Fall 2018

Fall 2018 Health Law Symposium

New York Law School

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New York Law School Health Law Colloquium

VERTICAL AND HORIZONTAL INTEGRATION IN HEALTH CARE AND HEALTH COVERAGE—WHAT’S HAPPENING; GOOD OR BAD?

DATE
November 5, 2018

TIME
6:00 p.m.–7:45 p.m.

LOCATION
New York Law School
W301
185 West Broadway
New York, NY 10013

CLE
1 credit in Ethics and Professionalism and 1 credit in Professional Practice (NY transitional and nontransitional)

MODERATOR
Adam Herbst Esq., M.B.A., Chief Legal, Planning and Government Relations Officer for Blythedale Children’s Hospital and Adjunct Professor, New York Law School

PANELISTS
Richard N. Gottfried, Chair, New York State Assembly Health Committee
Jeffrey Farber, M.D., President and CEO, The New Jewish Home
Nancy Neveloff Dubler LL.B., Consultant for Ethics, NYC Health + Hospitals, Medical & Professional Affairs, Adjunct Professor, Division of Medical Ethics, NYU Langone Medical Center; Professor Emerita, The Albert Einstein College of Medicine/Montefiore Medical Center
Salvatore J. Russo, Adjunct Professor of Law Brooklyn Law School and a Fellow of the New York Academy of Medicine
Steffie Woolhandler, M.D., M.P.H., Distinguished Professor of Public Health, City University of New York at Hunter College, Lecturer in Medicine, Harvard Medical School, and Adjunct Clinical Professor and Staff Physician, Albert Einstein College of Medicine/Montefiore Medical Center

RSVP: www.nyls.edu/HealthLaw

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AGENDA

6:00pm Welcome – Anthony W. Crowell, Dean and President of New York Law School

6:05 – 7:50pm Panel Discussion Moderated by Adam Herbst, Chief Legal Officer, Blythedale Children’s Hospital

CLE Details: NYLS is accredited by the State of New York to offer this program with 1 Credit of Ethics and Professionalism Continuing Legal Education and 1 Credit of Professional Practice Continuing Legal Education. Transitional and Non-Transitional use.

BIOS

Moderator:

Adam S. Herbst, Esq., MBA Mr. Herbst is Chief Legal, Planning and Government Relations Officer for Blythedale Children’s Hospital. He also serves as the Hospital’s Chief Compliance Officer. In this role, Mr. Herbst has legal and compliance oversight for the Hospital and is responsible for developing corporate planning strategies and administering government relations, the ethics program, as well as advocacy and community relations. Mr. Herbst has devoted a considerable portion of his career specializing at the intersection of where health care law meets with communications, technology and ethical issues. Mr. Herbst has worked on issues related to housing, education, public health, economic development and has trial experience in both federal and state courts, as well as arbitrations throughout the country. He is a frequent speaker on health care access and informed consent. Mr. Herbst is an Adjunct Professor at New York Law School, teaching Health Law and Policy, and is also the Co-Director of the Health Law Clinic.

Panelists:

Nancy Neveloff Dubler LL.B. is Consultant for Bioethics at the New York City Health and Hospitals Corporation and Adjunct Professor at NYU Langone Division of Bioethics. She is Professor Emerita at the Albert Einstein College of Medicine and formerly Head of the Division of Bioethics at Montefiore Medical Center. She received her B.A. from Barnard College and her LL.B. from the Harvard Law School. She lectures extensively and is the author of numerous articles and books on termination of care, home care and long-term care, geriatrics, adolescent medicine, prison and jail health care, and AIDS. Her most recent books are: Bioethics Mediation: A Guide to Shaping Shared Solutions, co-author, Carol Liebman, Vanderbilt University Press, 2011; The Ethics and Regulation of Research with Human Subjects, Coleman, Menikoff, Goldner and Dubler, Lexis/nexis, 2005; Ethics for Health Care Organizations: Theory, Case Studies, and Tools, with Jeffrey Blustein and Linda Farber Post (2002). She consults often with federal agencies, national working groups and bioethics centers.
Jeffrey I. Farber, MD, is the President and CEO of The New Jewish Home (TNJH) in New York, a health system for older adults which serves more than 10,000 clients annually through a diverse portfolio of services including short-term rehabilitation, long-term skilled nursing, low-income housing, day programs, and a wide range of home health and care management programs across 3 campuses in Bronx, Manhattan, and Westchester. The organization is committed to transforming eldercare for New Yorkers so they can live meaningful lives in the places they call home. Technology, innovation, applied research and new models of care put The New Jewish Home at the vanguard of eldercare providers across the country.

