

THE WAVE OF PBM AND INSURER INTEGRATION CONTINUES AS CIGNA AND EXPRESS SCRIPTS ANNOUNCE A MERGER OF THEIR OWN

Last week, Cigna Corporation, the fifth largest health insurer in the country, and Express Scripts, the nation's largest stand-alone pharmacy benefit manager ("PBM"), issued a statement outlining Cigna's plans to acquire the PBM giant for \$67 billion. This deal is just the latest example of a health insurer and PBM joining forces, coming just a few months after news that CVS Health would be acquiring Aetna Inc. for \$69 billion. Only days after news of the Cigna/Express Scripts merger, Centene Corporation announced it had made a major investment, the amount of which has not yet been disclosed, in RxAdvance, a cloud-based PBM led by former Apple CEO John Sculley. In the wake of this recent news, this article will discuss the potential impact of such mergers on health care delivery, along with possible antitrust implications and practical takeaways for providers currently doing business with these entities.

HEALTH CARE DELIVERY: SPOTLIGHT ON CVS AND AETNA

This week, shareholders at CVS Health and Aetna formally approved the merger that would unite CVS's pharmacy and PBM capabilities with Aetna's insurance business. CVS's acquisition of Aetna is a continuation of a years-long process to transition the pharmacy retail company into an integrated health care delivery platform. In their joint announcement, CVS and Aetna described the deal as an opportunity to "redefine access to high-quality care in lower cost, local settings."

Post-merger, Aetna will continue to operate as a stand-alone division within CVS, forming a company with approximately 9,700 pharmacy locations, 1,100 walk-in clinics and more than \$240 billion in annual revenue. For years, CVS sales of general merchandise has struggled as consumers increasingly purchase online or at larger retailers. While CVS aims to utilize the acquisition of Aetna and its 22 million members as a means to get customers in the door, CVS also plans to repurpose space in its stores to provide more room for the higher value health care services. CVS clinics initially offered basic health care services such as treating colds and strep throat but now offer more intensive, and lucrative, services such as specialty pharmacy services, blood draws and the treatment of chronic conditions such as diabetes. CVS has also been testing vision and audiology centers. The goal is to provide the types of services that traditional health care systems offer but improve the patient experience by capitalizing on CVS's accessible locations and utilizing CVS's growing team of advanced practice providers to offer better patient coordination and lower costs.

CVS ultimately aims to capture patients in lower cost settings and attract non-emergency patients from hospitals, which see millions of patients in the emergency care setting every year, for services that could be avoided or directed to an outpatient setting. If the merger survives regulatory approval, CVS and Aetna would have the opportunity to offer patients and employers both access to health care providers (through CVS's MinuteClinics and retail pharmacies) and access to PBM (CVS Caremark) and health insurer (Aetna) coverage in an effort to manage the utilization and costs associated with health care services.

CIGNA, EXPRESS SCRIPTS AND THE ROLE OF PBMS

So what are PBMs and why the rush to partner with them? Prescription drugs account for roughly 12 percent of all medical spending in this country and continue to gain relative market share, as drugs like the hepatitis treatment Sovaldi displace traditional care modalities. The PBM industry manages over \$370 billion of that medical spend, acting as middlemen that employers and health insurers hire to negotiate and manage prescription drug plans and arrangements with pharmaceutical manufacturers on their behalf. PBMs also serve as pharmacy utilization managers. Payers and employers rely on PBMs to assist in addressing rapidly increasing prescription drug spend and utilization in part by implementing prescription adherence and other clinical programs.

Payers who have their own PBMs argue that they are better able to manage the entire patient, as they have access to more valuable health care and utilization data in real, or nearly real, time. Effectively, managing medical costs without managing prescription spend is difficult. And, with prescription drug spending on the rise, PBMs are becoming a highly desirable target for payers.

This is especially the case given the not insignificant fees charged by PBMs for their services, fees which are not particularly transparent and not subject to the level of regulatory oversight applied to many other members of the health care continuum. Currently, the PBM market is highly concentrated with approximately 70 percent of all prescriptions handled by just three PBMs – CVS Caremark, United Health Group-

owned OptumRx and Express Scripts. Theoretically, these PBMs are designed to lower drug prices; however, this theory comes with its share of critics questioning whether they are effective in doing so.

As the largest unaffiliated PBM in the country, many industry experts believed it was only a matter of time before Express Scripts became an acquisition target for a health insurer. In their joint announcement, Cigna and Express Scripts stated that the companies' merger would expand consumer choice by providing medical, behavioral and specialty pharmacy services across a wide array of retail and online distribution channels; increase patient-provider alignment through increased care coordination; and personalize health care for consumers by leveraging data and predictive analytics. However, whether consumers will realize savings as a result of the merger is yet to be determined.

ANTITRUST: WHO WILL REVIEW AND WHERE'S THE HARM?

Before these transactions can be consummated, there are several questions for federal antitrust enforcers to consider as they determine whether to challenge the mergers.

