STATE OF NEW YORK

DEPARTMENT OF FINANCIAL SERVICES

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CVS-AETNA HEARING

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One State Street

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SUPERINTENDENT VULLO: So good morning. Can everybody hear me?

Great. So it's a little after 10:00, so we are in good shape.

Good morning, everyone. I am Maria Vullo. I am the New York State Superintendent of the Department of Financial Services. I am joined today by Laura Evangelista, Executive Deputy Superintendent for Insurance, Troy Oechsner, Deputy Superintendent for Health Insurance, and also Stephen Wiest of our Health Insurance Bureau.

We are holding this public hearing today pursuant to Insurance Law Section 1506 to consider the application by CVS Health Corporation and CVS Pharmacy Inc. to acquire Aetna Health Insurance Company of New York, which is a subsidiary of Aetna Inc.

This transaction has received a significant amount of attention for good reason. As proposed by the parties, the transaction has potential

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benefits but it also presents potential risks to markets, to consumers, and to the people of the State of New York. And in my role as Superintendent, I am duty bound to protect the consumers of the State of New York where I can.

It is important to note that DFS, my Agency's specific approval authority with regard to this transaction, as to the proposed acquisition by CVS of Aetna Health Insurance Company of New York, which is one of Aetna Inc.'s subsidiaries, DFS also acts in an advisory capacity to the Commissioner of Health with regard to approval of the acquisition of control of two New York managed care organizations, and those are Aetna Health, Inc. HMO and Aetna Better Health Inc., which is a managed long-term care plan.

In addition, and very importantly, Aetna has three Connecticut domestic insurance companies that hold licenses from this

department to transact insurance business in the State of New York, including Aetna Life Insurance Company, which also writes life insurance and annuity policies. And so this hearing is also to consider the potential impact of the proposed transaction on those New York licensees, and most importantly, on Aetna's New York policyholders.

Just yesterday the Connecticut Insurance Department, which held its public hearing on October 4, approved the change of control application for Aetna Life and other companies domiciled in Connecticut. Because the Connecticut company sells a very substantial amount of insurance policies in the State of New York, prior to the public hearing in Connecticut I sent a letter to the Connecticut Insurance Department outlining some of DFS's significant concerns with regard to this proposed

transaction. I did so because Connecticut domiciled insurance companies write a significant number of health insurance policies to New Yorkers and Connecticut is the state where CVS's change of control applications with regard to those Aetna companies were filed and subject to review.

The United States Department of Justice has also approved the CVS-Aetna transaction. They did that last week subject to a consent decree requiring the divestiture by Aetna of its Medicare Part D prescription coverage.

While that decision addressed horizontal aspects of this transaction from the insurance perspective, specifically the proposed combination of CVSs and Aetna's Part D businesses, unfortunately the Justice Department has taken a very myopic view and has failed to address the substantial impacts of this vertical integration

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would have on consumers across the country.

There is no question that this transaction, were it to proceed, would have a significant impact on the State of New York. As New York's insurance commissioner, however, my jurisdiction primarily lies in the health insurance aspects of this transaction and the impacts there are significant.

In 2017 Aetna Life's direct insurance business written in New York was about $3.5 billion in premiums. That amount exceeds the direct premium writings of any other state or territory. These premium writings in New York constituted 10.7 percent of the company's total direct accident and health insurance premium writings, and represented approximately 33 percent of the overall accident and health insurance market share in the State of New York. To state the obvious, this makes New York a very significant

market for Aetna. Although the Connecticut Insurance Department has now addressed CVS's applications for change of control regarding the Connecticut domiciled Aetna companies including Aetna Life, those Aetna Companies that sell insurance in New York hold the licenses from this department. Under New York's insurance law the New York licenses of the Aetna Companies as well as the CVS Insurance Company in the Part D market that are licensed in New York but domiciled in Connecticut and all companies licensed in New York but domiciled in another state are subject to annual review by this department. Specifically Section 1106(b)(2) of the New York insurance law states, and I quote, the superintendent shall issue a renewal license to any foreign or alien insurer if satisfied by such proof as she may require that such an insurer is not delinquent with respect to any

requirement imposed by this chapter and that its continuance and business in this state will not be hazardous or prejudicial to the best interests of the people of this state. Accordingly, consideration of the renewal of the New York licenses for the foreign insurers remembers impacted by this transaction will also be addressed as part of our review of this proposed transaction, applying the statutory standard.

In addition, CVS, which is the proposed acquirer, operates as a retail pharmacy and through Caremark as a pharmacy benefit manager also known as PBM. These facts further enhance the proposed transaction's substantial impact on New York's healthcare market, a matter, that, troublingly, the Department of Justice did not consider.

This transaction presents potential benefits as the parties have argued, but it also presents potential risks, including the risk of further

concentration and market dominance in the retail pharmacy market to the potential detriment of small businesses including independent pharmacies across New York State. CVS Pharmacy is not a DFS-regulated entity but it is one of the applicants in the proposed transaction we are considering today. Nor is CVS Caremark a direct DFS-regulated entity. However, as a PBM, Caremark contracts with numerous health insurance companies that insure millions of New Yorkers, not just Aetna and so DFS is carefully looking at this transaction through the lens of all of the health insurers in the State of New York.

This department has previously expressed, including myself, substantial concerns about the role of PBMs in the high cost of pharmaceuticals in this country and in the State of New York as well as the very nontransparent nature of PBMs,

which this proposed transaction now brings very much to the forefront of consideration.

Two years ago DFS proposed legislation for the licensing and direct supervision of all PBMs in New York State by DFS. Unfortunately the state legislature did not pass that law. Several states have passed PBM licensing legislation including the State of Kentucky which recently took action against CVS Caremark. DFS will continue to advocate for legislation for the licensing of PBMs by DFS, and in the meantime, DFS will continue to use its supervisory authority over health insurance companies in the State of New York to obtain much-needed information from PBMs including Caremark despite their opposition to transparency and regulation.

This background very much informs the Department's view of this transaction today.

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Turning specifically to the application for change of control that is before DFS under Section 1506(b) of the New York insurance law. That section provides that I, as the superintendent, shall disapprove an acquisition if I determine that such action is reasonably necessary to protect the interests of the people of this state. Under New York law the factors I am to consider in making this determination include the financial condition of the acquiring person and the insurer, the source of the funds or assets for the acquisition, whether the acquisition is likely to be hazardous or prejudicial to the insurer's policyholders or shareholders, and whether the effect of the acquisition may be substantially to lessen competition in any line of commerce in insurance or tend to create a monopoly therein. In short, the statute provides very broad authority, and my

responsibility is to consider the impact on the people of New York State and to ensure that, were this transaction to proceed, adequate oversight will be obtained so that promises being made by the companies today are kept in terms of the proposed reduction of costs to consumers and the proposed betterment of healthcare services to New Yorkers.

The department has spent a substantial amount of time over a period of many months reviewing this transaction and has had numerous meetings with the applicants, during which we have asked many questions and requested further information.

The purpose of this public hearing is to provide the public with the opportunity to comment on the proposed transaction so that the department has public input on the potential implications of the transaction for New York State, whether

positive or negative, as well as the impact on the availability, affordability, and quality of health insurance in New York. In our notice of this hearing we invited written comments and oral testimony. We have received a good number of written comments, and we have a number of witnesses who have asked to testify in addition to the parties.

Everyone who has requested to be heard will be heard today. They will present their testimony. I may ask questions. Based on those present here today it appears we will have the opportunity to hear from the parties themselves, from consumers, from providers, from pharmacists, from provider groups, and from members of the legislature. So we have a full audience of people wishing to be heard. I assure you we will consider all comments, written and oral. As described in the hearing notice, CVS

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and Aetna, who are the parties proposing this transaction, each will have 10 minutes to describe the transaction, and that 10 minutes is exclusive of our questions up here, followed by any other individuals or groups, each of whom will have five minutes for their comments. If needed, after members of the public testify, I may ask CVS and/or Aetna to answer additional questions. We will not close the hearing record today. We will follow up with the companies as needed to request additional information based upon what we hear, and as stated in the hearing notice the public will have five businesses days after today to submit any written additional written comments, as information gathered at this hearing might cause members of the public to provide additional information and we will hear that.

So I have said a lot already but

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I do want to set forth a few specific issues before we go to the oral testimony today. I set forth some of these things in my letter to the Connecticut Insurance Department but I wanted to set them forth before the witnesses' testimony which can be on any subject but I wanted people to understand the issues that we are considering in evaluating this transaction.

First, the transaction's impact on premiums. CVS claims that this transaction would result in operational synergies and that the combined company would achieve substantial financial cost savings. CVS also claims efficiency gains from its MinuteClinics in CVS Pharmacies, where consumers can stop in without an appointment to see a nurse or a physician's assistant. As of today, it remains unclear whether, how, or when these cost savings would result in lower premiums or other

actual savings to New York's consumers. It is imperative that any claims of cost savings be specified from the perspective of the New York consumer, including the many Aetna policyholders and that guardrails are placed to ensure that any promises that are being made today in other words to obtain governmental approval are actually realized.

Second, the transaction's impact on pharmaceutical costs. Pharmaceutical costs are the single largest driver of premium increases today. As I already mentioned, CVS owns a very large PBM, pharmacy benefit manager, CVS Caremark. We have great concerns that PBMs are just another cog in the wheel for profit making, to the detriment of consumers.

Today, the top three PBMs control 70 percent of the business in this highly opaque industry. CVS Caremark is one of the three PBMs with this

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dominant market power, and this merger, if approved, would further cement its position by removing Aetna as a potential competing client as well as a possible competitor in the PBM market. It is also worth stressing again that PBMs lack full transparency and are not directly regulated in New York at the present time. As I said, we will continue to advocate for the licensing of PBMs by this department before the state legislature.

Regardless, were this transaction to proceed DFS would have the right to full transparency of CVS Caremark through our licensed insurers in the Aetna group and DFS would thereby have examination authority over the CVS entities through New York's existing holding company statutes.

This transaction also raises significant market competition concerns with respect to pharmaceuticals because CVS Caremark as a PBM would have the

power and the financial incentive to offer Aetna larger rebates or other significant discounts to draw policyholders away from other insurers, resulting in an even larger Aetna market share.

As a result, small and regionally based carriers without an affiliated PBM may be disadvantaged, thereby harming New York's market and consumers.

We are told that this will not happen. DFS must have the ability to ensure that this promise, in fact, will be the case for the transaction to proceed. Relatedly, we are concerned from a competitive standpoint that Aetna may create incentives to use CVS services rather than the services of other retail pharmacies which would lead to drug price increases. Through the merger we are concerned that Aetna may created cost sharing structures network designs or other incentives for

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its insureds to utilize CVS services other than those of CVS's competitors, creating greater concentration in the retail pharmacy business and harming independent pharmacies. This would not only increase CVS's market share and the retail pharmacy industry, but the reduction in competition could result in the loss of small businesses and higher drug prices passed onto consumers including New York policyholders of other insurance companies regulated by DFS.

Third, the department has data privacy concerns. CVS Caremark currently has access to drug claims data, patients' electronic medical records, and other member information from insurers that utilize its PBM services, and that presently compete with Aetna. We must ensure that this transaction will not compromise consumers' data and that consumer data is not shared within the

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post-acquisition entities for the purpose of increasing CVS's and Aetna's market share and profits. CVS must also commit to strong safeguards to protect and prevent the sharing of customers' data, both within the organization and outside of it. The privacy of the data must be amply protected from third parties and, yes, from hackers. New York has been a leader in cybersecurity, and we must ensure that CVS, the entire enterprise, complies with our cybersecurity requirements. This transaction, if it proceeds, would create an even larger corporate organization in the healthcare space. This means that a tremendous amount of very sensitive consumer data would be under the control of this very large corporate enterprise. A data breach would have devastating consequences for consumers. We do not want another Equifax or Anthem breach so commitments in this

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area are crucial and regulatory oversight of any commitment to data privacy and protection is essential to fully protect both consumers and competitors.

Fourth, financial questions. The proposed transaction involves a considerable amount of debt. The overall transaction is 69 billion dollars. That's approximately $207 per Aetna share. The amount of the debt being undertaken is over 40 billion dollars that CVS would be assuming to finance this transaction. The department has already expressed its concern that this increased debt may created pressure on Aetna to raise premiums or take other actions that negatively impact consumers. We understand that CVS has committed that the ultimate parent company, CVS Health, and only that company will bear the responsibility for the transaction debt, and that it will use CVS Health's

revenues from other business operations as well as what otherwise would be dividends and share repurchases to pay down the debt. In our view there must be a clear, enforceable commitment that New Yorkers will not pay a penny to finance this acquisition in insurance premiums or otherwise.

Also, the considerable pressure to repay debt may cause the resulting company to repay its debt obligation before investing in the pro-consumer measures that are being advocated including infrastructure improvements that would be beneficial to consumers and provide relief to premiums. We must make sure that the promises being made here will be kept.

Fifth, community support. As we all know, CVS has a substantial retail operation that is present in many communities across New York State. One of the stated objectives of this proposed transaction is that these

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retail stores will be utilized to further the company's expansion into the healthcare market. CVS claims that this transaction will benefit consumers because of the geographic availability of CVS stores in communities that can provide better access to healthcare services.

At DFS we are very focused on ensuring that financial services companies are serving and investing in all of New York's communities across the state. I am very interested in hearing how CVS intends to implement its business plan across New York State in a manner that serves New York's communities fairly and equitably, including those communities most in need of affordable healthcare services.

Finally, Aetna's reach. As mentioned, Aetna insures millions of New Yorkers. As part of this proposal Aetna must commit to maintaining Aetna's products, services, networks

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and that this transaction's proposed savings are actually felt by New Yorkers including in premium reductions. I have already expressed my concerns that Aetna has not participated in the individual market on New York's Health Exchange under the Affordable Care Act.

If the transaction proponents are really serious about their claim to protect New Yorkers in communities across the state, then they will support the Affordable Care Act markets in New York, assist New Yorkers who are uninsured and underinsured, and provide healthcare service to everyone, not just the rich.

