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# **The Negative Consumer Effects of Corporate Mergers on Life-Saving Drug Availability**

*John Marshall*

## ABSTRACT

As the market for pharmaceutical drugs has grown, pharmacy benefit managers (“PBMs”) have been able to carve out a niche market for themselves and have become extremely profitable. However, their ability to regulate medication prices may be compromised through mergers with other entities involved in the complex pharmaceutical market. As illustrated by the CVS and Aetna merger, it is clear that a more effective regulatory body must step in or be formed to ensure that private companies cannot exploit individuals who rely on these life-saving drugs.

## I. INTRODUCTION

Pharmacy benefit managers, also known as PBMs, may be the largest, most profitable group of businesses that no one knows about. In 2016, PBMs managed pharmacy benefits for 266 million Americans,<sup>1</sup> and in 2017, the biggest PBMs had higher revenues than the biggest pharmaceutical companies.<sup>2</sup> For example, Express Scripts, one of the largest PBMs, reported \$100 billion in revenue while the pharmaceutical giant Pfizer reported revenues of \$52 billion.<sup>3</sup> PBMs have effectively created one of the most profitable business models in the American economy, and they have done so without alerting the general public to their existence.<sup>4</sup> How have PBMs managed this massive rise, and how does the CVS-Aetna merger affect this ever-growing market?

This Article will explore the nature of PBMs, starting with their historical model and continuing into the modern model used today. Next, this Article will discuss the advantages and disadvantages of the PBM system, and how the system has responded in an ever-changing health-care economy. Finally, the Article will suggest possible avenues for reform.

## II. HISTORY OF PBMs AND THEIR FUNCTION IN THE MODERN AMERICAN MEDICAL SYSTEM

In 1968, Pharmaceutical Card System Inc. was founded and became the first Pharmacy Benefit Manager, also known as a PBM.<sup>5</sup> Before PBMs, prescription drug coverage was administered separately from medical and hospital benefits of health insurance.<sup>6</sup> In 1960, eight years before PBMs were introduced, the outpatient prescription drug market was only worth around \$2.7 billion, with 96% of the retail prescription drug market in the United States being financed out-of-pocket by individuals.<sup>7</sup> Employers began to offer prescription drug coverage as medications became more effective, and subsequently more expensive.<sup>8</sup> As time progressed, more and more of these new plans were administered by PBMs.<sup>9</sup> As out-of-pocket financing for prescription drugs decreased,<sup>10</sup> PBMs became increasingly profitable. In

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1. Cole Werble, *Health Policy Brief: Pharmacy Benefit Managers*, HEALTH AFFAIRS, at 1.

2. Kevin A. Schulman & Barak D. Richman, *The Evolving Pharmaceutical Benefits Market*, 319 JAMA 2269, 2269 (June 12, 2018).

3. *Id.*

4. See U.S. Pharmacy Benefit Management Market Size, Share & Trends Analysis Report By Business Model (Standalone, Health Insurance Providers, Retail Pharmacy), By End Use (Commercial, Federal), And Segment Forecasts, 2019–2026, GRAND VIEW RESEARCH (Mar. 2019), <https://www.grandviewresearch.com/industry-analysis/us-pharmacy-benefit-management-pbm-market#:~:text=Industry%20Insights,9.2%25%20over%20the%20forecast%20period>.

5. Brian S. Feldman, *Big Pharmacies Are Dismantling the Industry That Keeps US Drug Costs Even Sort-of Under Control*, QUARTZ (Mar. 17 2016), <https://qz.com/636823/big-pharmacies-are-dismantling-the-industry-that-keeps-us-drug-costs-even-sort-of-under-control/>.

6. Schulman & Richman, *supra* note 2.

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.* (out-of-pocket financing refers to money that is not reimbursed by an insurance company).

1990, the prescription drug market was valued at approximately \$38 billion.<sup>11</sup> However, only 57% of the payments were out-of-pocket, a precipitous drop from 96% only 30 years earlier.<sup>12</sup> Out-of-pocket financing continued to decline throughout the 20<sup>th</sup> and into the 21<sup>st</sup> Century,<sup>13</sup> while the market for prescription pharmaceuticals skyrocketed from \$121 billion in 2000 to \$360 billion in 2017.<sup>14</sup> This rapid growth has not only allowed for PBMs to exist, it has enabled them to flourish.