Prior to joining TNJH in December 2017, Dr. Farber served as Chief Medical Officer and Senior Vice President of Population Health at Mount Sinai Health System, New York, where his responsibilities included overseeing clinical operations to drive performance in the health system’s value based contracts, managing total cost of care for > 300,000 lives across all lines of business. He led the development and monitoring of programs and systems to evaluate the quality, value, and efficiency of care across the clinically integrated network of 3400 physicians, including practice transformation, patient and provider engagement, care management, and specialized clinical solutions.

Dr. Farber received his MD from Albert Einstein College of Medicine of Yeshiva University and a Masters in Business Administration from University of Massachusetts Amherst, and is Associate Professor of Geriatric Medicine, Icahn School of Medicine at Mount Sinai.

Dr. Farber’s research interests include models of care for older adults, population health management, and the clinical interface with healthcare finance. He is a nationally recognized speaker and has twice received federal grant funding through the U.S. Health Resources and Services Administration. Dr. Farber’s research has been published in The Annals of Internal Medicine, JAMA Internal Medicine, and The Journal of Hospital Medicine.

ASSEMBLY MEMBER RICHARD N. GOTTFRIED
CHAIR, COMMITTEE ON HEALTH

Richard N. Gottfried has chaired the New York State Assembly Committee on Health since 1987. He is a Democrat representing the 75th Assembly District in Manhattan. He is a leading state health policy-maker not only in New York but also nationally.

His work has focused on creating and expanding public health insurance programs in New York, including Child Health Plus. He sponsors the N.Y. Health Act to create a universal publicly funded single-payer health plan – like an improved version of
Medicare but for everyone. He is a leading proponent of patient autonomy and reproductive freedom.

He sponsored the law to allow medical use of marijuana and works to expand it. His legislative work includes: promoting primary and preventive care; authorizing formation of accountable care organizations (ACOs); the Health Care Proxy Law (which allows people to designate an agent to make health care decisions for them if they lose decision-making capacity); the Family Health Care Decisions Act (which enables family members to make health care decisions for incapacitated patients who have not signed a health care proxy); managed care reforms; giving patients access to information about a doctor's background and malpractice record; licensing of midwives; insurance coverage for midwife services; and the HIV Testing and Confidentiality Law. He works to protect funding for Medicaid, community health centers, school health clinics, HIV/AIDS services, and other health concerns.

He is a graduate of Cornell University (1968) and Columbia Law School (1973). He is a member of the New York Academy of Medicine, the National Academy for State Health Policy, the Public Health Association of New York City, the New York Civil Liberties Union, the Reforming States Group, the Art Students League of New York, and the China Institute. He was first elected to the Assembly in 1970.

