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December 16, 2019

Senator Chuck Grassley
Committee on the Judiciary, Subcommittee on
Antitrust, Competition, Policy and Consumer Rights
Washington, DC
C/O Jason Covey, Hearing Clerk
[redacted]
(202) 224-5225

Re: Questions for the Record from Senator Chuck Grassley of Iowa, *Your Doctor/Pharmacist/Insurer Will See You Now: Competitive Implications of Vertical Consolidation in the Healthcare Industry*

Dear Senator Grassley:

I commend the Committee for holding its hearing on vertical integration in healthcare and I appreciate your follow-up questions for the record (QFRs). The following excerpt summarizes my bottom-line opinion regarding vertical integration and consolidation generally and in the healthcare industry in particular:[1]

> [T]he form and extent of vertical integration is itself an outcome of the competitive process. That is, competition—where it is sufficient—pushes firms to adopt efficient organizational structures that align with their market strategies. Some may choose not to vertically integrate and realize greater benefits of specialization and economies of scale. Others may choose to vertically integrate in pursuit of benefits from improved coordination across internal divisions or other efficiencies. Neither is inherently better or worse than the other and, in many cases, the two organizational forms coexist and compete intensely.
>
> Valid generalities are few. For policy-makers and antitrust enforcers, the question to ask is not, "*Is vertical integration in healthcare good or bad?*" Either answer would be partly wrong and partly right. Instead, the question to ask is, "*Is this specific vertical healthcare transaction likely to harm competition or not?*"

The QFRs largely relate to competition and transparency in the pharmacy benefits management (PBM) industry. My expertise is most centered on issues related to competition and policy with

[1] Testimony of Dr. Cory S. Capps, PhD, June 12, 2019, https://www.judiciary.senate.gov/imo/media/doc/Capps%20Testimony.pdf.

respect to healthcare providers (physicians, hospitals, outpatient centers, etc.) and healthcare insurers.[2] Although I understand the PBM industry reasonably well, I have not studied it in sufficient detail to offer opinions on most of the QFRs. To the extent that I believe my expertise or testimony is relevant, I indicate as much below.

QFRs and Responses (responses in italics)

1. We heard from some of the PBM witnesses that these mergers [among PBMs and insurers] make it easier for companies to control or minimize the total cost of care for consumers. Do you agree? Why or why not?

   I have not studied PBMs or mergers of PBMs and insurers in sufficient detail to provide an answer. A merger of a PBM and an insurer would be a vertical merger, so all of the opinions and principles in my original testimony would apply to such mergers.[3]

   In addition, the Federal Trade Commission (FTC) is generally responsible for reviewing mergers among PBMs;[4] *the Department of Justice's Antitrust Division (DOJ) would generally review a merger between a health insurer and a PBM;*[5] *and other vertical mergers involving PBMs could be investigated by either agency.*[6] *Whichever agency conducts the review, close evaluation of likely effects on consumers is a central and standard component of an antitrust review. While I cannot provide any direct evidence or opinion, I can state that the antitrust agencies' reviews of mergers among PBMs, or PBMs and insurers, surely included close examination of effects on costs of care and on consumers.*

2. Have these mergers and consolidations [among PBMs] resulted—or will they likely result—in lower costs to the government? Why or why not?

   I have not studied PBMs providing services to or on behalf of the government in sufficient detail to provide an answer.

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2 *See* https://www.bateswhite.com/people-Cory-Capps html#Selected-Work.

3 Testimony of Dr. Cory S. Capps, PhD, June 12, 2019, https://www.judiciary.senate.gov/imo/media/doc/Capps%20Testimony.pdf.

4 FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc.," April 2, 2012, *at* https://www.ftc.gov/sites/default/files/documents/public_statements/statement-federal-trade-commission-concerning-proposed-acquisition-medco-health-solutions-express./120402expressscripts.pdf.

5 DOJ, "Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger," September 17, 2018, *at* https://www.justice.gov/atr/closing-statement.

6 DOJ, *U.S. v. CVS Health Corp. and Aetna Inc*., "Closing Statement," October 10, 2018, *at* https://www.justice.gov/atr/case-document/file/1100111/download.

3. Is the PBM industry competitive? Are consumers benefiting from that competition? Are there high barriers to entry for new competitors in the PBM industry?

   See response to QFR #1. Beyond that, I have not studied competition among PBMs or barriers to entry in the industry in sufficient detail to provide an answer.

4. What specific legal or regulatory obstacles, if any, is the FTC currently facing in ensuring a competitive and transparent marketplace in the pharmaceutical supply chain?

   I am not aware of any such obstacles. In my experience, the FTC and DOJ both promote effective competition policy and enforcement, often through "competition advocacy" efforts including interactions with the legislative branch.[7] *Thus, as a general matter, I would expect either antitrust agency to freely describe any legal or regulatory obstacles to the effective pursuit of its enforcement mission.*

5. [A]re PBMs fulfilling the roles that they claim to play? Are they functioning in the marketplace as intended in negotiating down drug costs? Why or why not?

   See response to QFR #1.

6. What specific legislative actions, if any, should Congress be considering at this time to increase transparency in the pharmaceutical supply chain and best ensure that cost savings or efficiencies are actually passed on to consumers?

   I am not aware of any specific legislative action Congress should be considering.

   I will note for general consideration that transparency can have ambiguous effects on competition and pricing. On the one hand, transparency may make for more informed consumers who are better able to shop for the best price, which can make firms compete more aggressively. On the other hand, and perhaps less obviously, transparency can also reduce the incentive for firms to compete on price. For example, if one firm's price cut is immediately observed and matched by rivals, then why cut price in the first place?[8] *In this case, secret price-setting is more effective and beneficial to customers than is public price-setting (i.e., transparency).*

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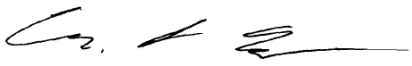
[7] *See* FTC, "Advocacy," *at* https://www ftc.gov/policy/advocacy and Antitrust Division (DOJ), "Competition Policy and Advocacy Section," *at* https://www.justice.gov/atr/about-division/cpa-section.

[8] For a discussion of transparency in the context of healthcare markets, *see* David Cutler and Leemore Dafny, "Designing Transparency Systems for Medical Care Prices," *New England Journal of Medicine* 2011, 364(10): 894–895, *at* https://dash harvard.edu/bitstream/handle/1/26640487/nejmp1100540.pdf.

Likewise, it is difficult to craft legislation that regulates pass-through or other competitive outcomes without distorting incentives in unproductive and contrary ways—the "law of unintended consequences." For example, recent research examines the effects of minimum medical loss ratio (MLR) regulations intended to cap health insurers' profit margins and, thereby, result in lower premiums.[9] *In practice, however, the MLR can increase if premiums fall or if medical spending increases. The research finds that health insurers that fell short of the minimum MLR requirement came into compliance not by decreasing premiums but rather by allowing medical costs to increase.*[10]

This is not to say that legislative solutions to market failures should be avoided entirely, but rather that, to be effective, such solutions should be crafted with caution and care.

Sincerely,



Cory S. Capps, PhD
Partner

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[9] The MLR is the percentage of a health insurer's premium revenue that is spent on medical care; for example, a health plan with an MLR of 82% spends 82 cents of every premium dollar on medical care. *See* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.

[10] Steve Cicala, Ethan Lieber, and Victoria Marone, "Regulating Markups in US Health Insurance," *American Economic Journal: Applied Economics* 2019, 11(4): 71–104, *at* https://home.uchicago.edu/~scicala/papers/MLR/MLRdraft.pdf.