Drug manufacturing companies began to acquire PBMs during this age of massive growth in the prescription pharmaceutical market.<sup>15</sup> The acquisitions were quickly undone by the Federal Trade Commission (“FTC”) because of the sizable conflicts of interest these acquisitions would provide.<sup>16</sup> If these deals were allowed, it would enable pharmaceutical manufacturers to set pricing policies, obtain sensitive information from their competitors, and push their own drugs over their competitors—regardless of value to the patients.<sup>17</sup> In the late 1990s, as a result of the actions of the FTC, pharmaceutical manufacturers began to sell PBMs to make them private, independent companies.<sup>18</sup> PBMs continued to be independent until the past decade, when pharmacies began to take a swing at acquiring PBMs.<sup>19</sup> However, PBMs have also faced heightened scrutiny in recent years, including 17 lawsuits against American PBMs for fraud, antitrust, and deception from 2005 to 2015, seven of which came in 2015 alone.<sup>20</sup> In 2016, Great Lakes Medical Pharmacy accused Express Scripts of violating antitrust laws by not allowing most unaffiliated pharmacies into its Medicare Part D network.<sup>21</sup> The suit, filed in the Eastern District of Missouri, alleged that Express Scripts terminated the relationship between the two parties without cause despite Great Lakes participating in the Express Scripts network from October of 2012 to October of 2015.<sup>22</sup> Although the parties later settled out of court,<sup>23</sup> it is safe to assume antitrust suits against PBMs are not going away.

However, before detailing antitrust issues in mergers involving PBMs, it is important to understand their business model. Since their creation, PBMs have functioned as a complicated private regulator between pharmaceutical manufacturers, pharmacies, and insurance companies.<sup>24</sup> For health insurers, PBMs develop and maintain lists, also known as formularies, of covered medications for health

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11. *Id.*

12. *Id.*

13. *Id.* (down to 13% in 2017).

14. *Id.*

15. Feldman *supra* note 5

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.* (showing CVS purchased Omnicare for \$12.7 billion and Walgreens announced their intention to purchase Rite Aid for \$17.2 billion.)

20. *Id.*

21. Michael Scott Leonard, *PHARMACY ACCUSES EXPRESS SCRIPTS OF BLOCKING RIVALS FROM ITS NETWORKS: Great Lakes Medical Pharmacy v. Express Scripts*, 24 No. 8 WESTLAW JOURNAL HEALTH LAW 8, 1 (2016)

22. *Id.*

23. Great Lakes Medical Pharmacy, LLC v. Express Scripts, Inc., No. 4:16-CV-01973, 2017 WL 4169846 (E.D. Mo. July 24, 2017).

24. *Pharmacy Benefit Managers and Their Role in Drug Spending*, THE COMMONWEALTH FUND (April 22, 2019), <https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending>.

insurers, which are then able to be obtained by the companies' insured.<sup>25</sup> The formulary indicates the co-pay required by insurance agencies, as well.<sup>26</sup> PBMs also help to determine out-of-pocket costs of these medications for the insured.<sup>27</sup> Insurance companies also pay PBMs to "use their purchasing power to negotiate rebates and discounts from drug manufacturers."<sup>28</sup>

There are extensive negotiations that occur behind the curtain of prescription medications.<sup>29</sup> PBMs are hired to coordinate the sale and reimbursement of prescription drugs between insurers, pharmaceutical manufacturers, and pharmacies on the local and national level.<sup>30</sup> In return for this service, PBMs give their employers "industry specific knowledge not found in most human resources departments,"<sup>31</sup> and negotiating power due to their large patient pool that helps purchasers acquire rebates and discounts from manufacturers and pharmacies.<sup>32</sup> Of these duties, the PBM business model heavily depends on their ability to control pricing mechanisms.<sup>33</sup>

In the past, PBMs functioned based on fees charged to their employees.<sup>34</sup> Recently, however, there has been a shift in that dynamic.<sup>35</sup> The new model revolves around "three important pricing measures for prescription drugs: Wholesale Acquisition Cost (WAC), Average Wholesale Price (AWP), and Average Manufacturer Price (AMP)."<sup>36</sup> The WAC functions as an equivalent to the manufacturer's suggested retail price.<sup>37</sup> However, the WAC is only sometimes relevant when it comes to the pricing of drugs.<sup>38</sup> The AWP "is an industry-wide published list of prices, primarily used by wholesalers selling to pharmacies."<sup>39</sup> Pharmacies do not pay this price, however, and instead only use the AWP as a basis for the price used during negotiations with PBMs.<sup>40</sup> Finally, the AMP is the average price that manufacturers receive for a certain drug from either wholesalers or pharmacies, including any discounts or rebates unrelated to PBMs.<sup>41</sup> While there are other metrics used for generic drugs, the three metrics listed above are the most important when discussing the business model of PBMs.<sup>42</sup>

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25. *Id.*

26. *See Id.*

27. *Id.*

28. *Id.*

29. Mark Meador, *Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry Through Regulations*, 20 ANNALS HEALTH LAW 77, 77 (2011).