**Salvatore J. Russo** is a health care lawyer with over thirty-seven years of experience. He is the recently retired Senior Vice President and General Counsel of NYC Health + Hospitals. Mr. Russo was the corporate officer in-charge of equal employment opportunity at NYC Health + Hospitals. Mr. Russo was secretary for the Board of Directors of NYC Health + Hospitals. He was the secretary and member of the board of directors of the NYC Health + Hospitals Assistance Corporation (DSRIP CSO). Mr. Russo has previously served as the In-house Counsel for Maimonides Medical Center of Brooklyn, Director of Legal Affairs for the Greater New York Hospital Association, and Counsel to the Health Leaders of New York, formerly known as the Metropolitan Health Administrators Association. Mr. Russo is a Phi Beta Kappa graduate of New York University College of Arts and Science. He was awarded the degree of Juris Doctor from Hofstra University School of Law School. Mr. Russo has the distinction of receiving the award for school service from his high school, college (Dean Robert Bruce Dow Medal) and law school, respectively.

Mr. Russo is Adjunct Professor of Law at Brooklyn Law School. He also is a Fellow of the New York Academy of Medicine. Mr. Russo writes and lectures extensively in the area of medical/legal topics. He is a contributing author for, “The Legal Manual for New York Physicians (first, second & third editions),” and “The Complete and Easy Guide to Health Law.” Some of his other publications include, “All Right, Mr. DeMille, I am Ready for my Close-up, (A Health Care Lawyer’s Practical Guide to Considerations to Negotiating a Film/TV Contract),” and, “In the Matter of AB,” which were both published in the New
York State Bar Association Health Law Journal. In addition to being an adjunct law school professor, Mr. Russo has been a speaker on various topics in health law at Fordham Law School, Brooklyn Law School, Seton Hall Law School, and Queens Law School, as well as at numerous programs for bar associations and other professional organizations.

Mr. Russo is on the Executive Committee and is a member of the Nominations Committee of the Health Law Section of the New York State Bar Association ("NYSBA"). He is also the past Chair of the Health Law Section of the NYSBA. He is a past member of the House of Delegates of the NYSBA. Mr. Russo is the past Co-chair of the Health Rights Committee of the Section on Individual Rights and Responsibilities of the American Bar Association. Mr. Russo is the past Chair of the Public Health Committee of the New York State Bar Association. He is also the past Chair of both the American Bar Association’s AIDS Coordinating Committee, and the Special Committee on AIDS and the Law of the New York State Bar Association. Mr. Russo is a member of the New York City Bar Association and the New York State Bar Association.

Mr. Russo has received honors and awards from various organizations. In 2015, 2016 and 2017, Mr. Russo received the highest possible rating of "AV Preeminent" for both legal ability and ethical standards from Martindale-Hubbell. He is the Joseph P. Crisalli 2010 Award for Distinguished Service recipient from the Congress of Italian-Americans Organization. Mr. Russo was recognized as a Distinguished Law School Alumnus, and was awarded the Hofstra University School of Law Outstanding Public Service Award for 2007. He was selected as Seton Hall Law School Health Law & Policy Program's Distinguished Guest Practitioner for 2006. Additionally, Mr. Russo is the recipient of the Senior Level Healthcare Executives Regent's Award for 2003 of the American College of Healthcare Executives, the New York City Health and Hospitals Corporation Diversity Award 2002 (Corporate Headquarters Division), the Xaverian High School Alumnus of Distinction Award for 2000, and the 1999 Health Leaders of New York, formerly known as Metropolitan Health Administrators Association, Award of Distinction.

Mr. Russo is active in his community and serves as a member of the Board of Trustees of Xaverian High School in Brooklyn, New York. He also serves as a member of the Board of Directors of St. Athanasius Academy in Brooklyn, New York. Mr. Russo is an emeritus member of the Board of Directors of the Congress of Italian-Americans Organization. He is a liturgical minister at St. Athanasius Roman Catholic Church in Brooklyn, New York. Mr. Russo is married to his high school sweetheart for thirty-seven years, Sandy, an Associate Professor, Chair and Director of the Department of Nursing at Touro College. They have three children, Stephen, Matthew and Christopher. The Russo family resides in Brooklyn, New York.