Shortly after the CVS/Aetna announcement, questions swirled as to which federal agency would review the deal. Both the Federal Trade Commission ("FTC") and the Antitrust Division of the Department of Justice ("DOJ") conduct antitrust reviews of proposed mergers. The DOJ has traditionally reviewed transactions involving health plans, while FTC has taken on the responsibility of reviewing deals involving retail pharmacies and PBMs. Because the CVS/Aetna merger involves all three players (a health plan, a pharmacy and a PBM), it was initially unclear as to which agency would review. The DOJ won out and was assigned to review the CVS/Aetna transaction. As such, the DOJ will likely review the Cigna/Express Scripts merger as well.

Over the past two years, DOJ challenged and stopped two health insurance mega-mergers – the **\$54 billion merger** between Anthem, Inc. and Cigna Corp., and the **\$37 billion merger** between Aetna and Humana Inc. The FTC, meanwhile, recently reviewed CVS's acquisition of Target's pharmacy business as well as Walgreens Boots Alliance Inc.'s acquisition of Rite Aid Corp., a transaction that was significantly scaled down to gain approval. Historically, both the FTC and the DOJ have actively challenged horizontal mergers – or mergers between competitors operating in the same product market.

However, CVS's proposed acquisition of Aetna, as well as Cigna's proposed acquisition of Express Scripts, is considered a vertical merger. Vertical mergers involve firms in a buyer-seller relationship. While vertical mergers tend to have less adverse competitive effects, and therefore have typically evaded attention of the agencies, new DOJ Assistant Attorney General for the Antitrust Division Makan Delrahim recently criticized past DOJ settlements that allowed vertical mergers with behavioral restrictions, such as internal firewalls or limitations on rate increases, arguing that these conditions don't work and force antitrust enforcers to become monitors and regulators. The DOJ backed up these comments shortly thereafter by challenging AT&T's vertical acquisition of Time Warner Cable.

The question the DOJ will be trying to answer is whether these mergers between PBMs and health insurers will harm consumers, either through higher prices or reduced access to health care products and services. In these cases, the fear is that the acquiring company (i.e., CVS or Cigna) will use the power they have in one product market (i.e., the PBM market) to force consumers to another product market (i.e., the health insurance market or the retail pharmacy market), potentially foreclosing a more efficient rival and leading to lower competition, increased prices or decreased consumer choice. Recently, CVS announced that the DOJ issued a "Second Request" for more information relating to the transaction. This shows that the DOJ is taking a hard look at the potential competitive effects of this transaction. Unlike the recent health insurance mega-merger cases, which saw the DOJ challenge the transactions and win based on more traditional horizontal merger grounds, vertical mergers are viewed as being more complementary and harder cases for antitrust enforcers to win.

Undoubtedly, CVS and Cigna will make the argument that a vertically integrated firm with multiple health care products is more efficient and actually increases competition by allowing the merged firms to compete more effectively against rivals such as United Health Group, the country's largest health insurance payer, and its wholly owned PBM, OptumRx. Further, the parties will likely point to the fact that OptumRx is currently offered as a PBM option to other payers, undercutting any argument that the transactions will foreclose rival payers from PBM products. There are arguments on both sides of the antitrust analysis, so it will be interesting to see whether DOJ challenges one or both of these transactions on antitrust grounds.

PRACTICAL TAKEAWAYS

The news of the CVS/Aetna and Cigna/Express Scripts mergers is likely to be just the start of a series of shifts in the health care

landscape.

- Providers should be aware of any potential business impacts of the proposed mergers on their existing payer and PBM contracts. These include pricing leverage, network access and forced or unforced patient steerage concerns. To the extent possible, providers should review their payer and PBM agreements to determine what, if any, assignment and termination rights they may have. Providers may also want to take steps to lock in favorable rates negotiated with payers or PBMs involved in these acquisitions.
- In the wake of the merger announcements, and given the agencies' ongoing success in challenging horizontal provider mergers, providers may need to more actively focus on their own opportunities for vertical consolidation and integration by exploring opportunities such as forming PBM functions and establishing and growing new clinical and care coordination operations including retail clinics, mail order pharmacy operations and care coordination/medication therapy management services.
- In January, Amazon, Berkshire Hathaway, Inc. and JPMorgan Chase & Co. announced a joint plan to form an independent health care company focused on lowering costs for their U.S. employees. Many view Amazon's entrance into health care as a threat to PBMs and retail pharmacies, and some see CVS's acquisition of Aetna, as well as Cigna's acquisition of Express Scripts, as an attempt not only to disrupt health care delivery but also to preempt any impact Amazon may have on their PBM and retail revenue streams. Providers should consider ways in which they might similarly partner with logistics providers in order to facilitate ease of use and the patient care experience in response.

In sum, CVS's proposed acquisition of Aetna, and Cigna's of Express Scripts, would make these entities much larger players in the health care system. Moving forward, providers should consider the strategic and competitive opportunities and implications that may arise from their increased role and influence.

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