30. *Id.* at 78.

31. *Id.* at 79.

32. *Id.*

33. *Id.*

34. *Id.*

35. *See Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *See Id.* at 80-81. ("Generic drugs are subject to a different price list, the Maximum Allowable Cost (MAC). Unlike the AWP, however, there is no one standard MAC price list, but rather a range of acceptable prices. While they view the MAC as "an upper payment limit," most plan sponsors are unaware that "PBMs use lower MAC prices to reimburse pharmacies, while charging them higher MAC prices, increasing the spread retained by the PBM.")

PBMs negotiate the discount off the AWP as the reimbursement rate to pharmacies for a drug.<sup>43</sup> This discount is then shared when the PBM charges the insurer whose insureds purchased the drug.<sup>44</sup> Therefore, the discount the PBM can obtain is a major selling point in attracting insurance providers looking for the best deal.<sup>45</sup> Further, the more clients a PBM has, the more bargaining power they have, as they control which pharmacies will be available to the vast array of patients the PBM's clients control.<sup>46</sup>

While PBMs do make a sizable profit negotiating with insurance companies, the majority of their income comes from rebates.<sup>47</sup> Manufacturers offer rebates to PBMs that are based on the amount of market share increase the PBMs give the manufacturers for a certain drug.<sup>48</sup> Often PBMs withhold from insurers information regarding rebates, as PBMs are not required to share such details.<sup>49</sup> Generally speaking, PBMs simply pocket the money from the rebate they receive.<sup>50</sup>

For example, say Delta, a PBM, negotiates a deal between ACME, a drug manufacturer, Omega, an insurance company, and Beta, a pharmacy. The deal consists of the PBM placing ACME's new drug (a revolutionary high blood pressure medication that will dominate the market when it is released) on their formulary, making it available to all patients insured by Omega. Beta wants the business from this new drug, and they know they must go through Delta to receive it. After going through Delta, Beta receives a discount off the AWP from Delta. Because this new drug is so fantastic, it dominates the high blood pressure market and ACME begins to receive a huge amount of the market share. ACME then pays Delta a rebate based on their new market share, which Delta pockets as profit. Despite doing little more than simply negotiating a deal between ACME, Omega, and Beta, Delta has made a significant profit. Delta can further amplify these profits by negotiating with more pharmacies to sell the drug, thus leading to a higher market share and higher rebates. It pays to be the middleman.

At the center of all these transactions is the formulary. Most formularies are comprised of three tiers.<sup>51</sup> The first tier consists of generic drugs that have the lowest co-pay.<sup>52</sup> The second tier consists of preferred name-brand drugs, for which the PBMs obtain the highest rebates.<sup>53</sup> Finally, the third tier consists of non-preferred name-brand drugs, which have the highest co-pays.<sup>54</sup> The financial incentives for PBMs arguably run counter to that of everyday patients. Mark Meador writes:

For example, assume drug A costs \$50 and the PBM will keep \$5 of the rebate from the manufacturer, while drug B costs \$100 and the PBM will keep \$6 of the rebate. The PBM has an incentive to promote drug B, even though drug A is more cost efficient for the plan sponsor, because it will see a larger rebate.<sup>55</sup>

43. *Id.* at 81

44. *Id.* (Put simply, this discount trickles down to the buyer, so the average consumer, theoretically, pays less for their prescriptions.)

45. *Id.* at 82.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *See Id.*

51. *Id.* at 83.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

This issue is compounded because of what the PBMs' formularies contain. Since prescription drugs are necessary for much of the American population, and PBMs service over 266 million Americans,<sup>56</sup> it seems as if PBMs can exploit the American populace for a higher rebate. The question then becomes whether the benefits of having PBMs in our healthcare market outweigh the costs.