These are just some of the topics that I wanted to raise at the start of this hearing. These topics have been raised previously with the parties in my letter to the Connecticut Insurance Department and in meetings with CVS and Aetna. By no means does this summary

indicate one way or the other how the department will decide the applications that are specifically before us. I have made no decision and I will not do so until my dedicated staff and I hear all of the testimony, both oral and written. So with that introduction, given that this is CVS's change of control application, it is appropriate for CVS to speak first today, and we would ask that CVS come forward. CVS will have 10 minutes to present its oral testimony exclusive of any questions. After CVS concludes, Aetna will follow for 10 minutes, also exclusive of questions. After Aetna I will request the witnesses who registered to speak today to come forward in the order in which they registered to speak. Each witness will have five minutes to speak, and I may ask questions.

If anyone here desires to speak but has not registered, please come up

and provide us with your name. If we have time we will gladly have you speak as well. So with that I ask Aetna to please come forward and begin the testimonial aspect of this public hearing. Thank you.

MS. FERGUSON: Superintendent Vullo, Executive Deputy Superintendent Evangelista, Deputy Superintendent Oeschner, Deputy Bureau Chief Wiest, and other department officials thank you for having me here today to discuss CVS's proposed acquisition of Aetna. My name is Betsy Ferguson. I am the deputy general counsel for CVS Health. On behalf of CVS Health, I want to express our appreciation for the Department's serious review and consideration of this matter and the time and attention you and your staff have devoted to understanding the benefits of this transaction for the citizens of New York.

Most of you know us as the local

pharmacy in your community, but we are more than that. We are a front door to a back to better health. We have long been at the forefront of putting patients first and improving health in our communities. Over the past years we have taken bold steps that define us as a healthcare company. We removed tobacco from our stores. We are promoting healthier food options. We are waging a multi-front fight against the opioid epidemic by limiting prescriptions consistent with the CDC guidelines, in order to help reduce the chance for addiction. We are also providing increased counseling, expanding access to safe and convenient drug disposal locations. Here in New York, we have donated 77 drug disposal boxes to police departments across the state, and we are expanding our commitment by bringing disposal boxes into pharmacies. We have 49 new drug disposal boxes in CVS pharmacies.

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These drop boxes have already collected over three metric tons of unused medications.

Our commitment to public health is central to our purpose and a reflection of who we are, a healthcare innovator committed to working to build a better, more affordable and easier way to navigate the healthcare system for all Americans.

Today, the high cost of prescription drugs is one of the nation's most pressing problems and a major source of financial worry for consumers here in New York. We are addressing this challenge comprehensively by negotiating lower drug prices and reducing out-of-pocket costs, and we are giving patients, prescribers and pharmacists expanded capabilities so they can evaluate the prescription drug coverage in realtime and identify lower cost alternatives.

Our acquisition of Aetna signals

our next bold step as a company. Our healthcare system in many ways is still a work in progress. It was built for a different time, for a different consumer with different needs. It is fragmented, complex, and burdensome for consumers and providers and it is unsustainably expensive. It faces huge demographic and chronic care challenges as well. The State of New York and this department have recognized these same challenges and have adopted numerous state initiatives intended to explore alternative approaches to delivery of healthcare services. In adopting the state health innovation plan this department acknowledged the need for innovative new approaches to achieve optimal health outcomes for all New Yorkers. Our vision is aligned with your policy goals. We seek to create a new healthcare platform that's easier to use, less expensive, and puts consumers at the center of their care.

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The Aetna-CVS merger will benefit consumers in New York and result in a meaningful cost savings and other consumer benefits. Importantly it will inject much-needed change into a broken healthcare system.

I would like to highlight three ways this combination will benefit New Yorkers. First, we will put consumers at the center of their care. Consumers are looking for more value, convenience and help in making healthier choices in their everyday lives. By effectively coordinating patient care, we will provide consumers the information and resources they need to better manage their own health. A key driver of consumer benefits from the combination is the ability to combine CVS Health's pharmacy data and expertise with Aetna's medical data and expertise. By enhancing access to data and through greater use of predictive analytics the combined company will create targeted

interactions with patients that will provide greater access to healthcare, better care coordination across providers, and post-discharge support by pharmacists and other providers to increase medication adherence and reduce hospital readmissions. Together increased patient interactions will help lower medical costs and help improve health outcomes for consumers. We will expand opportunities to bring accessible healthcare services to consumers and to complement the care that they receive from their physicians so they have the support they need to stay healthy between doctors' visits. For example, we will modernize and simplify communications to patients when prescriptions are filled to help them effectively manage their medications to increase adherence and reduce costly medical complications.

Second, today, one out of every two Americans lives with a chronic

disease. We will increase our focus on preventing and managing these conditions. By combining pharmacy and medical information, pharmacists will better be able to help provide information from the doctor to the patient at the pharmacy counter. We will empower patients to more effectively manage their health.

We believe this combination will strengthen that relationship and improve continuity of care between a physician and his or her patient. A physician may see a patient several times a year, while a pharmacist may see the same patient once or twice a month. This provides a natural opportunity to reinforce the instructions and messages of the physician as pharmacists engage with patients to help to prevent disease and coordinate care effectively. Diabetes is a key area where we have an opportunity to reshape the delivery of

care. Today an estimated 1.7 million New Yorkers have diabetes. We will be able to deliver preventative counseling for prediabetics. Once a diabetic is diagnosed we can make it more convenient for patients to manage their care. This would mean advanced care between physician visits, expanding the use of convenient digital tools such as remote monitoring of key indicators, and improved care followup.

Today these types of innovations are often offered in an ad-hoc or fragmented way. Combining CVS Health and Aetna's resources and skill sets will enable us to better support and coordinate the care that consumers are seeking across healthcare settings.

Third, to make real progress in making healthcare simpler, more accessible and more affordable, we have to break down the barriers to better care. We know health can only provide if consumers are connected to

pharmacists and providers who live in their communities and understand their personal experiences. In New York we have made more than 1.6 million in charitable donations. Some specific examples in New York include providing funding for tobacco treatment and smoking cessation, supporting the expansion of the Northside Child Development Centers mental health programs and schools and supporting addiction treatment programs. Our commitment to being a positive force in local communities is a central tenet in how we operate as a company, and we are proud of the work we do with our local partners.

I'd like to next address a concern that you expressed, that when CVS and Aetna have merged, the combined company will have the incentive to favor Aetna and disadvantage smaller insurers, including those not affiliated with PBMs. That concern is

unfounded.

Health plans and other payers make up a substantial portion of CVS Health's revenues. Any action by the combined company that would disadvantage health plans competing with Aetna would be extremely short-sighted. Rather than looking to harm those important customers, CVS will be looking to expand and improve on the products and services it offers to these customers.

We testified before Congress about those providing those enhanced offerings in an open-source type model. It's not surprising then that healthcare plans have responded positively to the proposed merger. In New York, healthcare customers have not indicated an intent to terminate the contract, and we have other potential clients that have expressed an interest.

For us, the combination with

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Aetna is the next step in our company's long-standing commitment to healthcare of all Americans. We don't see it as more of the same, but rather a bold innovation that will reshape how healthcare is accessed and delivered, starting first by putting the patient at the center of all we do. Building from that simple premise, we will create a new healthcare platform that's easier to use, less expensive for consumers, and that partners with the local healthcare partners to deliver superior coordinated care.

Finally, I would like to take this opportunity to confirm the transaction meets all seven of the factors that you set forth. I submitted an affidavit to the Department that presents key facts around those factors.

Thank you for the opportunity to describe the benefits of our combination with Aetna. We are

committed to working with New York State regulators to ensure consumers receive high-quality, affordable healthcare. I appreciate the opportunity to testify here today.

At this time, after questions, I would like to turn things over to Steve Logan.

SUPERINTENDENT VULLO: Great.

So thank you, Ms. Ferguson for that.

I do have a few questions based upon what you have said. You have indicated that part of the goals of this transaction is the, sort of, use of pharmacists and, you know, the fact that a physician may see a patient a few times a year but the pharmacist may see the same patient more frequently. And so the question that I have about that is, well, you already have the retail pharmacies so you could already do those things. You don't need Aetna to do those things, and so what's your,

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I guess, comment on that?

MS. FERGUSON: Yes, so actually, I think it's really interesting. The way physicians and pharmacists communicate today is like it's 50 years ago. There are faxes that go back and forth. The pharmacist may call the doctor in the morning, the doctor may call back at a break, that pharmacist may still be there, another pharmacist may be on staff. What we would do is create what I call a skinny EMR, so that the pharmacist can actually received messages via EMR into the pharmacy -- and not just CVS pharmacists, by the way. This is something for all pharmacists, so that they can get this messaging in the standard EMR the doctors use in sort of a skinnied-down version so they would know if a doctor wanted to send a message to the pharmacist, it could come through that. Any pharmacist on duty could look at that when the

patient came in, and send messaging back and forth between the pharmacist and the doctor. "Saw your patient today. They haven't been in for two months to pick up their medicine. Right? So all your patient --

SUPERINTENDENT VULLO: Right, but CVS could do that today. I don't see where Aetna allows it to do that which it can't already do today, right? You could create a system today for the sort of interaction of the pharmacy with the providers. What does Aetna add to that? Why do you need to spend $69 billion to acquire Aetna to do that?

MS. FERGUSON: Well, it's a lot of money, but today, the incentives aren't aligned. Today pharmacists aren't paid for these type of interactions. To create the skinny EMR we need health plans at the table and we need doctors at the table, and we need pharmacies at the table.

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SUPERINTENDENT VULLO: Right. But you have the health plans through the PBM. Why do you need to acquire Aetna? Again, you have all of that. You have the health plans. You have, you know, probably a third of the PBM market. Again, it's not that you have that aspect of it -- right -- so you could create a model and do that, you know, without buying Aetna.

So I guess what I am suggesting is you don't need this to do that so why approve a transaction to acquire Aetna when you could already do these things, and you have had the ability to do it, and maybe you can spend that $69 billion on that.

MS. FERGUSON: Well, I don't think we have $69 billion just to develop internal programs that may or may not get uptick. We believe that the way incentives are currently aligned the reason the market hasn't done this -- and no one in the market

has done this -- no other PBM has done this, no other health plan has done this, is because we don't think the incentives are aligned the right way. We think this transaction helps align incentives in such a way that it will help pharmacist practice at the top of their license. Right now we think pharmacists in many states are doing things that should be done by technicians and that they should be treated fully as health care providers in a way many states don't have them treated.

SUPERINTENDENT VULLO: Okay, and so then, turning then to a comment that you made about so if all of that is true and would happen, you know, why, then, is there not the incentive through the PBM and through this acquisition to favor Aetna, and your response to that was that that's unfounded because CVS Caremark, its PBM -- the PBM has relationships with all

of these other health insurers, and so the incentive to favor Aetna is not there because the other health insurers won't contract with CVS as a result of that, and so that might be the case but there's no real transparency into that. So my question is, if you really believe that's the case, will CVS agree to the Department's bill to license PBMs in the State of New York just like Kentucky has done, Arkansas has done, and multiple other states.

MS. FERGUSON: We won't oppose the bill.

MR. OECHSNER: Speak into the Mick.

SUPERINTENDENT VULLO: Will you support the bill? Will you vocally support the bill?

MS. FERGUSON: I'm not in a position without the input from my government affairs to say that we'll support it, but we certainly wouldn't oppose it.

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SUPERINTENDENT VULLO: Okay. How do you answer the concerns of the independent pharmacists who have raised concerns? There's already some written comments on that and I understand that there's one or more intending to speak today. They make up a large percentage of the pharmacy market in New York. They are already concerned about CVS and other similar large chains, and they are serving the communities. They have -- they don't have the capital that a large corporation like CVS has, and what will this to do to them and, you know, small businesses across the state, which is something we have to consider as well.

MS. FERGUSON: Yeah, absolutely. Today, independent pharmacies make up 57 percent of Caremark's networks. It's an eight percent increase since 2013, and while I empathize as a pharmacy with reimbursement across the entire pharmacy space, reimbursement

drops year over year in the pharmacy space but our independents in the Caremark network are paid higher reimbursement than chains are, and that includes CVS. So they will --

SUPERINTENDENT VULLO: Right, but there are still retail pharmacists who claim that they can't get into the sort of Caremark networks or the preferred on the formularies and all of the things. Now, you know, certainly, if we had full oversight through licensing of PBMs we might be able to address some of these issues, but I think these are valid concerns that they might not get within the sort of reimbursement and now you have, you know, a large health insurer also potentially become a part of this, and doesn't that amplify their concerns and their ability to survive?

MS. FERGUSON: Yeah, so I actually think it doesn't amplify their concerns. I think that independent

pharmacies participate in preferred networks, typically through PSAOs which are organizations that are owned by large corporations and take the negotiating power of many, many independent pharmacies and negotiate very effectively for them. So we do have numerous PSAOs and independent pharmacies that are in preferred networks. We think independents serve an important purpose and we have no interest in independents not existing. Let me get back to 50 percent of our networks in New York are made up with independents. Or independents make up 57 percent of our networks. Sorry -- let me get my statistic right. That would be helpful.

SUPERINTENDENT VULLO: So this -- you have said in all of the documentation it's -- not just in what you said, so I am not trying to just say it's you. There's lots of people that have submitted this on behalf of

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the parties and the proponents of this transaction, that there is a goal -- although the statements are stronger than a goal -- of reduced costs and improved healthcare. And those are both very laudable things, but I have a concern and I said this in my opening remarks. It's one thing to state all of those things as part of a governmental approval process. It's another thing to have guardrails and ensure that those things will actually come to pass. And if you are going to say that those things will happen, then I would assume that there is some written business plan within CVS that sets forth all of these things, quantifies the costs that -- of savings and sets forth how in New York this is going to be achieved. So I am asking you is there such a document, specific to New York, as to how the reduced costs are going to be received and benefit the consumer and the better

healthcare across New York State, which retail pharmacies are going to benefit? Which of the 500 some-odd pharmacies -- how is that going to be spread out across New York's communities? So is there such a written business plan that sets this forth? And maybe there's not, but we haven't seen it, so we would like to have it.

