The Impact of Aetna's Proposed Medicare Part D Stand-Alone Prescription Drug Plan Divestiture to WellCare

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1. Introduction

The purpose of this testimony is twofold. First, I will provide background information on the Medicare Part D stand-alone prescription drug plan (PDP) market and present recent market concentration trends. Second, I will demonstrate how Aetna's proposed divestiture of its PDPs to WellCare would increase PDP market concentration.

2. Background[3]

A. The Medicare Part D Stand-Alone Prescription Drug Plan (PDP) Market

In 2018, 43 million of the 60 million people with Medicare have prescription drug coverage under a Medicare Part D plan.[4] Of the 43 million, 25 million (58%) are covered under a stand-alone prescription drug plan (PDP) while the remaining 18 million are enrolled in Medicare Advantage prescription drug plans (MA-PDs).[4] I focuses exclusively on the PDP market in what follows.

B. How Part D Premiums Are Determined

Part D plan sponsors compete on premiums to attract enrollees, but do not set premiums directly.[5] Plan sponsors submit bids to the Centers for Medicare & Medicaid Services (CMS) that represent their revenue requirements (including administrative costs and profit) for delivering basic benefits to an enrollee of average health. CMS then calculates a nationwide enrollment-weighted average among all the bid submissions. The monthly premium an enrollee pays for a plan is a subsidized base premium ($35.02 in 2018) plus (or minus) any difference between his plan's bid and the nationwide average bid. If an enrollee picks a plan that contains supplemental coverage, the enrollee pays the full price of the additional coverage.

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[2] I thank the American Medical Association for supporting my work in preparing this report. This report reflects my views and opinions, not necessarily the views of the American Medical Association.

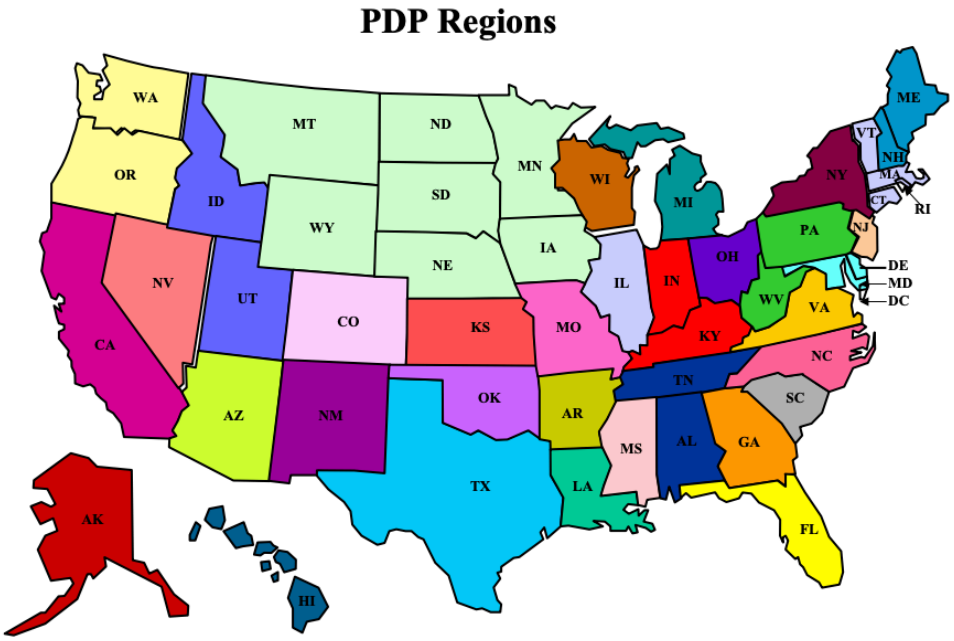
[3] This section is derived from my May 29, 2018 testimony.