### III. ADVANTAGES AND DISADVANTAGES OF THE PBM MODEL

While there are undoubtedly issues with the PBM business model, it is not without merit. Some argue that through negotiating discounts with pharmacies and manufacturers, using less expensive drug alternatives when appropriate, and filling prescriptions for those who have chronic conditions by mail, the PBM business model helps consumers and other third parties save billions of dollars each year.<sup>57</sup> In support of this argument, some research indicates that consumers with PBM-administered prescription drugs pay anywhere between 15% to 50% less for drugs than non-insured customers buying the same drug.<sup>58</sup> PBMs have demonstrated, on average, 18% lower prices on brand name drugs when compared to the prices that non-covered customers pay for the same drug.<sup>59</sup> In addition, non-covered consumers paid 47% more than PBM-covered customers for generic prescription drugs.<sup>60</sup> As mentioned before, the discount that is negotiated in the AWP is often passed on to the customer, which helps to increase the discount received by the patients served by the PBMs.<sup>61</sup>

Another benefit of PBMs is their extensive use of mail-order pharmacies. Mail-order pharmacies help those who are unable to travel to pharmacies for their prescriptions by giving larger prescription sizes, dispensing more formulary drugs that give manufacturer rebates to the PBMs, and increasing substitution from name-brand pharmaceuticals to generic ones, saving the customer more money in the process.<sup>62</sup> The average price paid by consumers for brand-name prescription drugs dispensed by mail-order pharmacies was 27% less than the price that those without coverage paid at retail pharmacies for the exact same drugs.<sup>63</sup> The gap for generic drugs was even larger, with mail-order prescriptions costing 53% less than what consumers without coverage paid at retail pharmacies.<sup>64</sup>

Finally, because PBMs compete, there is a vested interest in trying to maintain low costs.<sup>65</sup> PBMs act much in the same way a regulator would, using the leverage they have vis a vis the large patient pools in their control, to force drug companies to sell their drugs at discounted rate, therefore keeping drug prices lower for the consumer than they otherwise would be.<sup>66</sup> But, it is important to note that while there may be incentive for PBMs to push more expensive drugs, they also have a

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56. Schulman & Richman, *supra* note 2.

57. Joanna Shepherd, *The Fox Guarding the Henhouse: The Regulation of Pharmacy Benefit Managers by a Market Adversary*, 9 NW J.L. & Soc. POL'Y 1, 2 (2013).

58. *Id.* at 3.

59. *Id.* at 7.

60. *Id.*

61. Meador, *supra* note 30, at 81.

62. Shepherd, *supra* note 58, at 8.

63. *Id.*

64. *Id.*

65. Meador, *supra* note 30, at 81-82.

66. *Id.* at 81.

vested interest in gathering business by keeping prices low for insurers and their customers, so Mark Meador's aforementioned example earlier may be an overblown concern.

However, unlike government regulators, PBMs can be bought by any other corporation involved in these complex transactions.<sup>67</sup> This prompts serious concerns over antitrust issues regarding a single company having too much control over the complex market in which PBMs exist.<sup>68</sup> To illustrate, let us return to the example given earlier with DELTA, ACME, OMEGA, and BETA. Imagine, instead of dealing with separate entities, DELTA was purchased by OMEGA. Because OMEGA has DELTA's formulary, including the new blood pressure medication, they can not only control which pharmacies their customers have to go through to obtain the drugs, but they could also control the medications listed on their formulary. Given the fact that the highest rebates come from drugs on the second tier<sup>69</sup>, which are preferred name-brand drugs, OMEGA would have a vested interest in pushing high priced drugs on their customers, while also limiting their own co-pays.

#### IV. THE CVS-AETNA MERGER

For a real-world illustration of possible negative ramifications from a merger in the PBM industry, look no further than the CVS-Aetna merger. On November 28, 2018, CVS formally completed their acquisition of Aetna, a prominent health insurance provider.<sup>70</sup> CVS also owns Caremark, a large PBM.<sup>71</sup> This means that CVS now controls a huge PBM, a nationwide pharmacy system, and an insurance provider whose network includes approximately 22.1 million medical members, 12.7 million dental members, 13.1 million pharmacy benefit management service members, 1.2 million health-care professionals, 700,000 primary care doctors and specialists, and 5,700 hospitals.<sup>72</sup>

The proposed merger was vehemently opposed by many actors in the health care market, but perhaps the most prominent detractor was the American Medical Association ("AMA").<sup>73</sup> The AMA filed a 141-page brief that argued the proposed merger would break federal antitrust law and significantly harm patients.<sup>74</sup> In the AMA's brief, they argued that the merger would "likely substantially diminish competition in many health care markets to the detriment of patients."<sup>75</sup> AMA President Barbara McAneny, M.D. raised concerns that while CVS and Aetna described the merger as a vertical merger that involves two companies that do not operate in the same market, the merger may actually be horizontal because the two companies

67. See Schulman & Richman, *supra* note 2.

68. See Meador, *supra* note 30, at 85.

69. *Id.* at 83.