MS. FERGUSON: There isn't one right now. It's -- as we discussed with your staff, it's a little bit the chicken and the egg. There is lots of work doing done but until we actually close, there is lots of sharing that can't really go on, and so I think teams are working with ideas. We are thinking about pilots and we are looking forward to closing and really pinning down exactly how we're going to do this.

You asked for some information from me earlier in the week. I am working to put some things together for

you but we certainly don't have that of which you just spoke.

SUPERINTENDENT VULLO: So that's -- I mean, there are affidavits that have been submitted saying there will be reduced costs, there will be better healthcare. Those are great goals, but to, sort of, say it's being done without actually having the written business plan that says how and what those savings are, you know, is problematic. I mean, obviously, there's sharing issues or what-have-you, but some of this, as I said before, is not dependent on Aetna. It's other concepts and so, you know, that, again, raises concerns because it's not appropriate to say things to get transaction approval, and then, after transaction approval, say, oh, but you can't even inquire in all those things and you don't have the ability to, you know, demonstrate or ensure that New Yorkers will actually benefit

in the ways that you are proposing. Which, if it happens, would be a great thing. So, you know, I have stated the concern, and so you have confirmed there is no such written business plan, which I know my staff has been asking for over and over again. So whatever more you can provide us on that would be very helpful.

MS. FERGUSON: Yes, again, I mean, there is a difference between our ideas and what we are working on and having a specific, written work plan for New York. I think we are very comfortable that the plans we have are going to transform healthcare, save patients money, put them at the center of their healthcare, and help them take control of a fragmented system and be able to operate better in it. At the end of the day the goal at Aetna and CVS is that people lead healthier lives.

SUPERINTENDENT VULLO: Is there a

timeline on when you would expect to roll out whatever new innovations would be part of this transaction? You know, it's just a like a timeline. I mean, obviously, these are big idea, but is there a timeline? There is no specific written plan, but is there a timeline for a roll out such that we could actually say to a New Yorker, you know, there is going to become a point in time in the future when you are going to see this realized in your life.

MS. FERGUSON: And as I said earlier in the week, I will be getting back to you with th New York-specific timeline.

SUPERINTENDENT VULLO: Okay. We will wait for that. So thank you.

And let me just turn to you all. Is there something all you want to ask before? We're good? Okay. Great.

Thank you, Ms. Ferguson.

And next, we are asking for Aetna.

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MR. LOGAN: Can everybody hear me? Can everybody hear me?

SUPERINTENDENT VULLO: You have to speak kind of close to it.

MR. LOGAN: All right. Good morning, Superintendent Vullo, Mr. Oeschner, Ms. Evangelista and Mr. Wiest, I am Steve Logan, president of Aetna's New York and New Jersey market.

You have my written testimony as previously submitted, so if it's okay, I don't plan to read that here.

SUPERINTENDENT VULLO: That's fine.

MR. LOGAN: But I would like to make a few opening comments before I answer any questions you may have.

First, on a personal note, as one who has spent virtually my entire career working in this market to advance innovations around the products we offer to New York consumers, I truly believe this coming together of Aetna and CVS offers the most promising --

one of the most promising healthcare developments I have seen. The status quo is not sustainable. I see it year over year. Costs continue to rise, outcomes and patient experiences fall short of what New York consumers deserve. We seek to create a better experience for members at the local level, which means a local presence. Our vision will combine CVS's footprint, its retail footprint, its local presence with our health plan, our health plan analytics, and our broad network of providers, hospitals and medical partners throughout -- in New York and throughout the country. I would also like to just make the statement that in no way do we want to disrupt, displace or diminish the critical physician-patient relationship. In fact, we feel that some of the enhancements and services that we can bring to bear will help fortify that relationship.

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And a little bit about the commitment to the New York market. As you referenced, Superintendent, we service approximately 1.1 million medical members, 800,000 dental members, 50,000 student health plan members, and over 100,000 seniors in our Medicare Advantage plans. We have over 1,500 employees in New York. We have offices in Amherst, Albany, Long Island, throughout the New York City area. I am personally proud of the work that this team does on behalf of our members, our provider partner, our plan sponsor customers. I'm even especially proud of the work they do in the community. That same team this year alone has already dedicated over 14,000 volunteer hours to serve the communities for which we reside. Our goal through this transition is to grow our New York footprint and remain committed to New York.

Again, thank you for the time,

and I would be happy to answer any questions you may have.

SUPERINTENDENT VULLO: Great.

So thank you for that, Mr. Logan. So -- and I did read your entire written testimony, and we appreciate that, and that's all part of the public hearing record which is available to the public. So what will be your role, going forward if this transaction proceeds, as well as other members of Aetna management?

MR. LOGAN: My role will continue, as I understand it. No, but my role will continue as is, running the New York and New Jersey markets and my teams. Again, this is being managed as a separate unit and the messaging that we are giving our teams is that we need each and every one of them because its very different from --

SUPERINTENDENT VULLO: Have retention arrangements been discussed with CVS to sort of ensure that, you

know, Aetna employees, management as well will continue after the transaction so that what you are saying, which is Aetna has all this commitment to New York can actually be implemented by the people who have been doing it and are saying that they will be doing it in the future?

MR. LOGAN: We have -- I have been in a position -- I can't speak on behalf of CVS. I have been in a position and I have been giving reassurances to some key teammates, team members, and they're excited about it.

SUPERINTENDENT VULLO: Okay.

MR. LOGAN: I worry about a lot of things. I am not worried about employees.

SUPERINTENDENT VULLO: Okay, but this is a different thing. Aetna is currently an independent, you know, New York Stock Exchange, publicly held company where the management of Aetna

has been managing Aetna. And now, just -- I mean, you know, just CVS is going to be on top and the CVS board, which is also a public company, and is paying the Aetna shareholders to bring it, you know, to bring it under its wing, is going to be managing things and Aetna doesn't have a majority of that board and won't go forward, so just trying to understand how we can be sure that, you know, whatever Aetna's commitments are will continue because you now have different shareholders.

MR. LOGAN: Understood, and that's probably a question better for my CVS team.

SUPERINTENDENT VULLO: Fine, fine. I appreciate that.

You have said that there are about 1,500 employees of Aetna in New York, and is there -- and when you say you want to grow New York's footprint, what do you mean by that?

MR. LOGAN: I --

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SUPERINTENDENT VULLO: More employees?

MR. LOGAN: It would be my hope that we would have more employees. We have far more employees than we did five years ago in New York, and it's my hope that five years from now that we have even more.

SUPERINTENDENT VULLO: Okay. And is that by expanding in the health insurance market or something else?

MR. LOGAN: As I said, health insurance, commercial, Medicare, dental.

SUPERINTENDENT VULLO: How about the individual market on the New York State of Health?

MR. LOGAN: Presently we are not -- as you stated --

SUPERINTENDENT VULLO: How about joining the New York State of Health, the individual market, and helping people who are uninsured get insurance with Aetna's formidable networks?

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MR. LOGAN: That is something that we can discuss after the transaction.

SUPERINTENDENT VULLO: Okay. We appreciate that.

In terms of -- again, this sort of going forward, you know, and this kind of commitment to New York, I mean, I do note that as part of the Connecticut Insurance Department's decision on this transaction that Aetna has made commitments to maintain its headquarters in Connecticut and other things with employment in Connecticut. So, you know, one could argue that's obviously a positive economic development thing for Connecticut. One could also argue that that took precedence over the consumers including, you know, in other states, but how does that situation affect Aetna's ability to grow its footprint in New York given that there is a commitment made to Connecticut?

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MR. LOGAN: I see it having no impact.

SUPERINTENDENT VULLO: Because?

MR. LOGAN: Because we -- even for the past five years our corporate headquarters have not been in New York and we have been able to grow.

SUPERINTENDENT VULLO: Right, but you have committed also to not having less than a number of employees in Connecticut. I thought that was part of the commitment as well, is not to reduce the amount of --

MR. LOGAN: I would ask our CVS team to answer that.

SUPERINTENDENT VULLO: Okay. How did this deal come about? Who called who? Do you know?

MR. LOGAN: I don't know.

SUPERINTENDENT VULLO: Was it Aetna calling CVS or CVS calling Aetna?

MR. LOGAN: I don't know.

SUPERINTENDENT VULLO: You don't know? Who would know that?

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MR. LOGAN: You would have to ask CVS.

MS. FERGUSON: Our submission, I believe, laid out the framework.

SUPERINTENDENT VULLO: Okay. And the amount that the shareholders of Aetna would receive from this transaction in both cash and stock of CVS are $207 a share, do you know that?

MR. LOGAN: That sounds -- I don't know the specifics on it. That sounds correct, but I would have to defer.

SUPERINTENDENT VULLO: You are not on the board of Aetna Inc., or anything and you weren't part of those discussions?

MR. LOGAN: No, I was not.

SUPERINTENDENT VULLO: Anybody have anything here?

Okay, thank you.

MR. LOGAN: Thank you. Thank you.

SUPERINTENDENT VULLO: Okay.

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(Off the record discussion, technicalities.)

SUPERINTENDENT VULLO: So we have to make sure because we have to make sure the witnesses can be heard. I wish I had known that. We would have done something. We will not let you go through that again.

If, when the next witnesses come you can't hear please raise your hands and we will try to do it, to do our best. I will shut this and see if you can... great, okay, thank you.

Okay, so as said, we just took, you know, basically, the order in which people registered to speak, and the first people both from the Pharmacists Society of the State of New York, Kathy Febraio and Roxanne Richardson have both registered, so you can both come forward.

And, again, we are trying to keep it to five. I am not going to be such a stickler, but we obviously want to

make sure everybody gets to speak.

MS. RICHARDSON: We will do our best. I know you'll be able to hear me. My husband says you can hear me without a microphone most of the time, so.

I would like to introduce Kathy Febraio. She is the executive director of the Pharmacists Society of the State of New York. And as Director said, I am Roxanne Richardson. I am now serving as chair of the organization and a registered pharmacist for many, many years. I would certainly like to thank you for allowing us to testify.

As a voice of more than 2,300 community pharmacists we are very concerned how this merger or acquisition will impact the patients who rely upon their neighborhood pharmacists for their professional services. One thing I would like to correct Ms. Ferguson on was that we do have a group of pharmacists throughout

the state in different areas that are being paid for professional services, that do not get paid through the PBM, and it's something that has to have come about because of the horrible reimbursements that have come about over the years. And we can certainly get you more information on that. Bringing the insurance company and the PBM together in-house is tantamount to the fox watching the hen house. There is little incentive, in our opinion, to control costs or their business practices. One thing also: CVS says they pay the independent more than they are paying the chains, but there's really no way that we can verify that because there is no transparency in these payments. We know what we get paid and we don't know what the health plan pays or what the chains are paid. So I have to kind of question that.

We believe the State of New York needs to construct an infrastructure to

monitor the business practices and these vertically integrated entities to protect patient access and availability of their medications, and to help control healthcare costs. We certainly fully support the oversight of the industry -- the PBM industry -- by the state.

Network adequacy has been brought up, how CVS Caremark is the second largest PBM in the country, managing approximately 34 percent of cover lives. Obviously this gives them significant control over the pharmacy networks. Community pharmacies really have little negotiating power as far as any contracts that they get. It's funny that they're called negotiated contracts because usually it's a take-it-or-leave-it type of situation, and usually, if you don't take the contracts that are paying you under water, you don't get any contracts at all. So then you're not getting

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anything, and good-bye business.

So many of these things, you know, are kind of mentioned as negotiated contracts, or these terms can be kind of ambiguous.

Caremark can also simply exclude you from their networks completely if they feel like it. They are limiting patient access and also killing that relationship that the neighborhood pharmacist has with the provider and with the patient especially. Aetna did just this in 2017 and in 2018, precluding many, many independent pharmacies from even bidding on the preferred Medicare network participation. Ironically, as we have said the DOJ has approved everything, because Aetna's selling off their Part D well care business -- yeah, is selling off its business, CVS Caremark is still going to be in control of the Part D lives because that's the PBM.

We also feel that CVS

incentivizes patients to use certain pharmacies by lowering the copays for those pharmacies. The out-of-pocket costs will increase if a patient wants to stay with their independent pharmacy that doesn't happen to be preferred, that's considered to be a non-preferred pharmacy, even if they are in the network.

Formulary construction. Obviously they have all those negotiating power and the formularies are considered a cost controlling industry standard, but since 2012 CVS Caremark has more than quadrupled the number of treatments that it will not cover.

I have to also just throw in here -- I know personally that I have seen a prior authorization denial for an anesthetic topical product, and the Caremark recommended other products which happened to be just narcotics, tramadol and oxycontin, to replace that

topical anesthetic for the patient.

Patients often choose their health plan based on the formularies and randomly timed changes by the PBM force patients and their providers to choose different therapies. So it maybe mid-year, but all of a sudden what you have been taking isn't covered. This can cause anxiety, new side effects, nonadherence and added cost, and decrease the quality of overall health to the patient.

So that's my little speech and now I will turn it over to Kathy.

SUPERINTENDENT VULLO: Thank you.

MS. FEBRAIO: Thank you, Roxanne. And I would like to discuss medical loss ratio. The MLR was developed as part of the Affordable Care Act to better provide value to patients and to increase plan transparency. Ironically, the contrary has resulted. There are two main types of contract models between a PBM and a health plan,

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and they both impact the medical loss ratio. In the rarely used pass-through model, there is no markup on the drug cost. The health plan pays fees to the PBM, which must be counted as administrative costs in the MLR ratio. So this model lowers a plan's MLR and potentially increases the plan's patient rebates.