[4] Cubanski, Juliette, Anthony Damico, and Tricia Neuman. "Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing." San Francisco, CA: Kaiser Family Foundation. May 17, 2018. Available from: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/

[5] This section relies heavily on the description of how premiums are determined in MedPAC. "The Medicare prescription drug program (Part D): Status report." Ch. 14 in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. March 2018. Available from: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf?sfvrsn=0

Part D's bidding process also determines the maximum premium amount Medicare will pay on behalf of low-income subsidy (LIS) enrollees (hereafter benchmark premium).[6] The amount is calculated separately for each of the 34 Part D geographic regions as the average premium among plans with basic benefits, weighted by each plan's LIS enrollment in the previous year. 25 of the 34 Part D geographic regions are a single state. The remaining 9 regions are comprised of multiple states (see Figure 1 for a map of the 34 Part D geographic regions). The formula used for the LIS program ensures that at least one stand-alone PDP in each region is available to LIS enrollees at no premium. In 2018, over 12 million (28%) of Part D enrollees (PDP plus MA-PD enrollees) received premium and cost-sharing assistance through the Part D LIS program.[4]

Figure 1. Medicare Part D Geographic Regions



Source: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/PDPRegions.pdf
Note: PDP=stand-alone prescription drug plan.

The importance of the 34 Part D regions in the determination of the maximum premium amount Medicare will pay on behalf of LIS enrollees, plus the fact that plan sponsors must offer a plan in at least one entire region (and cannot pick and choose which geographies within a region it offers plans),[7] makes Part D regions the relevant geographic level of competition. Hence, PDP market concentration is calculated for each of these 34 regions in what follows.

[6] In 2018, enrollees can have up to $18,210 in yearly income ($24,690 for a married couple) and up to $14,100 in resources ($28,150 for a married couple) and still qualify for a low income-subsidy. See https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html for details.
[7] Event Driven. "AET/CVS: Part D Overlap and Potential Divestiture Analysis." February 9, 2018.

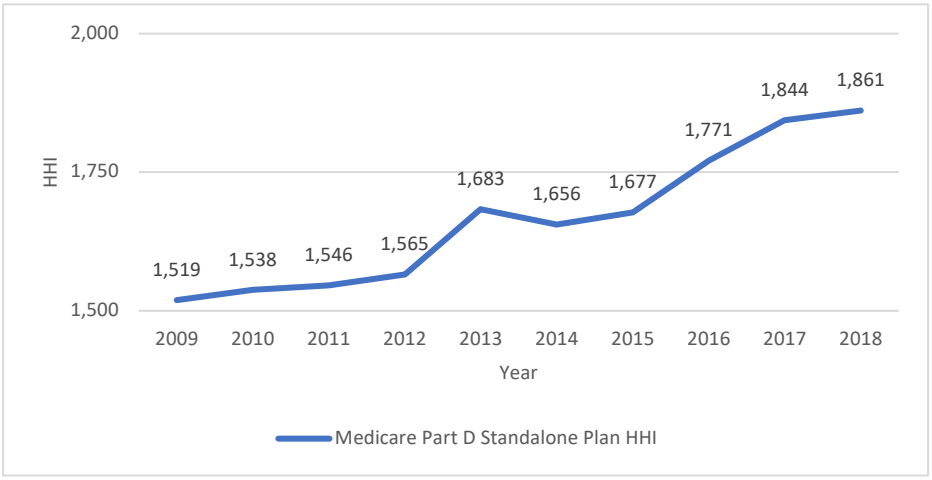
C. Measuring Market Concentration

I used the Herfindahl-Hirschman Index (HHI) to measure PDP market concentration. HHI has been used frequently as a measure of market concentration in merger cases brought by the Antitrust Division of the US Department of Justice (DOJ) and Federal Trade Commission (FTC) and is used in *Horizontal Merger Guidelines* (hereafter DOJ/FTC Guidelines), authored by these agencies.[8] HHI is calculated by taking the market share of each firm, squaring it, and summing the results. HHI values range from zero to 10,000. For example, if a market included two firms, one with 60 percent market share and the other with 40 percent market share, the HHI would be 5,200 (or $60^2 + 40^2$). The *Horizontal Merger Guidelines* consider markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated, and markets with an HHI in excess of 2,500 points to be highly concentrated. Market shares in each of the 34 Medicare Part D regions were calculated based on plan sponsor PDP enrollment.