70. *A New Path to Better Health*, CVS HEALTH, <https://cvshealth.com/aetna> (last visited Apr. 5, 2020).

71. David Dayen, *Why the Aetna and CVS Merger Is So Dangerous*, THE AMERICAN PROSPECT (October 12, 2018) <https://prospect.org/economy/aetna-cvs-merger-dangerous/>.

72. *Aetna Facts*, AETNA, <https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html> (Last visited Apr. 5, 2020).

73. *CVS-Aetna merger*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/delivering-care/patient-support-advocacy/cvs-aetna-merger> (Last visited Apr. 5, 2020).

74. *Id.*

75. *AMA urges DOJ to challenge CVS-Aetna merger*, AMERICAN MEDICAL ASSOCIATION (Aug. 8, 2018) <https://www.ama-assn.org/press-center/press-releases/ama-urges-doj-challenge-cvs-aetna-merger>.



acted as rivals in the stand-alone Medicare Part D prescription drug plan market and the PBM services market.<sup>76</sup>

The brief presented by the AMA relies heavily on the idea that the merger is a “horizontal merger” and not a “vertical merger.” Briefly, the term “vertical merger” refers to a merger where the merging companies exist in the same industry but sell different products.<sup>77</sup> For example, if Dell, a computer manufacturer, were to merge with a company that strictly made mousepads, it would be a vertical merger. The merger would be vertical because the mousepad manufacturer and Dell are involved in the same market, but do not compete with one another directly. Conversely, a “horizontal merger” is a merger in which two companies that sell similar products in the same market merge together.<sup>78</sup> To go back to the previous example, if Dell were to merge with a different computer manufacturer, then the merger would be horizontal, as the two companies sell similar products in the same market. As a result, horizontal mergers decrease competition in the market.<sup>79</sup>

With regards to the CVS-Aetna merger, the AMA argued that the merger was “expected to increase premiums due to an increase in market concentration in 30 of 34 Medicare part D regional markets.”<sup>80</sup> In 10 of those markets, the merger would exceed the threshold set by federal antitrust guidelines, therefore categorizing the merge as “presumed likely to enhance market power.”<sup>81</sup> The brief submitted by the AMA also pointed to the fact that both Aetna and CVS have large shares of the already concentrated PBM market.<sup>82</sup> The AMA used this point to express concern that the merger could violate the competitive guidelines set forth under federal antitrust laws.<sup>83</sup> As the AMA puts it, “With the acquisition of Aetna the PBM market would lose a national health insurance company with an established brand, a significant customer base, expertise, capital, and years of experience as a major player in the PBM market.”<sup>84</sup> Dr. McAneny expressed this point more directly, stating, “There is every indication that extensive vertical integration resulting from the proposed merger would raise prices, reduce choice and stifle innovation in markets for PBM services, health insurance, retail pharmacy, and specialty pharmacy.”<sup>85</sup>

In response to these concerns, the government allowed for the merger to proceed under a proposed remedy that contained five major components:

First, CVS must divest both of Aetna’s individual PDP [prescription drug plan] contracts with the Centers for Medicare and Medicaid Services....Second, the proposed Final Judgment required CVS and Aetna to transfer all data relating to Aetna’s individual PDP business to WellCare, including information regarding the amount that Aetna pays to retail pharmacies in exchange for filling prescriptions for Aetna members and any contracts with brokers that currently sell Aetna’s individual PDPs. Third, during the 60-day period following the sale to WellCare, the proposed Final Judgment gave WellCare the opportunity to interview and

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76. *Id.*

77. *Mergers*, FULLERTON COLLEGE <https://staffwww.fullcoll.edu/fchan/Micro/6mergers.htm> (Last Visited Apr. 5, 2020).

78. *Id.*

79. *See Id.*

80. *AMA urges DOJ to challenge CVS-Aetna merger supra* note 76.