With the spread pricing model, where the PBM charges the plan more for the drugs than it pays the pharmacy, and it keeps the difference as part of their payment, the spread is considered part of the medical claims expenditure. This improves the plan's MLR, improves the PBM's bottom line, and circumvents the intent of the MLR.

We have found many states are scrutinizing PBMs. In Ohio, the Columbus Dispatch investigation discovered $225 million in taxpayer funds going directly to CVS Caremark as a result of spread pricing models. As

a result, the Ohio Medicaid department is requiring all PBM contracts to switch to a transparent pass-through model by January 1.

In Kentucky CVS Caremark was assessed over $1.5 million in fines and placed on probation due to reimbursement violations. In the state of Kentucky they require PBMs to be licensed and therefore have this authority to do so.

West Virginia is moving back to a fee-for-service for their Medicaid plan, resulting in a potential $30 million in savings by eliminating the PBMs and the managed care plan model.

Last fall pharmacists here in New York City experienced sudden, drastic drops in generic medication reimbursements in the seven CVS Caremark Medicaid managed care plans. Payments to these pharmacies were often 40 percent or more below what they paid for the drug. Losing money on a daily

basis, pharmacies could not replace their inventory and it affected patient access to medications.

And with CVS Caremark controlling over 70 percent of the prescriptions, many pharmacies are in jeopardy of closing. The New York State reimbursement appeal laws that are in place were ignored. Following this CVS Health brazenly sent letters to pharmacies, offering to purchase their stores due to the dismal reimbursement environment, an environment they created. These are examples that highlight common business practices pharmacists see by the market-dominant PBMs, and it states a clear need for state regulation to protect patients, to improve drug costs and accountability.

We strongly urge the Department of Financial Services to create a robust infrastructure to regulate pharmacy benefit managers starting with

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the licensure and registration of these entities.

We believe the following is needed: Reporting functions to review network and formulary adequacy to ensure patient access to medications, reporting and oversight of copays to prevent patient steering, audit authority for the Department of Financial Services, a formal complaint and investigation process for patients and pharmacists affected by PBMs, and the creation of a PBM-funded emergency reserve fund in case of a health plan or PBM failure. We are creating entities that are becoming too big to fail and it is not the responsibility of the taxpayer to save them.

Thank you for your time and consideration.

SUPERINTENDENT VULLO: Thank you. Thank you, both of you, for your testimony.

I have just a question, just to

sort of understand. So if I am an independent pharmacy must I have a contract with the PBM in order to be able to dispense pharmacies that are covered by insurance?

MS. RICHARDSON: Yes.

SUPERINTENDENT VULLO: So then that gets to the question of negotiating power, and is there an organization -- that was discussed before -- an organization that helps the independent pharmacies in their negotiation with PBMs?

MS. RICHARDSON: There are what is called a PSAO that will sign contracts for pharmacies, yes, and it's usually a group of pharmacies rather than just single. There are still some independents that do this on their own. It's certainly a task, to say the least.

SUPERINTENDENT VULLO: Do you know -- what the -- if is there any study or is there something that would

set forth the reimbursement rates that the independent pharmacies get versus the reimbursement rates that the big retail pharmacies get. Was that just some -- is there some study or something that you're aware of that we can point to that shows that?

MS. FEBRAIO: We are not aware of a study that specifically looks at the difference between independents and chains. However, many states are investigating the difference between what the pharmacy is reimbursed versus what the plan, primarily a taxpayer plan, is paying. We are seeing much more research and study in that area.

SUPERINTENDENT VULLO: Right. The spread pricing, which I totally appreciate what you said about the MLRs, because if it's, you know, if it's in the medical claims then they have that 18 percent or whatever depending on -- to.

MS. FEBRAIO: And the incentive

to increase it.

SUPERINTENDENT VULLO: Right, right, right, right.

So if you are an independent pharmacy you cannot -- you need a PBM or you can't get pharmaceuticals or you just can't get them covered by insurance. I am not --

MS. RICHARDSON: That would be needed for coverage, yes.

SUPERINTENDENT VULLO: That would be needed for insurance coverage. Okay. Anybody? Yeah, go ahead.

MR. OECHSNER: Thank you. Thanks for the testimony.

In New York we have a bill that prohibits gag clauses. In other words, it prohibits and limits the ability of PBMs to restrict pharmacists from telling consumers when a drug costs less in retail than it would cost them for using their insurance. Can you speak to any concerns you have had with that?

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MS. FEBRAIO: Well, I think our primary concern with any law that we have passed in New York regulating PBMs is that it's very difficult to enforce without some entity having authority over the PBM in general and most of these laws reside in the public health law, which makes it a responsibility of the Department of Health currently, and they don't have that infrastructure. They are built very differently from the Department of Financial Services and struggle to enforce anything that we manage to get passed.

MR. OECHSNER: So you are saying that a legislation to give DFS authority over PBMs directly would greatly help in making sure that that's --

MS. FEBRAIO: We fully supported the Governor's proposal two years ago, and think that it is long overdue.

SUPERINTENDENT VULLO: Great. Thank you.

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MS. RICHARDSON: I would say, too, it's nice for the federal government to copy us, wasn't it?

SUPERINTENDENT VULLO: Yeah. Good point. All right, thank you.

Okay, the next person on the list is Dr. Charles Rothberg or Rothberg from the Medical Society of the State of New York.

DR. ROTHBERG: Thank you, Superintendent Vullo. I was here just a few weeks ago with my testimony. I am very proud to be a New Yorker. I think that the superintendent and her people really have a great command of all of the issues.

I was complimenting somebody, so thank you. Now I can talk. Now I can go sit down, right? And I also worked with Troy over the years on certain things, so thank you again.

So you have my written testimony and I will talk about some of the bullets points. But I also have the

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good fortune of speaking after the CVS and Aetna people, and I, too, would like to make some comments on their testimony, if I may.

Good morning. I am Dr. Charles Rothberg, a practicing physician in Suffolk County and the immediate past president of the Medical Society of the State of New York, and I thank you again for the opportunity to present my testimony.

As you know, the physicians of New York State have been sounding the alarm for years about healthcare consolidation and its consequences including, most recently, the proposal we are examining today.

MSSNY has issued several public statements and has written to the New York State Department of Financial Services, to the state Attorney General's Office, and even the Department of Justice, but I guess that didn't work out so well.

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We are very concerned about the implications that can arise from a behemoth health insurance company being acquired by a PBM giant. In addition to these concerns we have also been working with the AMA American Medical Association which itself has also written some opinion pieces to the Department of Justice expressing their strong concerns.

The other day I was speaking with an economist and she was very concerned in healthcare, and I asked her about vertical mergers because it appears to me that the Department of Justice has gotten this wrong and that they view all mergers as though they view horizontal mergers, and while this is technically different from an economics point of view, I think that the impact on consumers and on healthcare providers in the industry are no less considerable.

And I asked her if she could give

me an example of a vertical merger that benefitted the consumers. And I did this because I had given some talks at the AMA about vertical mergers in healthcare. So for example, where I am in Suffolk County, actually Long Island, we have a vertically integrated health system and we have a clinically integrated health system, one of the health networks. And at the time a few years ago the Attorney General's Office was interested in the clinically integrated system to be sure that it was actually providing a benefit to the consumers, and that it wasn't just some sham that organizations were using to affect their reimbursement. And what they found was that the clinically integrated system was less expensive than the vertically integrated one, and they abandoned their investigation. So with that in mind, I asked, well, what vertical mergers benefit consumers? And she gave me two. One was the

electric companies. Electric companies that are involved in energy production, maintaining the grid, and then, of course, the delivery to the consumers. I said, okay, that's reasonable. But what about another one? And she paused for a long time and then she said the MTA. So I asked her (laughter) -- thank you.

I asked her what do these two things have in common, because I wanted to be able to come here and talk about this. And she said, well, they are both monopolies, and I said, and they are both heavily regulated, aren't they? And I would offer that to participants here for consideration because that's not the kind of transaction that we are looking at today. But it's no less important than those two entities to the well-being of our citizens.

So I also wanted to thank Superintendent Vullo for her letter to

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the Connecticut insurance commissioner. Certainly, she discussed with you the things that she outlined in the letter, but I think that it's really, really important to just piece out the idea of the CVS MinuteClinics, because we feel, as the Medical Society that they might provide unfair competition to other medical providers and, of course, hospitals, which, when combined with the proposed ownership by CVS and a major health insurer creates major concerns about consumer choice, cost, and access. At previous testimony, a previous hearing that was conducted by the Assembly in June, the representatives of CVS and Aetna touted the value of their MinuteClinics, which I would respectfully disagree with, and they stated that these are physician run in New York State. And I would reiterate my testimony at that time that I have never seen a physician anywhere near one of those clinics.

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And yesterday, by chance -- and I'm the luckiest man in the world, I think -- we had a patient that came in. It wasn't from one of their clinics, but that was treated by a nonphysician, a mid-level provider, in an area of my specialty, improperly. They were given an anesthetic for an infection. And, again, I would argue that that physician teams provide better care than splinter teams, and there is abundant evidence for that. I would ask that that be considered. It's alarming to me, and I was quoted in a paper because this is shocking, that CVS thinks that they would like to be the front door to healthcare.

And back to the comments that we heard today, the idea that the combined entity will achieve anything that the separate entities were not inclined to do on their own is very curious to me, but the idea that they could reduce hospital readmissions is extremely

curious. We have in New York State a Medicaid waiver program called DSRIP which is a five-year program that involves $5 billion, I believe it was, or it's 5 billion a year, so it's $25 billion, and they are about halfway through that program. I think they are doing a good job but even with those professionals, with those dedicated resources, and with enrollment or engagement of all levels of providers, not just pharmacists and an insurer, but all levels of providers, physicians, therapists, pharmacists inpatient, outpatient. They are about halfway along to achieving their target. And in the 58 counties, I believe, that are involved, they have very different ways of achieving that which is very, very tailored to the special needs of the communities and I think that it's very naive or simplistic for a company like CVS and Aetna to suggest that in a retail

setting or an insurance setting alone that they can achieve what our state and all of our stakeholders are literally struggling but succeeding at. And, again, I would look at the enormity of that task with the company that states that they have no business plan, and the likelihood that they can achieve that.

Also, today, we heard that Aetna was committed to New York. And, look, they have a lot of employees there that volunteer their time. There's a lot of good employees in every organization. The CVS people said they gave a million dollars to some public service things like the opioids and whatnot. I think that's a pitiful amount to be talking about. We raise that much at our hospital every year, and there's only a few hundred of us physicians. Again, that just shows you the relative commitment that people have when they're part of a community. But just

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because the employees share our commitment to the state doesn't mean that the combined entity is going to share the commitment that their employees exhibit on their own.

For example, those of you who are old enough to remember Ingenix, which was a settlement that started here in New York because the Feds didn't do it, where an insurance company -- not the one we are talking about -- had a subsidiary that created a fraudulent database. That was the accusation, and they settled the claim, basically were cheating consumers of their reimbursement for their medical services. And Aetna was one of the companies that used that database. And one of the companies that settled.

Aetna, around the time of the Affordable Care Act being enacted, as a demonstration of their commitment to their subscribers let 600,000 of their subscribers go because of their

business plan. Maybe that's why they don't want to reveal their business plan today. And, of course, we heard that they don't participate in the New York Exchange, but they also ceased participation with about a dozen other states' healthcare exchanges under the Affordable Care Act. So that brings us back to their retail commitment. I think they do have an impressive retail presence. A lot of the communities that I serve, they actually have two CVSs. And my question is, and I don't have the answer, but my question, a rhetorical question is, if they feel that, or if Aetna feels that the CVS retail presence is going to provide access to healthcare to the citizens of New York State, are those locations located where the access is weak? Are they going to be solving a problem that we have or are they just going to be serving communities that already are well served? And I think that's an

important question to be answered when you consider a transaction of this magnitude. Just stuff I made up today, you know.

SUPERINTENDENT VULLO: I didn't make it up. It was actually in my speech.

DR. ROTHBERG: No, no, but these are the sort of things that -- and that's why people should come to these hearings, because you listen and we can exchange these idea and maybe get a better merger. I think the status quo, the idea that the companies said that the status quo is not sustainable. I don't know if that's true or if it's not true, but it's not a license for random and very difficult to reverse change. I think we need to have a plan. I think the company needs to have a business plan. I think we need to know what it is and how it dovetails with the objectives that we have for our healthcare system in this state.

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For example, the hospitals in this state, by statute, are all nonprofit. And so their ability to generate and raise capital for our projects is encumbered by that. Physicians have antitrust and Stark regulations that prevents us from engaging in the kinds of business activities that we would consider innovative. This company -- the combined merger -- does not have those same restrictions, and may actually interfere with the kinds of things that our hospital systems and physicians would like to engineer.

They say that there are no risks or that they don't wish to disrupt physician-patient relationships. Are there any physician groups that share that view of this merger or of these companies?

The opioid epidemic. There is a lot of blame to go around about that, and, unfortunately, in a related

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matter, there were hearings around the state, the marijuana legislation. That's a separate issue but I fear that we are hearing the same thing that we heard 20 years ago, and people need to stand up and be a little more critical. But the idea that CVS is limiting prescriptions as their defense against the rising opioid epidemic -- that's the law in this state. Is the commitment that this company has to this state merely to follow the law? We need some more leadership if we are going to grant a venture of this size.

I spoke about hospital readmissions and DSRIP. I want to share with you and, again, you have my written comments, and they are extensive. Patients change over the course of their lives and over the course of their illnesses, their perspectives, their needs and their ability to interact with the healthcare system. How does this combined

entity -- how does the retail presence allow somebody whose position in life, whose station in life through illness and through growing older or through maturing, evolve to meet the healthcare needs of those people? I think that they have a very unitary solution. I think they are going to do very well in solving the problems of a very finite group of people with finite healthcare needs, and they are going to do it at the expense of those of us who take care of the big picture.

I know you only wanted me to speak for five minutes, so I'll say that concludes my remarks.

SUPERINTENDENT VULLO: That's okay.