**Steffie Woolhandler, M.D., MPH** is a Distinguished Professor at The City University of New York's Hunter College, a primary-care doctor in the South Bronx, and a Lecturer in Medicine at Harvard Medical School, where she was formerly Professor of Medicine. A native of Louisiana, she graduated from LSU Medical School in New Orleans, and
completed an internal medicine residency at Cambridge Hospital and a research fellowship in General Internal Medicine at Harvard. During her stint as a Robert Wood Johnson Health Policy Fellow at the Institute of Medicine (now the National Academy of Medicine) she worked with Senator Paul Wellstone and then-Congressman Bernie Sanders. She has published more than 150 journal articles, reviews, chapters and books on health policy and is a leading advocate of non-profit national health insurance for the United States. She, along with Dr. David Himmelstein co-founded Physicians for a National Health Program. Among her influential scholarly articles are studies on patient dumping (which led to a federal ban on that practice, medical bankruptcy (co-authored with Elizabeth Warren), waste in hospitals and in medicine more generally, the lethality of being uninsured and proposals for single payer health reform.
My name is Richard N. Gottfried. I chair the New York State Assembly Committee on Health. I appreciate the opportunity to testify today. I urge the Department of Financial Services to reject the proposal by CVS Health Corporation and CVS Pharmacy, Inc. to acquire control of Aetna Health Insurance Company of New York. This acquisition would impair the health insurance market in New York, harm the quality and accessibility of health care for New York consumers, and significantly advance dangerous trends in health care and health coverage. It should be rejected under Insurance Law §1506.

CVS operates the nation’s largest retail pharmacy chain, owns one of the largest pharmacy benefit managers, is the nation’s second-largest provider of individual prescription drug plans, with approximately 4.8 million members, and had revenues of approximately $185 billion in 2017. It is a giant whose current size and scope of activities ought to raise loud anti-trust and anti-consumer 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, with over two million prescription drug plan members, and with revenues of approximately $60 billion in 2017. If the term “anti-competitive” 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 health care for millions of consumers.

This needs to be seen in a broader and profoundly threatening context.

Decades ago, health care 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, health care 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 its nature an integrated health care 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 on the same level – e.g., large or multi-specialty physician practices, or hospitals merging or affiliating in networks – and among payers – higher degrees of market control among fewer and increasingly dominant insurance companies.

In addition, there is vertical integration among providers, as, e.g., more and more physicians practice as employees of hospitals or hospital-controlled practices. Retail and pharmacy chains like CVS and Walmart are opening “drop-in” clinics on their premises, and these 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 already integrated with one of the largest pharmacy benefit managers and a growing number of retail clinics – with one of the largest insurance companies.

Some would assert that New York’s laws against the corporate practice of medicine and limits on corporate ownership of hospitals protect us from having our health care 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. Nothing in New York law limits that practice to episodic “drop in” services or prevents it from becoming a full-blown practice, 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 a 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 health care providers, it is easy for the insurance company-corporate combination to drive patients to its owned or controlled providers, using tools like restricted provider networks and payment arrangements.

What happens to a health care professional’s professionalism and ability to advocate for the patient 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 free-standing health care provider to compete, innovate, or survive?

The tendency of economic organizations to horizontal and vertical integration is both dangerous and nearly inexorable. As those entities amass greater and greater power from the combination of horizontal and vertical integration – we could 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, nurses), its customers (patients), and any independent providers left outside the structure.

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

Rejection of the 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.
Opening Statement of DFS Superintendent Maria T. Vullo for the DFS Hearing Regarding the Application by CVS Health Corporation and CVS Pharmacy, Inc. to acquire Aetna Health Insurance Company of New York

Opening Statement: CVS-Aetna Public Hearing

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

Pursuant to New York Insurance Law Section 1506, we are holding this public hearing to consider the application by CVS Health Corporation and CVS Pharmacy, Inc. to acquire Aetna Health Insurance Company of New York, 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 benefits. But it also presents potential risks, to markets, consumers and the people of the State of New York, who in my role as Superintendent, I am duty-bound to protect where I can.