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

hire Aetna’s current employees with expertise related to the individual PDP business. Fourth, CVS must, at WellCare’s option, enter into an administrative services agreement to provide WellCare with all of the services required to manage the divestiture assets through the 2019 plan year, which ends on December 31, 2019, including contracting with pharmacy networks, administering the plans’ formularies, and providing back-office support and claims administration functions. Finally, CVS and Aetna must allow WellCare to use the Aetna brand for the divestiture assets through the 2019 plan year.<sup>86</sup>

However, the AMA was not encouraged by the government’s plan, and criticized the proposed divestiture remedy because the buyer, WellCare, relied on CVS for PBM and retail pharmacy services.<sup>87</sup> Further, the AMA expressed concern that “CVS would have the ability to deny or restrict WellCare’s access to those PBM and pharmacy services after the merger, thereby threatening the success of the government’s proposed remedy.”<sup>88</sup> The government responded by asserting that “such foreclosure—whether directed at WellCare or any other insurer—is unlikely to occur.”<sup>89</sup> However, the court notes that the government’s conclusion was based on evidence that it did not describe, and that the government failed to explain how the “evidence supports its conclusions that CVS will not likely be able to profitably raise its prices.”<sup>90</sup> According to the court, “the government’s response to the AMA’s criticism is little more than a bald assertion that it is right and the AMA is wrong.”<sup>91</sup>

The court decided that instead of relying on the government’s responses, it would hold a hearing on the Motion to Enter the Proposed Final Judgment to ensure that the decision was made in light of the public’s best interests.<sup>92</sup> The standard of review for a court making a public interest determination is provided by the Tunney Act.<sup>93</sup> Under the Tunney Act, the court shall consider:

(A) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration of relief sought, anticipated effects of alternative remedies actually considered, whether its terms are ambiguous, and any other competitive considerations bearing upon the adequacy of such judgment that the Court deems necessary to a determination of whether the consent judgment is in the public interest; and

(B) the impact of entry of such judgment upon competition in the relevant market or markets, upon the public generally and individuals alleging specific injury from the violations set forth in the complaint...<sup>94</sup>

“The public interest inquiry is not a *de novo* determination of facts and issues; the court need only confirm that the settlement is within the reaches of the public interest.”<sup>95</sup> Throughout the hearing, the government repeatedly asked the court to ignore many of the objections to the proposed final judgment.<sup>96</sup> The government further asserted that the court should disregard all evidence regarding theories of

86. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 49 (D.D.C. 2019).

87. *Id.* at 50-51

88. *Id.* at 51.

89. *Id.* (citing *United States v. Airline Tariff Pub. Co.*, 836 F. Supp. 9, 27 (D.D.C. 1993)).

90. *Id.*

91. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 51 (D.D.C. 2019).

92. *Id.*

93. *Id.* at 52.

94. *Id.* (citing 15 U.S.C. § 16(e)(1)).

95. *Id.* (citing *United States v. Microsoft Corp.*, 56 F.3d 1448, 1460 (D.C. Cir. 1995)).

96. *Id.*

harm the government did not allege, harm that is occurring outside the individual PDP market, and “efficiencies” gained from the merger.<sup>97</sup> However, despite the government’s arguments, the court refused to ignore the possible ramifications of the merger and proceeded with the hearing.

The AMA argued against the merger based on three major concerns:

i) Aetna’s divestiture to WellCare will not effectively remedy the harm to the PDP market alleged in the complaint; (ii) the proposed final judgment’s failure to address effects in markets adjacent to the PDP market—like the market for PBM services—will undercut the effectiveness of the divestiture remedy and harm the public; and (iii) entry of the proposed final judgment without modification will harm HIV and AIDS patients in need of affordable, quality healthcare.<sup>98</sup>

The AMA’s first argument contended that the proposed solution of divestiture to WellCare would not fix the competitive harm to the PDP market. The AMA pointed to the Herfindahl-Hirschman Index to indicate that the divestiture would still leave the PDP market overly concentrated and that competition would be severely reduced.<sup>99</sup> Further, the AMA argued that WellCare is too small to be an adequate replacement in the PDP market as Aetna was, leading to further anti-competitiveness in the market.<sup>100</sup>

In response to the first argument, the government presented a witness, Terri Swanson, the Vice President in Charge of Aetna’s Medicare Part D products prior to the divestiture, whose testimony focused on the already highly competitive nature of the PDP market.<sup>101</sup> CVS also presented another expert, Dr. Lawrence Wu, who testified that the AMA’s HHI analysis showed that the PDP market would be moderately concentrated under the government’s guidelines, rather than highly concentrated.<sup>102</sup> As a result of these testimonies, the court sided with CVS and the government’s analysis.<sup>103</sup>

AMA’s second contention, that the government’s proposed judgment did not address the merger’s effects in the PBM services market, was argued on several grounds. The AMA first stated that CVS could raise their PBM prices across their newly-expanded insurance business when selling their products to health insurance competitors.<sup>104</sup> If those competitors could not find cheaper PBM services, they may be forced into raising their prices on their insurance products or be forced to accept reduced profits.<sup>105</sup> According to the AMA, this would result in CVS having more attractive insurance offerings to the general public, which would allow them to grow even more.<sup>106</sup>

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97. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 52-53 (D.D.C. 2019).