DR. ROTHBERG: But if I can just say one thing, just thanking everybody.

SUPERINTENDENT VULLO: Sure.

DR. ROTHBERG: We are very concerned about this consolidation. I thank the DFS for its recognition of

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these concerns, and urge you to reject the acquisition from going forward in New York. At the very least, it is imperative that there are requirements placed on CVS and Aetna to ensure that this enormous, combined entity preserves access to our community healthcare providers.

I do want to say one thing because the pharmacists reminded me about the PBMs, which is, in my view, dreadful that it is not regulated, and that it's not at all okay. This idea of asymmetry of information is what these companies exploit, and when I was talking to the PPS in my DSRIP, they can't get the information from the insurance companies so that they can -- they have to actually create their own information, which slows down their process of reducing hospital readmissions. I think that the insurer themselves should be responsible for the activities of the PBM. They are

essentially taking the PBM's product and reselling it to the people who purchased that insurance, and I think they should be held responsible.

Thank you.

SUPERINTENDENT VULLO: Thank you.

I mean, look, we agree that the insurance company has a responsibility, vis-à-vis the PBM, and that certainly, in the course of our work, we can examine the PBMs. But there needs to be the responsibility direct by the PBM through a licensing regime, and why does that matter? Because people say, you know, well, you can still find out some information. It matters a lot because taking action -- number one -- against the insurance company doesn't result necessarily in the benefit to the consumer in terms of premiums, right? But if you can take the action directly against the PBM which is broader, and you can sort of do something about the practices. You

know, so just to --

DR. ROTHBERG: We fully support what you are saying.

SUPERINTENDENT VULLO: So, let me ask you. How many members does the Medical Society of the State of New York have?

DR. ROTHBERG: What did Phil tell you last week? I count 20,000 paid. About 20,000 members.

SUPERINTENDENT VULLO: Thank you.

DR. ROTHBERG: That's it?

SUPERINTENDENT VULLO: Thank you. Anybody?

DR. ROTHBERG: Thank you very much.

SUPERINTENDENT VULLO: Thank you. Okay.

So next witness I have is Joanne Hoffman Beechko. All right. Okay.

I didn't see an affiliation there but I assume you will tell us.

MS. BEECHKO: I will.

SUPERINTENDENT VULLO: Great.

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MS. BEECHKO: Thank you. Thank you for having me. I own my own community pharmacy in Huntington. Full disclosure: I am a part of PSSNY state society, but I am here as a representative of the community of my patients. Small business owners who are my patients, hardware stores, car washes, delis, schoolteachers, policemen and women, firemen and EMTs, nurses, doctors, dentists, people who work for the local highway department, the local town government. You get my point. This is my patient base, and I have been their pharmacist for 28 years. I have reached out to several members of my community and inclusive in my remarks will be a couple of statements from some of them.

I purchased my store in '97 knowing that a Genovese would open across the street. Genovese is no longer around, transferred hands many times, and has since closed. That was

not a problem. I could handle this old-fashioned competition. Good old American competition.

Excuse me -- I will move this up here. Then CVS opened a couple of blocks away and, again, I could handle this. But when CVS was allowed to buy Caremark all bets were off. A retail giant now had a PBM contract negotiating entity as an arm of its business. In theory these entities were supposed to have a firewall between them, and yet constantly my patient base would come in to tell me of letters that they would receive offering them coupons and transfer benefits for them to use CVS. Then mail order contracts designed by Caremark made maintenance medications only available through their mail order pharmacy or their local CVS two blocks away from me. My associates and I, other pharmacy owners, other pharmacists in the communities

scratched our heads, pondering how the FTC could have allowed this so-called vertical integration of two clearly symbiotic organisms from joining forces. My business dropped in half with this and other forced mail order companies and preferred pharmacy contracts, severing my patients from decades of care from me.

As years progressed and plans changed these same patients continued to come back to me for acute care medications, or to inquire if their plan would allow them to return to me. Along this pathway reimbursements for medications continued to decline with Aetna being one of the worst. The PBMs Caremark, Express Scripts and Optum, which control most of the market formulate these contracts of payable medications, and, as such, we have had no explanation yet today. So bear with me. We are paid what's called MAC, maximum allowable cost per pill or now,

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a new formulation called GER or generic effective rate which is a determination by each and every PBM, each individual contract, and they vary from contract to contract, so we never have any idea of what that really is, and then we get our professional fee of 0 to $0.40 for our professionalism and what we do. Branded drugs are oftentimes reimbursed to us below the cost of purchase, and we are talking about hundreds of dollars for a single medication. In turn I need to pay my wholesalers every two weeks, and so you see the problems that can occur. My prescription volume, as I said, has declined to half of what it was a few years ago, much of the prescriptions being directed to mail order houses owned by insurance carriers or PBMs or even down the block, as I said, to CVS where maintenance Rxs can be filled. This is an unsustainable, exponential decline in volume, which, more importantly

translates into my patients who I have taken care of for the past 28 years being forced unwillingly away. When I close and when my associates close there will be two to three major chain drug stores available to my community with the associated outages of medications, restrictions on fillings of certain drugs, hours or day waits for medications. I get deliveries twice a day. And the eventual increased costs we will see, both for over-the-counter medications as well as contracted copays and expected costs to the payers.

Currently we see quite often costs for patients changing on a daily basis. They will say to me, well, didn't I pay that last time? And those costs are based on the flux of the cost of medications in the market, contracted rates between the PBM and the patient. Those differ from the contract with the PBM and the provider.

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Those differ from the contract between the PBM and the payer. And all of this leads to much confusion for the consumer.

CVS sends requests to my patients' doctors for prescriptions all the times requesting refills. How is this even possible if there is a firewall between Caremark and the PBMs? We have all been witness to part of the current practice of buyouts of smaller entities, private physician practices, independent community pharmacies, smaller labs, testing facilities, the larger conglomerates, all in the name of efficiency and cost savings. But are we seeing this efficiency? Where will be the independent thinking of practitioners? All will be required to perform their jobs according to insurance carrier PBM protocols which we don't know what those are. With this approval of a CVS-Aetna merger, the pharmacy retailer CVS Caremark and

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Aetna will jointly decide what medications for what diseases in what quantities will be dispensed, and for how much to the patient and for what payment to the provider. They will also decide which doctors, which hospitals, which labs, which MRIs patients can utilize within network. Where will medical decision making end up? In a boardroom of a shareholders's meeting or the medical experts' practice sites? And once all the competition is pushed out where will the checks and balances be to determine appropriate therapies?

May I continue a little bit?

SUPERINTENDENT VULLO: Go ahead.

MS. BEECHKO: As a community member I speak for all of my customer patient base. A nurse who works in the pediatricians's office who sees a customer's entire pharmacy benefit being eaten up by two drugs on formulary when less expensive,

effective agents can be used, or, in the caring of her elderly mom, when all the medications are all put into a bag, discontinued and inactive, and if she were not a nurse we don't know what would have happened to her mom. These are just little stories, so take it with a grain of salt. Or one of my patient-customers who is an attorney who reads and signs contracts for HR departments, who comments on the take-it-or-leave-it environment of the large entities now providing health care insurance coverage and the enormous amount of cost layering between the patient and the insurance carrier.

One of my patients was forced to wait a mail order, and came in to ask me how she was supposed to get her valsartan. This drug has just been recently recalled because of bad -- a company in China which was making it inappropriately. Not all

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pharmaceutical houses had this drug, but many did. Her mail order company told her she needed a new prescription and that was the only supply they had. She came in to me and, of course, we took care of her.

Consumers will be limited in choices by allowing another giant merger to occur. There is supposed to be competition in a free market society. All businesses must be concerned with their bottom line, but the healthcare business has taken this to a new low level. Healthcare's primary concern should be just that -- the care of the health individual. And when an insurance carrier which earns its profits for its investors is a major decision maker in the management of patients' care, the hospitals and doctors it contracts with, the services, testing, standards of practice it sets up and joins with pharmacy benefit manager which develops

and promotes separate proprietary nontransparent prescription coverage contracts with payers, providers and patients, and then they join with the major retail community store which accepts those contracts, fills those prescriptions and earns income from those same prescriptions, we have a perfect storm for a directed, no choice, limited healthcare offering for a huge percentage of people in this country. I would ask the question, as has been asked, exactly how are the costs going to be reduced and how is the care going to be made better and more efficient?

In closing, I would like to just quickly read, if I can get into my cell phone. I apologize. From one of my nurses, sent me this. CVS Caremark has been called out in multiple lawsuits for misleading patients, limiting their choices and changing more for prescriptions than any other

pharmacies. I would say that there are other PBMs that have also been called out, as we know historically, for some of these same things. If Aetna, a health insurance company, were to become a subsidiary of CVS Caremark, it stands to reason that Aetna would be directed to follow the PBMs' predatory corporate strategy. These are not my words. These are the words of a nurse who is my patient, that works in the community. From a nurse's point of view, as a patient advocate I observed CVS's practices firsthand as they make it difficult or impossible for our practice to provide the correct treatments for our patients. This includes refusal to dispense Epipens to children and adults with life-threatening allergies, sending misleading messages to patients, directing them to pick up unnecessary prescriptions, overcharging and making particularly onerous the process of

requesting authorizations for nonformulary medications, even when the drugs on formulary are not appropriate for the patient's conditions.

The consequences of Aetna's policyholders would be dire under CVS Caremark's direction. This merger is going to -- is an ongoing trend to consolidate entities which should remain separate to ensure independent checks and balances on the health of our people, and it is the wrong directional step for our country.

SUPERINTENDENT VULLO: Thank you.

I have just a few questions if you don't mind.

MS. BEECHKO: Sure.

SUPERINTENDENT VULLO: It's interesting you call the people who come into your pharmacy your patients, because that's what they are. If they come to you and the drug that maybe their provider or you think is the appropriate drug is not on the

formulary, what happens? Do they not get the drug or do they just they have to pay for it out-of-pocket, or what happens?

MS. BEECHKO: Well it's complicated. That's called needing a prior authorization. In some instances the PBM which always tells us that they're under the auspices of the insurance company and they don't really have control over this, that it's the contract that they have with the insurance company, which -- you should know -- the PBMs create these contracts and sell them to the insurance companies or the payers. If a prior authorization is required we call the physician's office. We give them the information, the phone numbers, etcetera. Then the physician's office has to get involved to get the prior authorization. They have to get back to us, and then we can get the drug and dispense it to the patient. Is there a

time lapse? Oftentimes, yes. Can a patient pay out-of-pocket? Absolutely, but usually a drug that requires a prior authorization, we are talking 300 to a thousand dollars.

SUPERINTENDENT VULLO: It's expensive. Right, okay.

So, are you familiar with the two-to-one rule in New York for pharmacists and, sort of, and the number of staff that you can have?

MS. BEECHKO: Oh, technicians, you mean? Technician ratio. Yes, absolutely. You have to be.

SUPERINTENDENT VULLO: Can you explain that because one of the things that is notable about this transaction is the proposal that the CVS retail pharmacy will have more interaction with the patient by using nonlicensed medical professionals to do it, and so, wondering whether you can, sort of, speak to that and that rule in New York.

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MS. BEECHKO: Do you have half an hour?

SUPERINTENDENT VULLO: No, just trying to understand how, on a smaller pharmacy level that is, and then what you think would be the application of it in a CVS pharmacy, for example.

MS. BEECHKO: I don't know if this will help you, but currently, full disclosure, I probably do approximate 60 or 70 prescriptions a day now, down from close to 200 at one point. And those 70 prescriptions feel like 150 because of the interactions that we have with our patients. There is a one-to-one ratio in my store, pharmacy technician-to-pharmacist. There is sometimes, although not any longer. In the olden days I had the funds to have a counter person who would simply pull the medication out of the bin for the patient and then ask the patient if they needed counseling from the pharmacist. The technicians are not

allowed to do any counseling. Only pharmacists or pharmacy interns can do counseling with patients. Only pharmacies or pharmacy interns can answer medical questions or help patients with any of those questions. Can a technician or a counter person help somebody go outside and find the dulcolax? Yes. Can they instruct them that dulcolax now has two completely different formulas? One is a stool softener and one is a laxative, and which one do you need and what are you using it for? No.

So there are lots and lots of issues with this.

SUPERINTENDENT VULLO: Okay. I appreciate that. Anyone else?

Thank you.

MS. BEECHKO: You're welcome.

SUPERINTENDENT VULLO: The next on our list is Chuck Bell from Consumers Union.

MR. BELL: Hi, Superintendent

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Vullo. I am Chuck Bell from the Consumers Union. We're the advocacy division of Consumer Reports.

SUPERINTENDENT VULLO: Can people hear him? I just wanted to make sure.

MR. BELL: Again, I am Chuck Bell from Consumers Union, the advocacy division of Consumer Reports, based here in Yonkers, New York.

I am sharing a copy of our 12-page written testimony with you, which we have shared with the Department of Justice, the Senate Antitrust Committee, California and Connecticut regulators and now New York. Consumers Union is deeply concerned about this proposed merger because PBM health insurance and retail pharmacy markets in this country are already highly concentrated. According to the US Council of Economic Advisors, three huge companies, CVS Caremark, Express Scripts, and OptumRx control 85 percent of the PBM markets. All

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three of these PBMs are entering into potentially dynastic combinations with health insurance companies. We have Aetna CVS and Cigna Express Scripts receiving approval from the Department of Justice to merge and we have United Health OptumRx which already operates respectively. At the same time, Aetna is the number three insurer in the country and the top four insurers controlled 83 percent of the combined national market in 2014. Seventy percent of local insurance markets are already highly concentrated, according to the 2017 National AMA analysis.

These new insurer-PBM combinations threaten to become major healthcare oligopolies. We're seeing the carnivalization of the American healthcare system unfold and accelerate before our eyes. So if we are concerned about that now, now is the time to raise our voices. A particular concern is that the PBM market is

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largely unregulated, resulting in an opaque pricing and rebate structure that gives both the drug makers and the PBM incentives to allow higher prices and rebates. PBMs do not report in detail on the $150 billion they pay every year in rebates to public or private employers and the healthcare programs each year. They are not required to exercise fiduciary duty to get the best deal for their customers, rather than get the best deal for their investors and executives.