D. PDP Market Concentration Trends

Figure 2 shows the average PDP HHI (weighted by PDP enrollment) from 2009-2018. In 2009, PDP HHI was 1,519 – just above the DOJ/FTC 1,500 threshold for a moderately concentrated market. Since 2009, it has been steadily increasing. By 2018, PDP HHI had increased to 1,861 – an increase of 342 HHI (23% increase). In 2009 3 PDP regions had HHIs above the DOJ/FTC Guidelines' highly concentrated threshold of 2,500 and 9 PDP regions had HHIs in the 1,500 to 2,500 moderately concentrated range. By 2018, all 34 PDP regions were above the moderately concentrated threshold of 1,500 and 2 PDP regions were above the highly concentrated threshold of 2,500.

Figure 2. Average Part D Region-Level PDP Market Concentration (Weighted by PDP Enrollment), 2009-2018



Source: Author's analysis of April snapshots of PDP enrollment data published by CMS from 2009 to 2018 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html
Notes: PDP=stand-alone prescription drug plan. HHI=Herfindahl-Hirschman Index.

[8] U.S. Department of Justice and Federal Trade Commission. "Horizontal Merger Guidelines." Washington, DC: DOJ/FTC. August 19, 2010. Available from: https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf

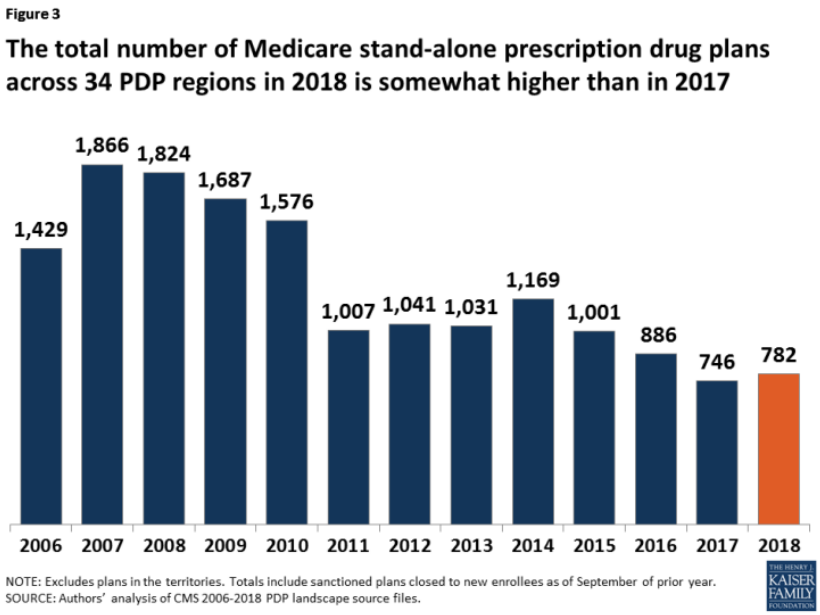
E. Reductions in the Number of Plans and Increases in the Shares of Top Firms

In addition to increases in HHI, consolidation in the PDP market can be seen in the reduction of the number of PDP offerings and the shares of the top PDP firms. Analysis from the Kaiser Family Foundation shows the number of PDP offerings decreased by 54% (from 1,687 in 2009 to 782 in 2018) during the 2009-2018 timeframe analyzed in Figure 2 above. Additionally, PDP enrollment among the five largest firms in the market has grown during this time.