98. *Id.* at 54-55.

99. The Herfindahl-Hirschman Index (HHI) is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in a market and then summing the resulting numbers. It can range from close to zero to 10,000. *Herfindahl-Hirschman Index (HHI)*, INVESTOPEDIA. <https://www.investopedia.com/terms/h/hhi.asp> (Last Visited Apr. 5, 2020); *U.S. v. CVS Health Corp.*, 407 F. Supp. 3d at 55.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 59.

104. *Id.* at 56-57.

105. *Id.* at 57.

106. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 57 (D.D.C. 2019).

In response to this argument, CVS presented evidence to undermine the AMA's theory, again relying on the testimony of Dr. Wu.<sup>107</sup> Dr. Wu explained that CVS must compete vigorously to retain its PBM customers and that raising prices would be a massive gamble as it could result in health insurance companies simply going to other PBMs for their services.<sup>108</sup> According to Dr. Wu, the highly competitive nature of the PBM market would not allow for CVS to act in the way the AMA portrayed.<sup>109</sup> The court concludes:

This evidence combined strongly suggests that, if CVS were to raise its PBM prices, customers like WellCare could simply switch to a less expensive PBM or stop contracting for those PBM services altogether. Were CVS to raise PBM prices in this scenario, it would risk losing PBM market share without disadvantaging WellCare or other competing insurers at all. To say the least, that would be an enormous risk for CVS to take.<sup>110</sup>

The final argument presented by the AMA, that the merger could endanger HIV and AIDS patients, is supported by the testimony of Dr. Michael Wohlfeiler of the AIDS Healthcare Foundation. In his testimony, Dr. Wohlfeiler demonstrates that, "if the proposed final judgment were to cause patients to leave HIV-and-AIDS-specific treatment providers for providers that are unequipped to treat those conditions, the judgment could cause harm."<sup>111</sup> However, the court found this argument unpersuasive. The court pointed out, "[f]or the reasons already discussed, however, the record did not establish that the proposed final judgment will likely result in CVS gaining the ability to steer patients away from their current healthcare providers."<sup>112</sup> The court elaborated further, stating:

[I]f the record did not establish that CVS will be likely to steer customers away from WellCare, which relies on CVS for PBM services, it certainly did not establish that CVS will be likely to steer patients away from the AIDS Healthcare Foundation, which uses a different PBM and maintains its own pharmacies. As such, the potential harm to this segment of the public was not persuasively established on the record either.<sup>113</sup>

Despite the strongly worded concerns given by the AMA, as well as similar briefs submitted by other parties, on September 4, 2019, the U.S. District Court for the District of Columbia approved the merger between CVS and Aetna.<sup>114</sup> Judge Richard Leon stated that the evidence "persuasively supported why the markets at issue are not only very competitive today, but are likely to remain so post-merger."<sup>115</sup>

## V. HOW TO RESOLVE THE PROBLEMS IN THE CURRENT PBM SYSTEM

If nothing else, the litigation around the CVS-Aetna merger brought to light one glaring flaw in the PBM model: how utterly fragile it can be. While the experts

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.* at 58.

112. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 58 (D.D.C. 2019).

113. *Id.* at 58-59.

114. *Id.* at 59.