It is important to note that NYDFS has specific approval authority with regard to this transaction as to the proposed acquisition by CVS of Aetna Health Insurance Company of New York, one of Aetna Inc’s subsidiaries. NYDFS 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, Aetna Health Inc. (HMO) and Aetna Better Health Inc. (Managed Long Term Care Plan). In addition, Aetna has three Connecticut domestic insurers that hold DFS licenses to transact insurance business in the State of New York, including Aetna Life Insurance Company, and this hearing is also to consider the potential impact of the proposed transaction on those New York licensees and – most importantly – the impact 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. Because the Connecticut company sells a very substantial number of insurance policies in 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 U.S. Department of Justice approved the CVS/Aetna transaction last week, subject to a consent decree requiring the divestiture, by Aetna, of its Medicare Part D prescription drugs coverage. While that decision addressed horizontal aspects of this transaction from the insurance perspective – specifically the proposed combination of CVS and Aetna’s Part D businesses – unfortunately the Justice Department has taken a very myopic view and failed to
address the substantial impacts that this vertical integration would have on consumers across the country.

There is no question that this transaction, were it to proceed, would have a significant impact on New York. As New York’s insurance commissioner, 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 approximately $3 billion in premiums, which amount exceeds the direct premium writings of any other state or territory. These premium writings in New York constituted 10.7% of the company’s total direct accident and health insurance premium writings, and represented approximately 33% of the overall accident and health insurance market share in New York. 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, those Aetna companies that sell insurance in New York hold DFS licenses. Under New York’s Insurance Law, the New York licenses of the Aetna companies (and the CVS insurers in the Part D market) licensed in New York but domiciled in Connecticut, and all such companies licensed in New York but domiciled in another State, are subject to annual renewal by DFS. 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 (s)he may require, that such an insurer is not delinquent with respect to any requirement imposed by this chapter and that its continuance in 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 impacted by this transaction will be addressed as part of our review of this proposed transaction, applying this statutory standard.

In addition, CVS, the proposed acquirer, operates as a retail pharmacy and, through Caremark, as a pharmacy benefit manager, or PBM. These facts enhance the proposed transaction’s substantial impact on New York’s health care 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 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 New York. DFS has previously expressed substantial concerns about the role of PBMs in the high cost of pharmaceuticals, as well as the non-transparent 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 Kentucky which recently took action against CVS Caremark. DFS will continue to advocate for legislation for the licensing of PBMs by DFS. In the meantime, DFS and will continue to use its supervisory authority over health insurers to obtain much needed information from PBMs, despite their opposition to transparency and regulation. This background also informs the Department’s review of this transaction today.

Turning specifically to the application for change of control that is before NYDFS, Section 1506(b) of the New York Insurance Law 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 insurers, 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 reduction of costs to consumers and the betterment of health care services to New Yorkers.

The Department has spent a substantial amount of time 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 this proposed acquisition 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. To date, we have received a good number of written comments and ten witnesses 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 provider groups, and from members of the legislature. So, we have a full audience of people wishing to be heard. I assure you that we will consider all comments, written and oral. As described in the hearing notice, CVS and Aetna, who are the parties proposing this transaction, each will have 10 minutes to describe the transaction, exclusive of questions, followed by any other individuals or groups, each of whom will have 5 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. And, as stated in the hearing notice, the public will have five business days after today to submit any additional written comments – as information gathered at this hearing might cause members of the public to provide additional information.
Before we go to the oral testimony today, I wanted to set forth a few issues that the Department has been 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 cost savings. CVS also claims efficiency gains from its “minute-clinics” in CVS pharmacies, where consumers can stop in without an appointment to see a nurse or 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 consumers. It is imperative that any claims of cost savings be specified by the companies from the perspective of the New York consumer, including the numerous Aetna policyholders, and that guardrails are placed to ensure that the promises of today – in order 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 mentioned, CVS owns a very large Pharmacy Benefit Manager (PBM), Caremark. We have great concerns that PBMs are just another cog in the wheel for profit-making – to consumers’ detriment. Today, the top three PBMs control 70% of the business in this highly opaque industry. CVS Caremark is one of the three PBMs with this 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. The consolidation of existing PBMs with insurers would make it increasingly difficult for new, independent companies to enter the PBM market.

