Figure 9-16: Sunshine/Centene Amount Paid per Unit by Month/Year - Aripiprazole Tablet**




***Source**: 3 Axis Advisors analysis of FL Claims Database, leveraging Medi-Span PriceRx for drug definitions and the NADAC database obtained from Data.Medicaid.gov*

In addition to the striking example outlined above, our patients have already told us personally about the consequences of lack of choice. The wealth of data mined from consolidation is providing companies with a map for increasing profit, without adding value, by steering patients towards vertically integrated subsidiaries.

For example, the combined CVS/Aetna pushes patients covered by Aetna plans into receiving care at CVS-run in-store clinics, instead of from their own trusted physician. *The Wall Street Journal* reports Aetna plans, "have dropped copayments for members if they go to … MinuteClinics" while going to other clinics "would generally require a copay." Similarly, "Blue Cross Blue Shield of Texas ... includes free primary-care visits at clinics it recently opened ... but members who use [independent doctors] would have a copay for primary care visits."

UnitedHealth Group has also already implemented this strategy. After UnitedHealth purchases clinics, (UnitedHealth is now reportedly the largest employer of physicians in the country) it informs patients that they have to sign up with a UnitedHealth-run Medicare Advantage plan or go somewhere else for care. Recently UnitedHealth's Optum subsidiary purchased Southwest Medical Associates and announced it was ending care for traditional Medicare patients — nearly 7,000 seniors in Southern Nevada were threatened with having to find new doctors. The two Medicare

Advantage Plans that Southwest planned to continue to accept are managed by UnitedHealthcare. Due to public outcry, Southwest (the Optum owned clinic) decided to allow existing patients with standard Part B to stay (for now). But any new Medicare patients have to sign up with UnitedHealthcare Medicare Advantage to get care at the UnitedHealth-owned clinic. This is anti-competitive and proves our point that these mergers steer patients both to insurance plans and site of care.

In 2018, about 5,000 Medicare Advantage patients in Central Texas say they were suddenly cut off from their long-time physicians. They received letters from United Healthcare saying in less than a month, they would be assigned new doctors. “It’s more than comfort,” one patient said while explaining why he likes seeing the same doctor. “I come from a family that has a history of a variety of chronic diseases, and so having an internist who is familiar with the early onset of cardiac and other complications that have run in my family [is] something that’s important to me.”

Even more recently, in New Jersey, United Healthcare is “dropping hundreds of doctors in its central and northern New Jersey Medicaid physician network,” NJ.com reports on Feb. 24, 2020. “The insurer appears to be trying to shift patients to Riverside Medical Group, a 20-office physicians’ practice owned by Optum, a sister company of UnitedHealthcare, both of which are subsidiaries of UnitedHealth Group.... UnitedHealthcare is essentially forcing patients to transfer to doctors it controls.”

Humana is also steering its Medicare Advantage enrollees to Walmart primary care clinics (many run by non-physicians) and Walmart’s Medicare drug plan, and is now opening Humana-owned clinics in Walgreens pharmacies.

Meanwhile, pharmacy 'deserts' are appearing in Ohio as independent stores close due to anti-competitive PBM pricing schemes. "When PBMs like CVS Caremark slash rates ... it ends up drying up patient access to health care in communities that typically have the greatest needs.”

Kickbacks in the supply chain may also be exacerbated by vertical integration and often lead to higher-prices for the sickest patients. For example “rebates from Sanofi might have induced insurers to leave [lower-priced insulin products like] Basaglar off their formularies,” reports *Kaiser Health News*. The patients obtaining the drugs frequently see no direct benefit from the rebates, which flows to the PBM or the insurer, and increasingly the PBM and insurer are one and the same.

And the stories go on.

In short, our patients win when there is a competitive market with independent physicians and pharmacies as well as online pharmacies. Such mergers make it nearly impossible for independent pharmacies and stand-alone PBMs to compete. Our patients will see higher insurance premiums, lower quality, and fewer novel insurance products that meet their specific needs.

Please remember, there are patients in behind these headlines that further demonstrate harm due to vertical mergers in the medical supply chain:

“Generic prescription jumps from $45 to $241 after CVS takes over Target pharmacy.”
http://www.latimes.com/business/la-fi-lazarus-20160422-column.html

CVS touts that they're "encouraging the use of lower-cost generic drugs." What they don't say is that CVS is where you'll likely find the highest prices. @ConsumerReports reveals a 1-month supply of 5 common generics would set you back $928 at CVS vs. $105 at Costco. Go #DPC and pay $29. https://twitter.com/AAPSonline/status/986457700782321664

"Independent pharmacists in [Arkansas] raised hell after they said CVS Caremark drastically cut payment rates to independent pharmacies, sometimes below cost, while inflating payments to its own CVS pharmacies." https://www.axios.com/newsletters/axios-vitals-fab5ea3f-d082-408e-b7ec-cb30e09a5aa6.html