F. Increases in the Shares of the Top 5 Plan Sponsors

In 2009, five plan sponsors accounted for 65% of PDP enrollment: UnitedHealth (25%, 4.2 million enrollees), Humana (12%, 2.0 million enrollees), Universal American (10%, 1.6 million enrollees), CVS Health (9%, 1.5 million enrollees), and Coventry Health Care (9%, 1.5 million enrollees).[9] By 2018 five plan sponsors accounted for 83% of PDP enrollment in 2018: CVS Health (24%, 6 million enrollees), UnitedHealth (21%, 5.3 million enrollees), Humana (20%, 4.9 million enrollees), Express Scripts (10%, 2.4 million enrollees), and Aetna (9%, 2.1 million enrollees).[10] If Aetna's plans were divested to WellCare in 2018, the combined Aetna-WellCare would have moved from fifth to fourth (13%, 3.2 million enrollees) and the combined market share of the top five plan sponsors in the PDP market would have risen to 87%. Figure 4 shows that the top five's share of the PDP market has steadily increased since 2009.

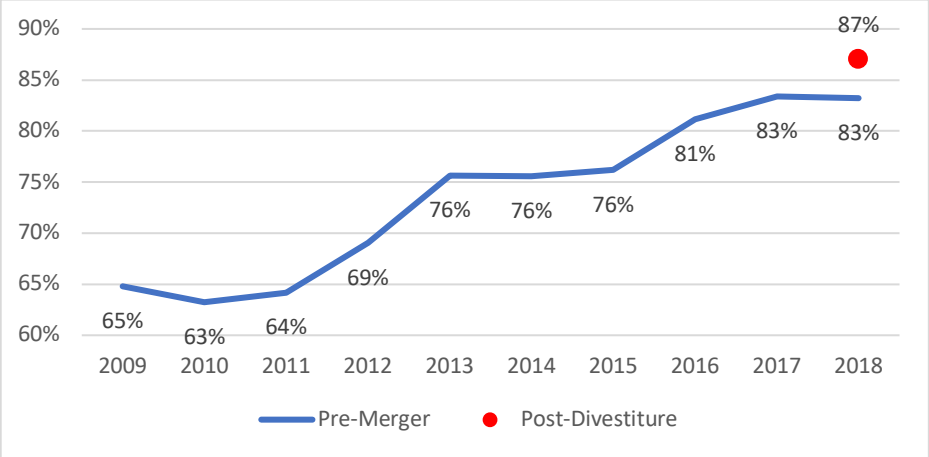
Figure 3. Number of PDPs, 2006-2018



Source: Cubanski, Juliette, Anthony Damico, Jack Hoadley, Kendal Orgera, and Tricia Neuman. "Medicare Part D: A Frist Look at Prescription Drug Plans in 2018." San Francisco, CA: Kaiser Family Foundation. October 13, 2017. Available from: https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2018/

[9] CVS Health was CVS Caremark at the time.
[10] Author's analysis of the CMS's April 2018 Part D monthly enrollment file. Sum of the individual insurer percentages is 84% instead of 83% due to rounding. Data available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html

Figure 4. Market Share of Top 5 Plan Sponsors, 2009-2018



Source: Author's analysis of April snapshots of PDP enrollment data published by CMS from 2009 to 2018 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html
Notes: Top 5 in terms of nationwide PDP market share. Pre-Merger assumes Aetna and WellCare have separate market shares while Post-Divestiture assumes Aetna and WellCare have one combined market share.

3. How Aetna's Proposed Divestiture of its PDPs to WellCare Increases PDP Market Concentration[11]

I do conduct two analyses in this section. First, to address the impact of Aetna divesting its PDPs to WellCare on PDP market concentration, I calculated 2018 PDP market concentration two ways: (1) assuming Aetna and WellCare have separate market shares (pre-merger HHI) and (2) assuming Aetna and WellCare have one combined market share (post-divestiture HHI). Second, I analyze how the divestiture would increase the combined entity's share of low-income subsidy enrollment across the 34 PDP regions.