115. George Khoukaz, *CVS-Aetna Merger to Proceed Forward Following a Gruesome Legal Battle*, 2019-SEP BUS. L. TODAY, 3 (September 2019).

put on by CVS and the Government attempted to show just how competitive the market is,<sup>116</sup> the AMA put on evidence that severely contradicted this point. If the AMA is correct in its analysis that CVS could essentially force its competitors into raising their own prices and subsequently force customers to CVS, the entire PBM system of regulating prices could come undone.<sup>117</sup> This Article asserts that this is the biggest flaw in the PBM system. While it is clearly true that PBMs *do* help regulate the market and decrease prices for customers whose insurance carriers use PBMs, because PBMs are private companies, they are easily subject to the kind of mergers that are presented in *U.S. v. CVS Corp.*

It would be an act of willful blindness to assume that this merger could not tempt other large healthcare companies to acquire PBMs in an attempt to gain more profit. And, due to the court's holding in this case, these mergers are now possible. The merger between CVS and Aetna amounted to nearly \$70 billion.<sup>118</sup> This figure indicates these types of massive mergers will only be available to the top earners in the market. If this is a sign of what is to come, mergers of this kind are going to become more commonplace, which will severely constrict the competition in the healthcare-providing market. As the AMA vehemently contended, this constriction of the market will affect patients far more than anyone else.

The question then becomes: what can we do about this constriction of competition? There are three potential solutions: (1) allow the market to regulate itself, as was suggested by CVS and the Government during the CVS-Aetna merger litigation; (2) have the government step in and take over the PBM industry, making these corporations government-run; or (3) have the government regulate the PBM market, controlling mergers and ensuring the competition in the market is consistently maintained to ensure no one company can take up too much of the PBM market.

The first solution seems to be the riskiest. Undoubtedly, this would be highly favored amongst healthcare corporations. However, there are deep concerns about markets effectively regulating themselves with no oversight, and considering the importance of the healthcare market, this solution seems unwise. The market *may* regulate itself, but if it does not, many will be forced to pay more for healthcare, which would have severe ramifications down the line. Therefore, this solution is not a viable long-term solution due to the uncertainty of whether these companies would be able to foster necessary competition in the market.

The second solution may seem the safest, but it also would carry the heaviest price tag. The CVS-Aetna merger was worth almost \$70 billion,<sup>119</sup> and Express Scripts has reported \$100 billion in revenue in the past.<sup>120</sup> The PBM market is giant, and ignoring for the moment the monumental political effort it would take to nationalize these corporations, the cost of nationalizing this market would be immense. If we were to indulge in a possible cost-benefit analysis for this solution, the benefit would be difficult to calculate. *Maybe* the government would be able to effectively lower prices across the board and make prescription medications less costly, but there is no way to accurately predict whether such a massive program would succeed or fail. The uncertainty involved in the decision is so significant that

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116. *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 59 (D.D.C. 2019).

117. *See Id.* at 55-57.

118. Brent Kendall, *Business News: Judge Approves Settlement Allowing CVS-Aetna Merger*, WALL STREET JOURNAL (September 4, 2019).

119. *Id.*

120. Schulman & Richman, *supra* note 2.

the benefit likely cannot be calculated accurately. As such we are left with a massive cost, and a suspect benefit. Therefore, this solution is probably too uncertain to be used.

Finally, we come to the third solution. This solution would require one main change from the government: enacting a provision in federal antitrust law that would make mergers like CVS and Aetna's presumptively invalid, and would require the merging healthcare companies to show that the public will not be negatively affected by their merger. This solution would require a showing from the companies that their merger is not in violation of federal-antitrust guidelines. Further, it would allow *amicus*, such as the AMA, to place a heavier burden on the companies to show to the public that these mergers would not constrict market competition and adversely affect the population as a result. The cost of this type of litigation pales in comparison to the previous two solutions, and this solution also carries the most tangible benefit. These proceedings would allow for the public to become more aware of the PBM market and would help to ensure competition in the field. This solution, in my view, gives us the most favorable cost-benefit analysis and is therefore the one that should be implemented.

## VI. CONCLUSION

PBMs are a massive, hidden market that is buried in the complexity of the modern healthcare system. However, for all of their faults, PBMs help with market regulation and with drug distribution significantly. The evidence clearly shows that PBMs do make drugs cheaper for their consumers, and the programs of at home delivery serve countless Americans and allow for a wide distribution of medications. PBMs are an integral part of the health care system, and their existence undeniably helps those in need of healthcare. However, the CVS-Aetna merger revealed that the PBM market is not as stable as it needs to be. If the CVS merger inspires more mergers, the PBM market could cease to protect patients, and instead be used as a way to strong-arm those who need life-saving medication into more expensive drugs. Therefore, Americans must act to preserve the PBM market with laws that guarantee the competition that the PBM market currently provides. More robust federal antitrust laws would be an excellent first step, but what is truly needed is for the American public to keep a close eye on this market, and make sure that large healthcare companies cannot do away with these private regulators in an attempt to increase their profit margins.