It also is worth stressing that PBMs lack full transparency and are not directly regulated in New York at the present time. As I said, DFS proposed a bill two years ago to gain full transparency, through the licensing of PBMs, which we will continue to pursue 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.

Further, this transaction 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 market share. As a result, small and regionally-based carriers, without an affiliated PBM, may be disadvantaged, thereby harming New York’s market and New York consumers. We are told that this will not happen; DFS must have the ability to ensure that this in fact will be the case were this transaction to proceed.

- **Relatedly, We Are Concerned from a Competitive Standpoint That Aetna May Create Incentives to use CVS Services, Leading to Drug Price Increases.** Through this merger, we are concerned that Aetna may create cost-sharing structures, network designs, or other incentives for its insureds to utilize CVS services over 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 in the retail pharmacy industry, but the reduction in competition could result in the loss of small businesses and higher drug prices passed on to 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 post-acquisition entities for the purpose of increasing CVS’s and Aetna’s market share and profits. CVS must commit to strong safeguards to protect and prevent the sharing of consumers’ data, both within the organization and outside of it. In addition, the privacy of the data must be amply protected from third parties and hackers. New York has been a leader in cybersecurity and we must ensure that CVS, the entire enterprise, complies under New York’s cybersecurity regulation. This transaction would create an even larger corporate organization in the health care space. This means that a tremendous amount of 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 area are crucial. 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 – over $40 billion – that CVS would be assuming to finance this transaction. The Department has already expressed its concern that this increased debt may create 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 substantial debt obligation before investing in other pro-consumer measures, including infrastructure improvements that would be beneficial to consumers and/or provide relief to premiums for consumers. We must make sure 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 retail stores will be utilized to further the company’s expansion into the health care 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 certain health care 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 access to affordable health care 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 (without DFS’s approval) 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 the New York Exchange. 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 health care 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 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 before us. I have made no decision and will not do so until my dedicated staff and I hear all of the testimony, both oral and written.

This is a very significant transaction and there are some very strong views on all sides. As I see it, the proponents of the transaction argue that the transaction will benefit the public in reduced costs and better health care access – goals that we strongly support. On the other side, however, there are significant risks in this transaction. Large corporate for-profit conglomerates do not have a good history of serving the public above their shareholders. And, here, we have independent pharmacists, medical providers, the uninsured, consumers suffering from too high pharmaceutical costs, who may suffer from this transaction. While we want to believe the benefits being advocated, it is important that companies are held to account for the advocacy that we are hearing in favor of this transaction – to ensure that it is not just puffery to get the transaction approved. Regulators, including DFS, must have oversight going forward.

We will continue to accept written submissions within five business days after this hearing. Anyone who wishes to submit a written statement should do so at the email address or mailing address (email is preferred) on the Department’s website regarding this hearing. The record will be closed on October 25, 2018, after which the matter will be fully submitted for the Department’s determination.
EDITORIAL AND COMMENT

It Is Time to Liberate Hospitals from Profit-Centered Care

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he way we pay hospitals is toxic. It rewards, indeed requires, bad behavior from hospital leaders and stifles the better angels of their nature.

In our market-driven payment system, hospitals’ success, and even survival, depends on generating profits. Even non-profit hospitals live or die based on profit margins (often labeled “surpluses” in non-profit facilities). Hospitals that lack profits (or the prospect of future profits that can entice lenders or investors) face a grim future. Unable to renovate or expand their original facilities, purchase new equipment, acquire other hospitals, or grow their provider networks, unprofitable hospitals often spiral downward. As one public hospital CEO admonished two of us, “no margin, no mission.”