A. Pre-Merger and Post-Divesture HHIs

Table 1 shows pre-merger and post-divestiture HHIs in 2018 for each of the 34 Part D regions. According to the DOJ/FTC Guidelines, mergers that would increase HHI by more than 100 points and result in post-merger HHIs between 1,500 and 2,500 "potentially raise significant competitive concerns and often warrant scrutiny."[12] 7 PDP regions would satisfy these conditions in the context of Aetna divesting its standalone Medicare Part D prescription drug plans to WellCare. These 7 PDP regions are (ranked from largest to smallest HHI change):

- Mississippi (Region 20) +230 HHI
- Arkansas (Region 19) +206 HHI
- Maine, New Hampshire (Region 1) +148 HHI
- Alabama, Tennessee (Region 12) +124 HHI

[11] This section is derived from my December 6, 2018 testimony.
[12] See Section 5.3 (pg. 19) of U.S. Department of Justice and Federal Trade Commission. "Horizontal Merger Guidelines." Washington, DC: DOJ/FTC. August 19, 2010. Available from: https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf

- Virginia (Region 7) +109 HHI
- Texas (Region 22) +109 HHI
- Louisiana (Region 21) +108 HHI

Table 1. Standalone Medicare Part D Prescription Drug Plan (PDP) Market HHIs, 2018

PDP Region	Pre-Merger HHI	Post-Divestiture HHI	HHI Change
20 - Mississippi	2,006	2,236	230
19 - Arkansas	1,984	2,190	206
1 - Maine, New Hampshire	1,546	1,693	148
12 - Alabama, Tennessee	1,602	1,726	124
7 - Virginia	1,606	1,716	109
22 - Texas	1,769	1,878	109
21 - Louisiana	1,717	1,825	108
24 - Kansas	2,045	2,140	95
8 - North Carolina	1,700	1,790	90
2 - Connecticut, Massachusetts, Rhode Island, Vermont	1,610	1,700	89
15 - Kentucky, Indiana	1,647	1,734	88
28 - Arizona	1,866	1,943	76
32 - California	2,007	2,079	72
30 - Oregon, Washington	1,614	1,686	72
14 - Ohio	1,755	1,824	69
6 - Pennsylvania, West Virginia	1,702	1,771	69
26 - New Mexico	1,717	1,782	66
10 - Georgia	1,977	2,042	65
13 - Michigan	1,795	1,858	63
18 - Missouri	2,015	2,078	63
23 - Oklahoma	1,996	2,054	58
5 - District of Columbia, Delaware, Maryland	1,797	1,854	57
29 - Nevada	2,383	2,440	57
17 - Illinois	1,547	1,596	49
31 - Idaho, Utah	1,836	1,884	48
3 - New York	1,844	1,891	47
4 - New Jersey	2,320	2,366	46
25 - Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	2,145	2,187	42
16 - Wisconsin	1,588	1,629	40
9 - South Carolina	1,687	1,726	39
27 - Colorado	2,256	2,290	33
34 - Alaska	2,715	2,738	24
11 - Florida	2,292	2,312	20
33 - Hawaii	4,898	4,911	13

Source: Author's analysis of April 2018 enrollment data published by CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.html)
Notes: PDP=stand-alone prescription drug plan. HHI=Herfindahl-Hirschman Index. Pre-merger HHI assumes Aetna and WellCare have separate market shares in 2018 HHI calculations. Post-divestiture HHI assumes Aetna and WellCare have one combined market share in 2018 HHI calculations.

B. Low-Income Subsidy Enrollment Shares

On page 5 of the Department of Justice's Competitive Impact Statement on the merger of CVS Health and Aetna,[13] it is claimed that

> *The merged company will account for between 35% and 55% of all low-income-subsidy-eligible beneficiaries, including those who enroll in Medicare Advantage plans with prescription drug benefits. When combined with other market factors, these increases in the share of low-income subsidy beneficiaries suggests that the merger would likely result in further loss of competition.*

The government continues on to state

> *Specifically, the merger would likely increase the merged company's ability to influence a critical feature of the Medicare Part D program called the low-income subsidy ("LIS") benchmark, which in turn would increase premiums and out-of-pocket expenses for basic individual PDPs—those plans that provide an equivalent to the minimum coverage set forth in 42 Case 1:18-cv-02340 Document 3 Filed 10/10/18 Page 5 of 19 U.S.C. § 1395w-102 and in which LIS beneficiaries can enroll (or be auto-enrolled) for free.*

In Table 2, I show that the government's aforementioned concern is still a concern for Aetna's proposed divestiture to WellCare. Specifically, if Aetna and WellCare were a combined entity in 2018, the combined entity's share of low-income subsidy (LIS) PDP enrollment would have been over 35% in 2 PDP regions (Regions 19 and 33). Additionally, its share would have been between 25% and 35% in 11 PDP regions (Regions 20, 1, 24, 22, 13, 7, 12, 14, 8, 9, and 15).