"For a bottle of generic antipsychotic pills, CVS had billed Wapello County $198.22. But South Side Drug was reimbursed just $5.73" by CVS PBM.
https://www.bloomberg.com/graphics/2018-drug-spread-pricing/

"CVS PBM paid independent Ohio pharmacist 18 cents per capsule of duloxetine while his wholesale cost is 23 cents. PBM charged Medicaid $1.53 per pill, pockets difference.
https://www.wsj.com/articles/why-cvs-loves-obamacare-1527633490

"A patient with HIV is using an anti-Obamacare provision in the Ohio Constitution to sue the state for forcing him to use CVS pharmacies."
https://twitter.com/AAPSonline/status/1014742237144539136

"CVS wants to be more than just a retail outlet," says Craig Garthwaite, a professor at Kellogg. "They're expanding the retail clinics so they won't be quite urgent care, but they'll resemble a DPC facility."
https://www.npr.org/sections/health-shots/2017/12/04/568292986/with-aetna-deal-cvs-looks-to-turn-stores-into-health-care-hubs

CVS CEO "surprised" by Azar's comments on Rx prices, while hinting at the extent of kickbacks: "Merlo said CVS has kept Rx price growth at 0.2%, despite manufacturer increases near 10%." But how much of the "savings" is passed along to patients?
http://thehill.com/policy/healthcare/395432-cvs-health-ceo-surprised-by-azars-comments-on-drug-prices

CVS PBM allegedly boosts its profits by overcharging insurers for medications while often reimbursing pharmacists less than the cost of the drug.
http://www.dispatch.com/news/20180312/cvs-accused-of-using-medicaid-rolls-in-ohio-to-push-out-competition

"Aetna whistle-blower put on leave last month following unsealing of suit alleging CVS Caremark perpetrated a $1B billing scheme." CVS "said it was unaware who filed the lawsuit until after its parent put out an offer to Aetna."
https://www.beckershospitalreview.com/legal-regulatory-issues/aetna-whistle-blower-put-on-leave-after-accusing-cvs-caremark-of-1b-billing-scheme.html

Hospitals have been closing at a rate of about 30 a year, thanks to mergers and acquisitions, and as "insurers push patients toward online providers like Teladoc Inc. and clinics such as CVS Health Corp's MinuteClinic."
http://www.chicagobusiness.com/health-care/hospitals-shut-30-year-pace-us-no-end-sight

"Cash price for diabetes drug Metformin at CVS quoted to me: $132. It was around $38 at Costco. Local small town pharmacy just sold it to me for $10. Identical amounts."
https://twitter.com/JuneSmith888/status/1001992194578935809

CVS uses its PBM to squash competing pharmacies while lining its own coffers at taxpayer expense, reports @WSJ. Its MO: slash payment rates below wholesale drug costs, overcharge Medicaid, then pocket the spread.
https://www.wsj.com/articles/why-cvs-loves-obamacare-1527633490

“CVS Caremark PBM improperly reported generic drug prices to the federal government, causing Medicare and its beneficiaries to overpay for medicines, while pocketing a difference in pricing,” claims Aetna actuary whistleblower in qui tam complaint.
https://www.statnews.com/pharmalot/2018/04/09/aetna-cvs-medicare-generics/

“CVS Caremark Agrees to Pay $38.5M to Settle Allegations That It Did Not Pass on Rebates, Discounts to Patients, Employers.”
https://web.archive.org/web/20100710023302/http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=50454

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Clearly there is a pattern of anticompetitive behavior among prominent vertically integrated actors in American medicine. And the recently completed CVS and Aetna merger is simply adding fuel to the fire, reports Professor Steven Pearlstein of George Mason University: “a dominant firm in one highly concentrated market [merged] with a dominant firm in an adjacent concentrated market in a way that allows the combined firm to use exclusive dealing and the lack of price transparency to increase its market power and drive independent competitors from the marketplace.”

Allowing such mergers to continue unaddressed means further increases in costs, potential without any corresponding benefit to patients. In fact such integration is lowering the quality of care as well as increasing costs. “In letters to state regulatory boards and in interviews with *The New York Times*, many pharmacists at companies like CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces where they said it had become difficult to perform their jobs safely, putting the public at risk of medication errors,“ reports Ellen Gabler. Meanwhile, a few states, notably, New Jersey, New York, and Texas, continue to block patients from receiving prescription medications directly from their personal physicians who know their patients’ individual medical condition and needs significantly better than employees of these large chains.

In conclusion, we appreciate your attention to our concerns, outlined above, and thank the DOJ and FTC for increased attention to anticompetitive tactics that squeeze competitors out of business and steer patients toward insurer-controlled products, away from alternate sources of care like their trusted independent pharmacists, pharmacies, and physicians. Please do not hesitate to reach out to us for further discussions.

Respectfully submitted,

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