Also according to the Council of Economic Advisors, the 85 percent market share of the three leading PBMs allows them to, quote, exercise undue market power against manufacturers and against the health plans and beneficiaries that they are supposed to be representing, thus generating outsized profit for themselves.

Over 20 percent of spending on prescription drugs is taken in as

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profit by the pharmaceutical distribution system. The council also said that policies to decrease concentration in the PBM market and other segments of the supply chain including wholesalers and pharmacies could increase competition and further reduce the price of drugs paid by consumers. And the concern is that this transaction may be taking us in a different direction than was recommended by the council.

While the CVS Aetna merger is generally described as a vertical merger, there is an important horizontal dimension to the transaction. Through this deal, Aetna will gets its own in-house PBM in CVS Caremark. Conversely, if the merger were challenged and set aside, Aetna would be in a great position with its 23 million covered lives to establish its own in-house PBM, and that would add some much-needed competition to

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this already highly concentrated market sector. Also, if the merger goes forward, there might be less competition for PBM services. As noted by Dr. Neeraj Sood of the University of Southern California, there is a significant number of metro areas around the country where Anthem is the number one or two insurer and Anthem WellPoint also operates, and this is highly significant because CVS Caremark has entered into a five-year contract with Anthem WellPoint to provide PBM services for Anthem WellPoint customers, through an Anthem unit called services IngenioRx, and this includes five big cities in Connecticut, where Anthem and WellPoint are the number one and two insurers. So in those local markets, CVS and Aetna could effectively be providing the lion's share of PBM services for insured customers and employers which potentially could have a damaging

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impact on competition and pricing and choice for customers.

The hammerlock of these three large PBM insurer combinations could, over time, sharply reduce horizontal competition in the insurance market. These three giant vertically integrated insurance-PBM combinations will be able to block competitive rivals from access to the respective customer bases for a broad range of medical services. They will be able to use the associated economies of scale and scope to edge out and possibly acquire their remaining competitors. And at the same time they may have very weak incentives to compete against each other. There will also be formidable barriers to market entry since any new competitor would likely enter at the same time on two levels, both as an insurer and a PBM to break into the market.

So we are extremely concerned that other regulators have not taken

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this problems seriously and sufficiently investigated the risks a merger approval could have very adverse consequences in the long run for healthcare consumers.

New York's market has been more competitive than most, but ours could tighten up, and so I think we have a good reason to be concerned here in New York.

So we urge the DFS to carry out a very thorough investigation of the merger consistent with your legal and regulatory authority and to share your findings with the public and other regulators, and if the merger goes forward, we urge you to impose conditions and restrictions to protect consumers in New York in the full range of areas where consumer interests are at stake. And these include access to affordable, accessible prescription drugs, affordable, accessible health insurance, the protection of

high-quality plan networks and retail and specialty pharmacy options, protection of health plan provider networks, especially high quality access to advanced primary care, and protection of the privacy and integrity of health information consistent with our privacy and cybersecurity laws and regulations.

SUPERINTENDENT VULLO: Okay.

MR. BELL: Thank you.

SUPERINTENDENT VULLO: Thank you. Anything from you all? No? Thanks.

MR. BELL: So this is something submitted also in California.

SUPERINTENDENT VULLO: Okay, so this is something submitted also in California.

MR. BELL: Yes, I wanted to give you a copy. I have this footnote in the testimony. We made specific suggestions for conditions and undertakings in California through the

Department of Managed Care, which may also be of interest to New York.

SUPERINTENDENT VULLO: Great. Okay. So let me just ask you, did you submit anything or meet with the Department of Justice or even the sort of Consumer Union national group or --

MR. BELL: We testified in Congress about the merger, yes, and shared a statement with the Department of Justice.

SUPERINTENDENT VULLO: With the Department of Justice. Was there any engagement there on conditions that would satisfy your concerns, that you know of?

MR. BELL: It hasn't been adequate. I can say that. No.

Thank you.

SUPERINTENDENT VULLO: Thank you. Assemblyman Gottfried, I see is here. If you would like to -- always good to see you. Assemblyman Richard Gottfried, who is the chair of the

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Assembly Committee on Health.

Thank you.

ASSEMBLYMAN GOTTFRIED: Thank you. So I am Richard Gottfried. I chair the New York State Assembly Committee on Health. And I urge the Department of Financial Services to reject the proposal by CVS to acquire control of Aetna Health Insurance Company of New York.

This acquisition would impair the health insurance department in New York, harm the quality and accessibility of healthcare for New York consumers and significantly advance dangerous trends in healthcare and health coverage.

It should be rejected under insurance law Section 1506.

CVS operates the nations's largest retail pharmacy chain, owns one of the largest pharmacy benefit managers, is the nation's second largest provider of individual

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prescription drug plans, and had annual revenues of approximately $185 billion in 2017. It is a giant whose current size and scope of activities ought to raise loud antitrust and anticonsumer alarms. This deal would give it control of Aetna, the nation's third largest health insurance company and fourth largest individual prescription drug plan insurer.

If the term anticompetitive has any meaning at all, it must mean a deal like this. Entities seeking monopolistic power always claim that their size will somehow benefit the consumers and others who will be at their mercy, and it is never true. In this case, what is at stake is not only competition in the insurance market but the control, quality and accessibility of healthcare for millions of consumers. This needs to be seen in a broader and profoundly threatening context.

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Decades ago, healthcare began to change from being based on small entities and professional practices. Driven partly by the possibilities and costs of technology and partly by the need to deal with large third-party payers, instead of relying on individual patients for payment, healthcare providers began to form larger and larger economic organizations driven increasingly by economic rather than professional imperatives.

Integration can have important benefits. A general hospital is, by nature, an integrated healthcare provider. Insurance is an integration of risk but integration can go well beyond what is driven by or serves clinical or risk sharing needs. There is horizontal integration among providers at the same level; for example, large or multispecialty physician practices or hospitals

merging or affiliating into networks. And among payers, a higher degree of market control among fewer and increasingly dominant insurance companies.

In addition, there is vertical integration among providers, as, for example, more and more physicians now practice as employees of hospitals or hospital-controlled practices. Retail and pharmacy chains like CVS and Walmart are opening or dropping clinics on their premises, and they are expanding into full-scale medical practices. We are now beginning to see vertical integration involving payers being economically integrated with clinical providers. We see the beginnings of insurance companies owning or controlling hospital and physician networks. The CVS-Aetna deal would constitute the integration of one of the largest pharmacy chains, which is increasingly integrated with one of

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the largest -- which is already, rather, integrated with one of the largest pharmacy benefit managers and a growing number of retail clinics, and one of the largest insurance companies. Some would assert that New York's laws against corporate practice of medicine and limits on corporate ownership of hospitals provide us -- protects us from having our healthcare providers being taken over by corporations like CVS or Aetna. If only that were so. Supermarkets like Price Chopper and pharmacy chains like CVS or Duane Reade may not technically own their retail clinics -- they rent space to physician practices. But when the commercial landlord also provides advertising and marketing, management services, electronic record systems, financing for capital equipment, etc., then the retailer might as well own the physician practice. And nothing in New York law limits that practice to

episodic dropping in services or prevents it from becoming a full-blown practice, an office-based surgery or almost anything else.

How can a private office-based practice compete with the advertising and branding power of a clinic attached to an national pharmacy chain? If a market-dominant insurance company like Aetna is teamed up with a giant like CVS, that develops a full network of corporate-controlled healthcare providers. It is easy for the insurance company corporate combination to then drive patients to its owned or controlled providers using tools like restricted provider networks and payment arrangements.

What happens to a healthcare provider's professionalism and ability to advocate for the patients when the professional is an actual or virtual employee of a large system controlled by a giant insurance company or other

corporation? What happens to patient choice or the ability of a freestanding healthcare provider to compete, to innovate, or to survive?

The tendency of economic organizations for horizontal and vertical integration is both dangerous an nearly inexorable. As these entities amass greater and greater power from the combination of horizontal and vertical integration -- we can call it rectangular integration -- that power is used for the benefit of the entity's owners to the disadvantage of its subcontractors or employees, in this case, hospitals, doctors and nurses, its customers or patients and any independent provider left outside that structure.

I do not want to see healthcare and health coverage go down that dark path. We all have a responsibilities to stand in the way of that degradation at every opportunity. Rejection of the

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CVS-Aetna deal by the Department of Financial Services will not win the war against that degradation, but it would be a great victory in an important battle for New Yorkers.

Thank you.

SUPERINTENDENT VULLO: Thank you, Assemblyman. Always good to hear from you. I will just say that, you know, there's been a lot of discussion this morning about PBMs and the concerns that have been raised about pharmacy benefit managers and DFS and the governor had proposed a bill two years ago which the assembly was supportive of, and we hope we can work and make that happen this year as well, including through the senate, and we do appreciate the assembly's prior support of that.

ASSEMBLYMAN GOTTFRIED: Thank you, although in many ways the PBM piece, troubling as that is, is really a small part of the overall phenomenon.

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I'm a lot more concerned about this corporate combination dominating our hospitals and doctors and physical therapists. I am more concerned about that than I am concerned about them dominating a PBM, dangerous as that is.

SUPERINTENDENT VULLO: Right. And we have heard from the Medical Society and also some hospital groups on those issues, too. Thank you.

ASSEMBLYMAN GOTTFRIED: Thank you.

SUPERINTENDENT VULLO: Thank you. I appreciate it.

Okay, the next witness we have is Lev Ginsburg from the Business Council of New York State.

MR. GINSBURG: Thank you, Superintendent, for the opportunity to give a couple of remarks.

My name is Lev Ginsburg. I am Director of Government Affairs for the Business Council of New York State. We're the state's leading business

organization, representing nearly 2,400 members, employing more than one million New Yorkers, businesses large and small, insurers and the insured, all across the State of New York.

On behalf of our members I wish to submit these comments into the record as part of the department's consideration of CVS's acquisition of Aetna Health Insurance Company of New York.

Year after year, our members report that the cost of healthcare is a leading cost driver in their businesses. This has only been exacerbated by changes brought on by the implementation of the ACA, and subsequently in increases in the cost of healthcare across the board.

Since CVS's acquisition of Aetna would result in substantial efficiencies and other savings that will directly benefit premium payers and result in greater access to

affordable healthcare, we view it quite favorably to employers across the State of New York.

As you know, the Justice Department has already given preliminary approval of the merger.

They said about this decision that the divestitures required here allow for the creation of an integrated pharmacy and health benefits company that has the potential to generate benefits by improving the quality and lowering the cost of healthcare services that American consumers can obtain.

We agree. This merger will have a beneficial impact on healthcare premiums for consumers, a primary issue to which the Department of Financial Services is particularly sensitive.

My primary consideration on behalf of the Business Council's members is how any given policy or transaction will affect the cost of

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healthcare for employers and their employees. The proposed CVS Health Corporation's acquisition of Aetna Health will provide the kind of change necessary in finding and providing affordable healthcare options for their employees.

We believe that the primary goal of this transaction is to enhance the abilities of these two companies to operate more efficiently and effectively, improve quality of service, and control healthcare costs. We believe that this integration will have downward pressure on premiums and healthcare costs. The Business Council represents many employers throughout rural upstate. These employers and their employees face problems that are more complex than just rising costs. They also lack access to primary care and other healthcare essentials. This transaction seeks to remedy some of that burden by following the healthcare

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consumer and offering more access to local care with the availability of more localized options such as retail health clinics. The uniqueness of the physical presence of each of these companies only helps illustrate the synergies conditions that will lead to better access. The proposed merger -- sorry about that -- the proposed merger holds promise of driving healthcare costs down and allowing the focus of healthcare to lean towards prevention and primary care. The integration of expertise of two totally different healthcare companies will allow for a deeper understanding of the health goals of New Yorkers and allow for a safer and more efficient and less expensive system. Healthcare providers throughout the state will continue to have choices regarding their participation with different health plans and will be able to contract with any or all of these insurers.

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Employers and employees will simply have more choices than they do today. This merger is designed to leverage CVS's vast array of clinical services to create efficiencies in healthcare delivery for privately insured New Yorkers. These efficiencies will ultimately translate into lower costs for employers and further economic growth in New York, adding more jobs and more opportunities, especially in rural areas.

Whether it be from an economic development perspective or an affordability of health perspective, this merger is in the best interests of New York and New York's businesses. Employers in New York are saddled with some of the very highest costs of doing business in the nation. Everything from property taxes to workers' compensation costs and the price of health coverage. In order to change New York's poor business reputation, we

need policies that work to lower these costs for employers. We need consistency and policy across the state's many regulatory agencies, and we believe that approval of this transaction will send a strong message that New York is an attractive place to expand business operations and create jobs.

SUPERINTENDENT VULLO: Thank you Mr. Ginsburg. I have a few questions.

You mentioned something about access to primary care, that there would be improved access to primary care in retail health clinics, and I am trying to understand why you think a transaction between a retail pharmacy and an insurance company is going to do that. Are you putting physicians in the pharmacies? Is that -- I'm trying to understand how you think that would occur.

MR. GINSBURG: Well, retail clinics.

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SUPERINTENDENT VULLO: You mean the MinuteClinics?

MR. GINSBURG: The MinuteClinics, sure. I mean, whether it's a physician, and we heard some others speak. It may be a physician or another provider. There are areas across the state, you know, that we have members in that operate, that there are no doctors available whatsoever. There are, however, opportunities for retail stores to be opened in those places.

SUPERINTENDENT VULLO: Right. I mean, so there are already about 20 some-odd CVS MinuteClinics, what they're called, across New York State in different parts of the state, but why would buying Aetna improve the ability to expand? I mean, presumably they could do it already, right? CVS could have more of those if that were a good thing. Why does Aetna being acquired, in the Business Council's

view further that goal? And again, people may disagree as to whether that's a good goal but I am just trying to understand why does this transaction move in that direction because Aetna is a health insurance company. It's not acquiring a provider group.