In this issue of JGIM, Ly and Cutler 1 demonstrate one noxious side effect of making profitability the arbiter of hospital success. Their analysis of changes in hospital profit margins between 2003 and 2013 indicates that hospitals won the profit game by boosting prices, not by improving efficiency, or through exemplary community service (e.g., by increasing their care for Medicaid patients). The losers cared for a disproportionate share of publicly insured patients (and presumably the uninsured, although Ly could not assess that) or had the bad luck to be located in rural America. Public hospitals lagged, while not-for-profits grew their profits even faster than for-profits. (Although not discernible from Ly’s analysis, MedPAC data indicates that investor-owned hospitals had much higher profit margins at baseline and retain a big profit lead. 2) Chaining up was a winning strategy, presumably because it increased hospitals’ leverage in negotiations with insurers, allowing them to command higher prices.

Ly’s conclusion that upcoding did not drive profitability gains will surprise many clinicians whose hospital managers obsess about capturing every billable diagnosis. While the study found a positive relationship between growth in a hospital’s casemix index (CMI) and growth in its profit margin, this finding was not statistically significant. Unfortunately, this analysis was underpowered because it used all-payer CMI data, which was available for only a subsample of 587 hospitals in eight states. Nationwide, increases in the Medicare CMI (available for almost all hospitals) strongly predict total margin growth (Dickman S, Woolhandler S, Himmelstein DU. Unpublished analysis of Medicare Cost Report and Medicare casemix data, 1998–2016). It seems likely that upcoding is an important profit-driver.

Hospitals did not always have to turn a profit in order to survive. In our past (and today in Canada, much of Europe, and our VA system), funds for capital investments came from government grants or charitable donations.

During the first three decades of the twentieth century, private donors funded almost all US hospital construction. 3 The federal government stepped in to provide capital funds to non-profit hospitals during the Great Depression, and its Hill-Burton program was the major funder of hospital construction in the post-war period. The seed of profit-based capital funding was planted by the hospital industry-controlled Blue Cross plans of that era, which paid hospitals a per diem rate that covered operating costs (including interest on loans, i.e., payment for existing capital investments), plus depreciation and a capital add-on to provide hospitals with reserves for future capital investment. 4 But even as late as 1965 (when Congress passed Medicare and Medicaid), hospitals’ reserves together with their long-term borrowing accounted for only 31.9% of hospital construction funds. 5

Two developments in the mid-1960s accelerated the shift from grant-based to profit margin-based funding for not-for-profit hospital capital. First, a 1963 IRS ruling triggered states to start offering tax-exempt bond funding for hospital construction, allowing hospitals to obtain loans with minimal down payments, and pay them off with future profits. Second, Medicare adopted Blue Cross’ capital payment model (with an extra profit allowance for investor-owned facilities). For hospitals with a good payer mix, this assured a flow of public dollars to build up reserves for future investments, and to pay off bondholders and investors. By the 1970s, 70% of construction was debt-funded, with much of the rest covered by hospitals’ reserves. 6

Before the mid 1960s, explicit (if often flawed) public decision-making guided the allocation of government funding for hospital construction. Thereafter, the flow of taxpayer dollars surged but public control of decision-making shriveled. Profitability determined which hospitals could afford new projects, and private boards and executives decided how to deploy those funds.
Medicare’s (and private insurers’) capital payment policies have undergone many twists and turns over the past half century. But the link between profitability and ability to expand and modernize has been a constant. In effect, all non-federal hospitals have been forced to become quasi-commercial enterprises, and to think of themselves in business rather than social terms. As profitability became mandatory for hospital survival, the distinction between for-profit and non-profit hospitals began to erode—although even decades later, for-profits continued to deliver inferior quality care at higher prices.