[13] https://www.justice.gov/atr/case-document/file/1100111/download

Table 2. Aetna and WellCare PDP Low-Income Subsidy (LIS) Enrollment Shares, 2018

PDP Region	Plan Sponsor	LIS Enrollees	Total LIS Enrollees in Region	LIS Enrollment Share (%)	Combined LIS Enrollment Share (%)
19	Aetna Inc.	20,654	99,214	20.8	37.8
	WellCare Health Plans, Inc.	16,821	99,214	17.0	
33	Aetna Inc.	5,601	16,133	34.7	35.7
	WellCare Health Plans, Inc.	157	16,133	1.0	
20	Aetna Inc.	20,713	138,045	15.0	33.7
	WellCare Health Plans, Inc.	25,809	138,045	18.7	
1	Aetna Inc.	5,444	108,889	5.0	32.8
	WellCare Health Plans, Inc.	30,276	108,889	27.8	
24	Aetna Inc.	14,296	61,349	23.3	31.4
	WellCare Health Plans, Inc.	4,991	61,349	8.1	
22	Aetna Inc.	58,731	445,982	13.2	28.8
	WellCare Health Plans, Inc.	69,905	445,982	15.7	
13	Aetna Inc.	46,604	269,772	17.3	28.6
	WellCare Health Plans, Inc.	30,623	269,772	11.4	
7	Aetna Inc.	27,901	183,014	15.2	28.3
	WellCare Health Plans, Inc.	23,942	183,014	13.1	
12	Aetna Inc.	28,211	285,255	9.9	25.9
	WellCare Health Plans, Inc.	45,579	285,255	16.0	
14	Aetna Inc.	39,379	241,541	16.3	25.4
	WellCare Health Plans, Inc.	22,090	241,541	9.1	
8	Aetna Inc.	48,129	275,312	17.5	25.1
	WellCare Health Plans, Inc.	21,078	275,312	7.7	
9	Aetna Inc.	23,514	106,678	22.0	25.1
	WellCare Health Plans, Inc.	3,287	106,678	3.1	
15	Aetna Inc.	57,829	346,007	16.7	25.0
	WellCare Health Plans, Inc.	28,708	346,007	8.3	
18	Aetna Inc.	27,542	147,467	18.7	23.9
	WellCare Health Plans, Inc.	7,742	147,467	5.2	
25	Aetna Inc.	52,599	290,412	18.1	23.4
	WellCare Health Plans, Inc.	15,280	290,412	5.3	
2	Aetna Inc.	40,306	391,817	10.3	22.7
	WellCare Health Plans, Inc.	48,562	391,817	12.4	
5	Aetna Inc.	31,443	205,945	15.3	22.2
	WellCare Health Plans, Inc.	14,363	205,945	7.0	
29	Aetna Inc.	10,065	54,681	18.4	21.9
	WellCare Health Plans, Inc.	1,885	54,681	3.4	
10	Aetna Inc.	37,825	206,234	18.3	21.8
	WellCare Health Plans, Inc.	7,075	206,234	3.4	
30	Aetna Inc.	14,382	229,397	6.3	21.6
	WellCare Health Plans, Inc.	35,059	229,397	15.3	
16	Aetna Inc.	21,005	127,546	16.5	21.5
	WellCare Health Plans, Inc.	6,455	127,546	5.1	
21	Aetna Inc.	12,075	150,735	8.0	20.6
	WellCare Health Plans, Inc.	19,019	150,735	12.6	
28	Aetna Inc.	6,958	89,130	7.8	19.4
	WellCare Health Plans, Inc.	10,368	89,130	11.6	
31	Aetna Inc.	5,482	63,851	8.6	19.0
	WellCare Health Plans, Inc.	6,631	63,851	10.4	
23	Aetna Inc.	11,169	115,504	9.7	18.9