MR. GINSBURG: So first and foremost, you know, I can't answer the business models for CVS. We don't even represent CVS, to be honest with you. But what I can tell you is when we look at policy in general, anything that has the opportunity in it to broaden access to healthcare, especially across upstate New York is something that we value and we think is worth pursuing. You know, I can't tell you whether there's going to be 50 new clinics or 150 new clinics, but if there is an opportunity for there to be two, if there's an opportunity for a manufacturer in Ogdensburg, to actually bring people to Ogdensburg because they

will have healthcare, than it's worth doing.

SUPERINTENDENT VULLO: I don't agree. I don't disagree. I don't know if you were here, but I asked CVS whether they actually have a business plan, a written business plan or any business plan to actually achieve all of that, and they don't, and they don't have something specific to New York that actually shows that this transaction will lead to that, and, of course, this transaction is a cost, so -- and those things require capital contribution. So I am trying to -- I mean, have you -- and I am not trying to put you on the spot.

MR. GINSBURG: No, no, no, that's fine.

SUPERINTENDENT VULLO: Are you aware of, you know, of any specific business plan or even an economic model that supports -- this is a different point -- the reduction of cost -- which

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we are totally in favor of the reduction of costs -- which would be reduction for employers and employees, but where is the economic study that says this deal, this specific deal will actually lead to that? I haven't seen it. I would love to see it.

MR. GINSBURG: You have seen more than I have, but what I mean to say is that when you look at two companies, and I look at CVS and they have a footprint across the State of New York. I don't know the details of that footprint. I look at Aetna and I know they have a footprint and it happens to be heavy in certain areas of the state and not in others. I look at two companies that have an opportunity to spread what they do across the entire state. I look at the opportunity for employees to actually go get to see a doctor without having to drive 100 miles, which happens through the north country. And I think that to walk away

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from an opportunity to allow those synergies to happen, and you are right -- I mean, I don't know. I don't know if there is a promise that this is going to happen or not in a perfect manner. But to walk away from an opportunity to see if we can improve things drastically and dramatically in places that need it is, I think, well worth trying.

SUPERINTENDENT VULLO: Certainly if it can be proven, but, again, there's lots of opportunities. We need to see the details as to how they would plan to realize those opportunities.

MR. GINSBURG: That's why you are there and I'm here.

SUPERINTENDENT VULLO: What if it doesn't happen? You know, and if you have the expansion in the north country or other places in upstate New York, what about those small insurance companies? Those small, regional insurance companies that are there? I

mean, if there is an expansion is that going to put them out of business?

MR. GINSBURG: I am not sure I follow your reasoning there but --

SUPERINTENDENT VULLO: Well, if there is an expansion, there is an --

MR. GINSBURG: An expansion of?

SUPERINTENDENT VULLO: The insurance company part of this, because this is an acquisition of an insurance company.

MR. GINSBURG: So you are concerned that competition and choice for employers might be problematic.

SUPERINTENDENT VULLO: Sure.

MR. GINSBURG: Well, I would argue that more choice --

SUPERINTENDENT VULLO: And small businesses may lose out.

MR. GINSBURG: I would have to say and quite frankly, I have heard some other anticompetitive conversations and words like unfair competition, and I am certainly not

talking about the antitrust level of unfair competition. I don't believe that competition is unfair by its very nature. I don't believe we need to protect one business against another one, trying to do a better job. That's the very nature of, sort of, our economic system. So, I mean, to answer your question, if Aetna, as Mr. Logan actually had indicated that perhaps, you know, they're game, intent to be here in New York and to grow, then so be it. That's more choice for my members. That's more choice for the million employees that we represent. I have no problem with that.

SUPERINTENDENT VULLO: Okay. All right. Anybody? Go ahead, Troy.

MR. OECHSNER: So, thank you for your testimony. You said -- okay, competition is good. Unfair competition presumably not so good. So one of the things that we have been concerned about is, of course, you have

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Aetna now being acquired by CVS, CVS has, of course, many clients who are there -- the competitors to Aetna. CVS has huge amounts of information data about claims runs on the pharmacy side which could be incredibly valuable to a competitor. They have said we have firewall agreements in place. Don't worry, trust us, because it would be bad for our business. Of course, history, and we have lived through I was here in 2008. We lived through businesses promising, trust us, it will be bad for our business if we don't -- we aren't on the level. Do you have any concerns that there is no, zero regulatory oversight to the firewall protections?

MR. GINSBURG: Troy, I don't know enough about the particulars of the issues that you are talking about, and I would probably say they would be best addressed, you know, by the parties. I just don't know enough to answer that.

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MR. OECHSNER: Thank you.

SUPERINTENDENT VULLO: Thank you. Appreciate it. Next, we have Amanda Dunker from Community Service Society of New York.

MS. DUNKER: So I am with the Community Service Society of New York but I am going to submit testimony on behalf of the Healthcare for Rural New York Coalition, so.

SUPERINTENDENT VULLO: Move that closer.

MS. DUNKER: So Health Care For Rural New York is a coalition of over 170 organizations statewide. We advocate on behalf of the consumers. Our goals are affordable health coverage for all New Yorkers, quality affordable health coverage for all New Yorkers, and part of how we do that is to make sure consumers are represented at hearings like this and in other policy discussions. So first I would really like to thank the department for

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holding the hearing and for the investigation you described. All the time and energy you're putting in to understand the transaction would have on New Yorkers. We have four areas of concern with the transaction where we feel like right now we are not sure how much regulatory oversight the state would be able to provide after the transaction occurred. So one is one that's been brought up before, which is the data issue. The company's insurance division will potentially have access to data on millions of consumers and the prices its rivals pay for prescription drugs, and so I think they have said, well, we will have a firewall and we won't share that, but we have also heard them say that that merger of data is one of the ways in which the public will benefit -- right -- because they will be able to combine that data on prescription drugs and medical records and leverage that

to coordinate care. So, you know, if CVS is allowed to absorb and run an insurance plan, unless safeguards are put into place that the public sees those safeguards, that it's not just a firewall inside the company and they are just telling us those safeguards are there, it would potentially have an unfair market advantage because it would gain access to all that information about its competitors' pricing strategies and we have pushed healthcare for all New York for much greater transparency about prices that insurance companies pay, that PBMs pay on prescription drugs and all other medical services, and we have heard again and again, that is a trade secret, we can't let the public know about those prices, we can't let regulators know about those prices because we can't let our competitors know about our pricing strategies. I am not a lawyer but it seems strange to

me that they could then just buy access to that data, and when the public wants it and regulators want it for the public good, it's a trade secret. And now, when they want to buy it and use it to -- probably against their competitors now they should just be allowed to buy access to it. And of course, all the security issues you mentioned before, I just don't think that there is any cybersecurity protocol that is safe enough to protect people from this type of huge database. A second area of concern is another one that's been brought up before, that the merger can create new incentives for Aetna to limit the providers its members may use and vice-versa. In their public comments CVS Caremark and Aetna talked about empowering consumers, integrating care and improving health outcomes while lowering costs. They mentioned some other examples too, but, you know, they

talked about using home devices to monitor vital signs, discharge care, transition planning, building community health hubs, but I think, as Superintendent Vullo argued earlier, there is no reason that CVS and Aetna have to merge to provide some of those fairly straightforward health services. The services they describe are already offered by various players in the healthcare sector. Aetna members can already use MinuteClinics if they wish to, but they can also use other urgent care or walk-in clinics. The benefits that will accrue to shareholders from this acquisition likely depend on Aetna members to use CVS clinics and pharmacies over other choices. The way that insurance companies do this is by imposing financial penalties for members who utilize other sources of care. Navigating provider networks is already a major headache for consumers. It costs consumers a lot of money

because it is so easy to make mistakes. I think this is just another way in which people are going to have difficulty navigating these networks.

And further, Aetna provides no evidence that increasing its members' use of walk-in clinics will mean better integration or coordination. New York State has worked for many years to create health homes for consumers in an effort to make sure that they receive appropriate, coordinated medical care. There are times when consumers may prefer walk-in clinics to their primary care doctors, and as a consumer coalition we always want more choice for our consumers. So it's not that MinuteClinics should not exist, but I don't think that there is a benefit to a greater public of an insurance company encouraging people to use MinuteClinic over a regular primary care doctor.

A third area which I think Chuck

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provided a lot more data on -- I'm sorry -- Chuck Bell from Consumers Union provided a lot more data on is this issue of competition and pharmacy benefit managers. This would have unpredictable effects on consumers. I have seen some health economists have argued that maybe this trend of combinations of PBMs and insurers means that this PBM model will go away, and that would probably be a good thing for everybody because it's not clear that PBMs offer value to insurance companies or consumers. I don't know how convincing I find some of those arguments but I just wanted to mention it to be fair. It would be good if insurance companies did this in-house instead of using these PBMs that are completely unregulated, if we can't get legislation passed to better regulate them. But it does remove -- on the flip side it does remove an avenue of competition because instead of, as

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Chuck mentioned, instead of Aetna forming its own PBM or doing it in-house it's just being bought by the PBM -- right -- so now there is no longer that chance that maybe another PBM will come to the market.

And the last area in which we have concerns are about the medical loss ratio requirements and so merging an insurance company with a provider undermines medical loss ratio requirements, which is an important strategy for keeping costs down for consumers. So the medical loss ratios are -- I think somebody -- PSSNY -- brought this up earlier. But the medical loss ratio is a limit on how much of its revenue an insurer can spend on anything other than medical care. So that definition of what is medical care is very important. The structure of the medical loss ratio, because it's a percentage, it already creates -- it lowers an insurer's

incentive to get good prices from providers in some sense because as long as they can define it as medical care they can pay whatever prices they want because they are allowed to -- that sort of helps them a little bit -- right -- because it's a percent of a bigger pie. So if they are allowed to raise premiums to cover increased medical costs the administrative costs including profits goes up as well. In other words, they can make more money by paying higher prices to providers for services and goods like drugs and in turn charge consumers more without running afoul of the medical loss ratio regulations. A merger between a provider such as the MinuteClinics and the pharmacies CVS operates and an insurer adds yet another incentive to raise prices. If Aetna and CVS Caremark merge, Aetna can pay higher prices for services provided to members through CVS Caremark, thus increasing

profits on the care providing side because it's medical care. But all of that money is going to the same huge conglomerate company, so, you know, we don't know what the size of that effect would be but I think it's something to think about. So we would argue that the department reject the transaction, and that if the transaction does go forward that we a have a lot more conversations about what types of New York regulation and legislation might need to pass to properly regulate such a huge corporation.

SUPERINTENDENT VULLO: Okay, thank you. Did you say that you will be submitting something on behalf of the Healthcare For Rural --

MS. DUNKER: Yes, we have written comments.

SUPERINTENDENT VULLO: Written comments -- just make sure you do that in the next five days. If you could we'd appreciate that. Thank you.

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Anyone? Troy, do you have any? Great. I appreciate it. Thank you.

We have next Donna Tempesta from the AIDS Healthcare Foundation.

MS. TEMPESTA: Good morning, everyone.

Like you said, my name is Donna Tempesta. I am a vice president at AIDS Healthcare Foundation or AHF. I want to thank you for the opportunity to speak today to you. AHF urges the department to reject the Aetna CVS merger. AHF is the largest nonprofit provider of care and treatment to people with HIV and AIDS in the world. We serve over one million patients in 41 countries. In the US we have healthcare centers and pharmacies in 12 states and have Medicaid and Medicare managed care plans in California, Florida, and Georgia. In New York we have five healthcare centers serving over 6,000 patients and operate five pharmacies serving over 5,000 patients.

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Our mission is to treat and advocate for people with HIV regardless of their ability to pay. As a safety net provider for vulnerable special needs population we are very troubled by the consolidations occurring in the healthcare industry, especially when the payers and the PBM and the providers become one and the same, as would be the case with Aetna and CVS. We recognize that Aetna is divesting its stand-alone Medicare Part D plan but that doesn't mitigate our concerns.

My remarks will focus on five concerns. We will be submitting a letter after this hearing so this will just be a brief summary of the five concerns.

Our first concern is about MinuteClinics which many have discussed today in the CVS pharmacies. MinuteClinics replace fundamental elements of the patient-physician relationship with cookie cutter

treatment administered by nonphysicians. This can be an even bigger problem with people with HIV. Even a routine flu shot can be dangerous for someone with a compromised immune system. We are especially concerned when the insurer has a business incentive to drive business to the MinuteClinic owned by the same company. The more an insurer is determining where a member should go the greater the risk that the patient may not get medically appropriate or even safe care.

Our second concern is about forced mail order and customer foreclosure, which I know has been discussed also by many today. To remain healthy a person with HIV needs to stay adherent to their medications. The pharmacist is often the healthcare provider closest to this individual providing counseling, support and refilling medications monthly. This is

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especially true for HIV specialty pharmacies like AHF. The woman who spoke from Huntington -- we have many patients that have been in our care for 30 years, and it's a shame when we cannot fill them anymore. They have to -- but they are being forced into CVS and others and it's really disheartening to see.

Our third concern is around oppressive pharmacy reimbursements. Again, many have discussed. Again, AHF is concerned about CVS's aggressive tactics in narrowing its networks to exclude small and specialty pharmacies. The merger only heightens our concern because a combined CVS and Aetna will be able to use its own increased leverage to raise costs for independent pharmacies. We fear they will drive down reimbursement rates and dispensing fees to uncompetitive levels. In fact, this is already happening in Arkansas where the state Attorney General is

currently investigating CVS Caremark for allegedly providing unprofitable reimbursement arrangements to independent pharmacies, forcing them to go under and then offering to buy these out -- these pharmacies out for pennies on the dollar. And again, you had discussed that. As for AHF it has experienced a form of oppressive reimbursements by CVS in the form of DIR fees imposed on pharmacies in nontransparent and arbitrary manners.