The price-boosting that Ly identifies as a key profit-driver (among non-profit as well as investor-owned hospitals) is just one of the ill-effects of making profit margin the mission. Hospitals’ manipulations of their payer and service mixes, the efforts squandered on financial gaming, and the ethical compromises that have become commonplace in the healthcare milieu are also, like price gauging, antithetical to the public’s interests.

Hospitals’ efforts to avoid money-losing patients, effectively excluding many of those most in need, have become so routine that many of us have become inured to this disgrace. New York City’s private academic medical centers exclude almost all uninsured persons and maintain separate clinic systems for patients with Medicaid, leading to the de facto racial as well as socioeconomic segregation of care, a situation that is not unique to New York. The CEO of the Mayo Clinic—which generated an operating surplus of $707 million last year, while investing $714 million in new capital projects—instucted employees to “prioritize” patients with private insurance over those with Medicaid, and even Medicare.

The profit imperative, even among non-profit hospitals, similarly distorts the mix of services that hospitals choose to offer or promote. Money-losing services like mental health and primary care are accorded second-class status, in contrast to the opulent resources devoted to elective cardiac and orthopedic interventions, even those of dubious value.

Selectively recruiting profitable patients and excluding the unprofitably ill require considerable bureaucratic effort and expense. But that is just the beginning. Much more is spent to maximize billings and collect payment. At one non-profit Utah hospital system, 2300 employees, 6% of all employees, work on claims processing and bill collections. Meanwhile, the patient chart has morphed from a clinical diary for facilitating care into a billing document driven by commercial imperatives, padded with redundant (and even misleading) material. Physicians now spend half their time on electronic documentation and other clerical/administrative tasks. Overall, the average US hospital now devotes more than one quarter of its budget to administration, a share that is continuing to increase, and is already twice that in Canada (or Scotland).

Why is hospital administration so much leaner in Canada? Although physician payment in Canada’s single-payer system looks a lot like US Medicare’s, its hospital payment strategy is dramatically different, more akin to the way we fund the VA. Canadian provinces (and Scotland) pay hospitals’ global operating budgets, with separate government grants for capital costs. Even countries like France, Switzerland, and Germany which have more complex universal social insurance schemes, fund much of new hospital investments through government grants rather than hospitals’ profits. This dampens US-style entrepreneurial incentives, leading to lower bureaucratic costs, less price-inflating gaming, and greater healthcare equity.

Profit-seeking does not just undermine efficiency and equity, it also fosters corruption. For-profit hospital firms have been most frequently implicated in the most egregious incidents, paying billions to settle fraud and abuse claims. But the faltering moral compass of non-profit and even public hospital leaders has an even greater impact because they control 80% of community hospitals, and almost all academic medical centers. Massachusetts General Hospital received $123 million in royalties and licenses over a four-year period, mostly from orthopedic device-makers whose high prices are borne largely by Medicare. In 2013, 73 leaders of academic medical centers also sat on the boards of 85 publicly traded healthcare firms, receiving median compensation of $209,000 per directorship, and, in addition, held 5,493,946 shares of stock in those firms. It takes extraordinary ethical gymnastics to justify such dual commitments.

Ly implies that a crackdown on hospital prices would lead to salutary change, goading hospitals to seek profit through efficiency. But controlling prices without eliminating profits could amplify current profit-inflating misbehaviors, e.g., prioritizing the care of privately insured patients. As long as profit-centered care remains the key to hospital survival, patient-centered and community-centered care will suffer.

No law of nature requires that hospitals make profits in order to thrive. What is needed is a single-payer reform that:

- PAYS hospital lump-sum operating budgets, like those for schools, fire houses, or VA hospitals;
- Claw back any money they do not spend on care; and
- Allocates truly needed capital funding through a region-wide accountable government grant program that directs investments to the highest priority, community responsive projects.

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**REFERENCES**