	WellCare Health Plans, Inc.	10,618	115,504	9.2	
4	Aetna Inc.	19,006	192,183	9.9	18.7
	WellCare Health Plans, Inc.	16,851	192,183	8.8	
6	Aetna Inc.	28,199	362,497	7.8	18.6
	WellCare Health Plans, Inc.	39,202	362,497	10.8	
26	Aetna Inc.	6,618	63,836	10.4	18.5
	WellCare Health Plans, Inc.	5,215	63,836	8.2	
32	Aetna Inc.	110,303	1,014,207	10.9	18.2
	WellCare Health Plans, Inc.	74,144	1,014,207	7.3	
17	Aetna Inc.	29,582	312,947	9.5	16.0
	WellCare Health Plans, Inc.	20,601	312,947	6.6	
27	Aetna Inc.	9,263	89,993	10.3	15.5
	WellCare Health Plans, Inc.	4,671	89,993	5.2	
3	Aetna Inc.	31,406	494,305	6.4	15.4
	WellCare Health Plans, Inc.	44,547	494,305	9.0	
11	Aetna Inc.	9,627	364,841	2.6	6.5
	WellCare Health Plans, Inc.	14,235	364,841	3.9	
34	Aetna Inc.	712	18,726	3.8	6.1
	WellCare Health Plans, Inc.	434	18,726	2.3	
TOTAL	**Aetna Inc.**	**912,573**	**7,563,445**	**12.1**	**21.7**
	WellCare Health Plans, Inc.	**726,223**	**7,563,445**	**9.6**	

Source: Author's analysis of 2018 PDP LIS enrollment data from CMS https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/LIS-Contract-Enrollment-by-County.html

4. The Impact of Market Power on Part D Premiums[14]

A number of studies have associated increases in market concentration with increases in health insurance premiums.[15] Other studies specifically analyze the impact of health care market concentration on Part D premiums and show Part D premiums increase when firms merge. A recent paper by Anna Chorniy and colleagues estimates that Part D plan sponsors mergers lead to higher premiums.[16] An earlier study by Claudio Lucarelli and coauthors also estimates that average premiums increase for merged firms.[17]

Based on HHI increases shown in Table 1, a number of Part D regions "potentially raise significant competitive concerns and often warrant scrutiny" based on the DOJ/FTC Guidelines. In my professional opinion, these concentration increases are likely to lead to premium increases.

[14] This section is derived from my May 29, 2018 testimony.

[15] See e.g. Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan. "Paying a premium on your premium? Consolidation in the US health insurance industry." *American Economic Review* 102, no. 2 (2012): 1161-85; Dafny, Leemore S. "Are health insurance markets competitive?." *American Economic Review* 100, no. 4 (2010): 1399-1431; Dafny, Leemore, Jonathan Gruber, and Christopher Ody. "More insurers lower premiums: Evidence from initial pricing in the health insurance marketplaces." *American Journal of Health Economics* 1, no. 1 (2015): 53-81; Scheffler, Richard M., Daniel R. Arnold, Brent D. Fulton, and Sherry A. Glied. "Differing impacts of market concentration on Affordable Care Act Marketplace premiums." *Health Affairs* 35, no. 5 (2016): 880-888; and Trish, Erin E., and Bradley J. Herring. "How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums?." *Journal of health economics* 42 (2015): 104-114;

[16] Chorniy, Anna, Daniel P. Miller, and Tilan Tang. "The impact of horizontal mergers on plan premiums and drug formularies in Medicare Part D." April 2018.

[17] Lucarelli, Claudio, Jeffrey Prince, and Kosali Simon. "The welfare impact of reducing choice in Medicare Part D: A comparison of two regulation strategies." *International Economic Review* 53, no. 4 (2012): 1155-1177.