Our fourth concern is about anticompetitive effects in health insurance markets. As your office argued and you discussed earlier today, in its September 17, 2018 letter to the Connecticut Insurance Department, a combined CVS Aetna would raise significant market concerns because CVS would have the power and financial incentive to offer larger drug rebates or other significant discounts. This would lure policyholders away from

other insurers to Aetna.

Finally we have some significant confidentiality concerns. CVS is currently being sued for revealing the HIV-positive status of up to 6,000 Ohioans through a mailing about prescriptions to their homes. This follows a 2017 breach by Aetna that revealed the HIV status of patients across several states including New York State. AHF is concerned that these episodes reflect an overall insensitivity shared by both parties of the merger to the special needs of people with HIV and the stigma they still face today.

For all these reasons AHF has significant concerns about the transaction and respectfully requests that you consider these concerns as you proceed with your review.

SUPERINTENDENT VULLO: Thank you. And so you said you were going to submit some written testimony.

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MS. TEMPESTA: Yes.

SUPERINTENDENT VULLO: Can you tell me more, and if you don't know it now, you can submit it, on what you said about some investigation in Ohio.

MS. TEMPESTA: Yes.

SUPERINTENDENT VULLO: Can you explain that a little more?

MS. TEMPESTA: Yeah. So what happened was -- my understanding is scripts -- a mailing went out to -- through their database to patients and in the window of the envelope it had a their status, HIV, so I will definitely follow up and get more clarification, but that's pretty much what had happened.

SUPERINTENDENT VULLO: Okay, thank you. I appreciate it.

MS. TEMPESTA: You're welcome.

SUPERINTENDENT VULLO: Next is Andre Barlow of Consumer Action.

MR. BARLOW: I would like to thank you for the opportunity to

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testify today regarding the competition concerns presented by CVS's proposed acquisition of Aetna and if the deal goes forward, the need for the Department of Financial Services to impose significant behavioral remedies to protect subscribers and market participants. I am here on behalf of Consumer Action, a national nonprofit organization that has worked to protect consumers for 47 years. The CVS Aetna transaction combines the largest retail pharmacy and one of the two largest pharmacy benefit managers and the third large health insurer in the United States, all under one roof. The deal creates a large vertically integrated firm that operates in markets where only a few meaningful rivals compete. Last week, the Department of Justice approved the acquisition on the condition that it divest Aetna's Medicare Part D plans, but did not include any behavioral conditions on

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the merging parties' future conduct. Despite the proposed divestiture we are concerned that CVS's acquisition will harm consumers because the DOJ failed to address the types of strategic exclusionary conduct presented by the merger. The DOJ also recently approved Cigna Express Scripts, another vertical integration between a health insurer and PBM. The two vertical transactions will dramatically change the healthcare industry and how it will function going forward because the three PBMs that control 85 percent of the PBM market are all integrated or will be integrated with a health insurer. The PBM market is anticompetitive. It lacks choice, transparency, and is rife with conflict. PBMs negotiate with pharmacies yet they own their own mail order and specialty pharmacies, and, in the case of CVS, the largest retail pharmacy. The PBMs control the formularies so they determine what

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drugs we are allowed to purchase, how many times we can fill the prescription, and the amount of our copays. If PBMs such as CVS can design the benefit in such a way that patients will pay higher copays at rival retail pharmacies. Vertical mergers don't always benefit consumers. Let's just look at CVS's acquisition of Caremark. We know that CVS has market power because it has been acting anticompetitively since its 2000 acquisition of Caremark, a PBM giant. CVS has used that power to exclude competition by forming its exclusive pharmacy networks that prevented consumers from access to pharmacists of their choice and increased their cost for prescription drugs. In addition to the exclusive arrangements CVS has engaged in the strategy of squeezing its rival pharmacies with take-it-or-leave-it, nonnegotiable contracts. Because they have no

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bargaining power, CVS was able to depress the dispensing fees to rival pharmacies to uncompetitive levels, while at the same time reimbursing its own CVS pharmacies at higher rates. In some cases these rival pharmacies were not reimbursed enough to cover the cost of filling the prescription. And in many cases CVS was reimbursing the rival pharmacies less than half of what was being charged to the health insurance plans. Moreover CVS has successfully steered many of its PBM customers to its mail order. But many of these patient reportedly come back to their independent and community pharmacists to ask questions about their prescriptions. In essence, CVS is free-riding on these rival pharmacists, and if it continues this could eventually turn and run them out of business. Before the merger Aetna has the incentive to deal with all pharmacies for its commercial insureds.

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Post merger these incentives change because CVS will have the increased incentive and ability to steer Aetna's patients to CVS mail order or its retail pharmacy stores. CVS will be able to cut off rival pharmacies' access to Aetna insurance through a variety of ways. The Department of Justice has made clear that it is not in the business of regulating merging parties post merger. So it is up to the state regulators to regulate the PBM industry and CVS Aetna's post-merger conduct to prevent competitive harm and to protect patients' access to the pharmacy of their choice. These patients' access concerns are particularly great in underserved urban, inner city and rural areas. Thus, the Department of Financial Services should continue to advocate for legislation to regulate PBMs and seek comprehensive relief to ensure that CVS will not have the

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ability to foreclose rival pharmacy competition, deny patients access to their pharmacy of choice and deny the medicines that patients need. Without stringent regulations on the PBM industry and the merging parties patients can anticipate an increase in prescription drug prices and out-of-pocket costs. Less choice, poor service, and less innovation.

Just a few recommendations in terms of regulating the CVS future conduct. The department should prohibit CVS from creating pharmacy networks that exclude rival pharmacies and drug formularies that deprive patients of the medicines they need, prohibit CVS from entering into or enforcing contracts with rival pharmacies that make it financially unattractive for them to fill prescriptions for their patients. Prohibit CVS from creating benefit designs that discriminate against rival

pharmacies, and develop a process for patients, pharmacies, and other providers to file complaints related to any CVS misconduct.

We appreciate the opportunity to testify on this important merger. Thank you.

SUPERINTENDENT VULLO: Thank you. And just -- have you submitted written testimony along with what your proposals are?

MR. BARLOW: Yes.

SUPERINTENDENT VULLO: Great, appreciate it. Anyone here? Great. Thank you.

Last that I have on our list unless something else has changed, is Heidi Siegfried from New Yorkers for Accessible Health Coverage.

MS. SIEGFRIED: So, hi, I'm Heidi Siegfried. I am the health policy director at Center For Independence of the Disabled in New York, which is an organization that helps people with all

kinds of disabilities -- mobility impairments, hearing impairments, sight, cognitive and -- so that they can live in the community and not be institutionalized. And then we have a project, New Yorkers for Accessible Health Coverage, which is a coalition of groups that serve people with serious illness and disabilities, who need comprehensive care, need access to comprehensive care, good formularies, you know, all that kind of thing. So we have worked -- we have worked a lot on having access to complete formularies. We have worked on, you know, step therapy, prior approval, the mail order drug issue, which are all obstacles to people getting the medications that they need. And we have also worked on network adequacy and most recently we helped office groups around the state with Partners in Healthcare For All New York to kind of see how people are accessing the

care that they need, not just MinuteClinics but, you know, specialists and we heard some incredible stories about people just, you know, giving up on seeking care because, you know, they just couldn't get it. So I don't have written remarks, but I just have a few remarks about this merger which is -- which, you know, it is a vertical merger which is a new thing. It's kind of a hydra, and it's been described as being part insurance, part PBM, part drug store. I mean, we barely know what it is and some people feel that, you know, this will act as a check on pharma and take a bite out of their pricing. The question is, what will happen with that bite? Well, you know will we, see as the business council believes, you know, premium decreases or will this somehow get lost in the maze, and, you know, the MLR someplace. We don't even know which side. So the other thing I

am concerned about is not just a pharma issue but also the MinuteClinics. You know, for people with disabilities, our civil rights act entitles us to accommodation and so it's really a negotiation with a provider for them to understand what your disability is and what are the needs that they might need to provide that they wouldn't provide to a person without a disability. And so it's a relationship that's important and I don't see that -- I am concerned about the rise in MinuteClinics just in general because I believe in primary care providers. So, I mean, most recently the City Council had a hearing where one of the younger City Council members admitted he didn't have is a personal care physician and was just using MinuteClinics so you don't have any kind of documentation of the medical history. I mean it's just a -- it's a worrisome thing. But for people with disabilities, they need access to

specialists. They -- there could be a lot of mistakes made in a MinuteClinic with a person who doesn't have the expertise that you would get from a primary care provider. So I don't like -- I mean, of course it has to be a choice, but I don't like to see them being pushed.

I missed the first part of this hearing which, I'm sorry that I missed it, because at the end I heard the questions that were being asked and I really appreciated them. But the reason was that I was at a continuing legal education about lessons learned from recent fraud and abuse cases in medical care. And so we were looking at fact patterns of, you know, medical necessity procedures that were not needed and that were billed and PBM pharma kickbacks which -- we have gotten so used to these rebates that we don't call them kickbacks anymore. But there were some attorneys that were

willing to use that word. And the upcoding -- I mean, it's just amazing to think about. It's kind of mind-boggling, all the incentives that exist in our current system now, that are hidden from view and that have to be investigated, and, I think with vertical integration we are going to have even more of these bad incentives that are going to lead to bad outcomes because it will become even more it will all still be in-house and not transparent, unless we figure out a way to make it more transparent.

One of the things that I learned was that a theme in this administration at the national level is to be what they said slightly more business friendly and more practical and pragmatic, and only insisting on a monitor if dot dot dot. So I think we really have to now appreciate the scrutiny of New York State and that we have to count on New York State to

protect us in situations -- protect consumers since that's who I represent -- in situations where maybe DOJ is not taking as critical a look at things. So I really appreciate this -- the demands for plans, the demands for transparency, and we really need to make sure that these promises that are being made about how this transaction is going to be so wonderful are secured. I for one have not drunk the Koolaid. I don't think the premiums going to necessarily come down as a result of this, and I think we really need to have oversight and monitoring if this is permitted to go forward. Thank you.

SUPERINTENDENT VULLO: Thank you. Okay.

That is the end of the list of people who had registered to speak, and I am going to do this. If there's anyone here who has not yet spoken but wishes to be heard I will open the mike

to you. Just want to make sure that anyone has that opportunity, and for those who may have thoughts in their head but maybe don't want to come up in a public forum and do so, you are more than welcome to write to us in whatever manner is easier for you, to provide us with your comments, as I said at the beginning of the hearing we will continue to accept written submissions within five business days of this hearing. But again, before I go onto my thing was there anybody who wants to be heard who hasn't yet been heard? Okay.

So that ends the oral testimony at this public hearing, and, you know, I said a lot in the beginning of this hearing and I think, as we heard today this is a very significant transaction and there were some very strong views on all sides. And I guess as I see it you have the proponents of the transaction arguing that the

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transaction will benefit the public in reduced costs and better healthcare access. Those are goals that we strongly support. On the other side, there are obviously significant risks in the transaction where you have large corporate for-profit conglomerates which, you know, some may say don't have a good history of serving the public above their shareholders. And we also have heard from independent pharmacists, medical providers. You also have the uninsured and you have consumers who are suffering from too high pharmaceutical costs that we have heard about today, and certainly the benefits that are being advocated by the proponents of this transaction are benefits that we fully believe in, in the Department of Financial Services, in the State of New York. But I do think that, as we move forward in the decision making phase, that companies must be held accountable for any

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advocacy that they are promoting in favor of the transaction to ensure that any such thing, such advocacy, turns into reality and is not nearly puffery in the process of transaction approval. And if, of course, as many have said, and certainly I said in the beginning, regulators including this department would have to have full oversight going forward. As I said in the beginning there is a specific transaction that is before us for approval and that is a change of control application for one Aetna New York domiciled company. As I also said there are licensees that are Aetna licensees that have licenses before the department, and so we consider that as well. And of course, our authority is to consider the people of the state. But as we all know, the Department of Justice has come up with its resolution, as has Connecticut. I will assure everybody that this department will take a full and

thorough review of all of the testimony that we've had, and as I said we have been working for months on this transaction and we will arrive at a decision that is based upon the authority that we have, and to protect both markets and consumers. Again, we will accept written submissions within five business days of this hearing.

Please if you're going to do so, I would encourage you to do it via the e-mail address that is on the Department's website. You can certainly use the United States mail but please note that that doesn't always get to the addressee as quickly as an e-mail might, and please use the e-mail address that is on our website, and look for our website in terms of, you know, the posting of when we get the transcripts and other things for this public hearing.

The record will be closed on October 25th. That's the five business

days that we are allotting, and then after that, the department will make its determination. And as I said we will do this considering all of what we have heard and the concerns that have been raised and in the context of the authority that we have under the insurance law and otherwise to assess this transaction.

So with that, thank you all for coming. I have somebody raising his hand.

SPEAKER: Is that the same address where we got for our confirmation for the hearing?

SUPERINTENDENT VULLO: I have no idea. Whatever it is, do not want send it to me. Send it to that e-mail, and yes.

Yes.

SPEAKER: Hi. Will you consider stopping the merger in the jurisdiction that you have or asking for more conciliations from CVS and Aetna?

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SUPERINTENDENT VULLO: We consider everything. We consider -- we have made no decisions. We are looking at this and this public hearing was an effort to obtain public comments, and we are continuing to do that again in that five business days, but we will consider everything and all options available to us.

SPEAKER: (Inaudible).

SUPERINTENDENT VULLO: Can you identify who you are?

SPEAKER: Sure, Tim Collier from Tudor Investments.

SUPERINTENDENT VULLO: I am not going to speak to people that are investment advisors or anything like that. I understand that, you know, there are public companies involved here. We are not going to give out any information more than what we have done there and that's not within our domain.

Okay, thank you.

(TIME NOTED: 12:52 P.M.)

CERTIFICATION

I, STEFANIE KRUT, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of October 2018.

STEFANIE KRUT