NEW YORK STATE ASSEMBLY

ASSEMBLY STANDING COMMITTEES ON INSURANCE AND HEALTH

PUBLIC HEARING

CVS Health's Acquisition of Aetna Inc.

Roosevelt Hearing Room C

Legislative Office Building

Albany, New York

June 4, 2018

9:30 A.M.

ASSEMBLY MEMBERS PRESENT:

ASSEMBLY MEMBER KEVIN CAHILL
Chair, Assembly Standing Committee on Insurance

ASSEMBLY MEMBER RICHARD GOTTFRIED
Chair, Assembly Standing Committee on Health

ASSEMBLY MEMBER PAMELA HUNTER

ASSEMBLY MEMBER JOHN MCDONALD, III

ASSEMBLY MEMBER WILL BARCLAY

ASSEMBLY MEMBER ANDREW GARBARINO

ASSEMBLY MEMBER MICHAELLE SOLAGES

ASSEMBLY MEMBER ANDREW RAIA

ASSEMBLY MEMBER PHILLIP STECK

ASSEMBLY MEMBER JAMES SKOUFIS

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(The public hearing commenced at 9:30 AM)

ASSEMBLY MEMBER KEVIN CAHILL, ASSEMBLY STANDING COMMITTEE ON INSURANCE: You all get bonus points for being here on a Monday morning except for Andrew Garbarino who is required to be here cause this is his job. My name is Kevin Cahill and I'm joined today by several colleagues, Assemblyman Richard Gottfried who chairs the Health Committee. I chair the Insurance Committee. We are joined also by Assemblyman John McDonald, Assemblywoman Pam Hunter, Assemblyman Will Barclay and the aforementioned Assemblyman Andrew Garbarino. This is a hearing regarding the proposed acquisition of CVS -- of Aetna Insurance Company by CVS and I will be back in a moment to offer an opening statement, but I want to give my colleague Mr. Gottfried a chance to kick us off.

ASSEMBLY MEMBER RICHARD GOTTFRIED, ASSEMBLY STANDING COMMITTEE ON HEALTH: I have other than that I have no opening comments.

ASSEMBLY MEMBER CAHILL: Okay. Well,

there we go. We're kicked off. So, I'll start off with my opening comments. Welcome to the hearing in which we'll examine the proposed question of Aetna by CVS Health. The purpose of this hearing is to evaluate this acquisition and the potential impacts it may have on the delivery of healthcare in New York State and on our insurance markets. I mention the colleagues who are here in attendance. Some may come and some may have to go for other obligations. I'll introduce them or Dick will as the day progresses. I want to thank particularly my staff in particular Brandon McAvoy who is I think already across the sea back in Ireland whose research and analysis of this subject was pivotal for the preparation of the hearing today. We have a great deal to cover but let me give you a little bit of background. In December of 2017, CVS Health announced plans to acquire Aetna, Inc., a vertical integration that would merge a for-profit retail pharmacy and retail health corporation with a pharmacy benefit manager and a health insurance company. The federal Department

of Justice is reviewing the details of this potential acquisition but completion of the transaction is subject also to approval by New York State regulators in terms of doing this here in the state. Since the announcement, a number of concerns have been raised surrounding the potential impacts of this merger and what it would mean to the viability of our healthcare markets. We're concerned with the impact on consumer costs with having a corporation, a privately health corporation with a vast amount of market share and power over healthcare. We are concerned with the viability and the independence of health providers in our state. We are certainly mindful of the complications and the potential of the integration of an insurance pharmacy healthcare provider that, that includes as part of its general mission the development of Minute Clinic walk-in clinics. We are also extremely concerned and if you ask me I'm primarily concerned with the role or lack of role of our New York State regulators in dealing with this potential transaction. I would like to

point out that the Department of Health, the New York State Department of Health, the New York State Department of Financial Services, and the Attorney General were all invited to provide formal testimony. All have declined. In addition to that, previously I've written a letter to these three entities and I've received a response from them that indicated that they have some level of involvement but that level was not detailed nor was there an opportunity for the kind of interchange that could have occurred with the hearing today. One of the things that I hope to accomplish by this hearing is to spur the State of New York into a position of proactivity rather than reactivity. We shouldn't just be concerned with what happens if the federal government approves it. We should be involved in the process of the federal government considering the approval or nonapproval of it. We've seen the impact in the past of the reactive approach that has existed in some of our other entities we've been dealing of late with a very serious crisis in terms of costs and viability of long-

term care insurance something that there have been signals being sent for many, many years but have not yet been completely dealt with by our administrative agencies nor was there anything done by them in advance to prevent the crisis from occurring. You in this room will because you're engaged in healthcare will have still very strong memories of the collapse of Health Republic, the coop here in New York like so many other states. Twenty-three states have coops, all saw problems with those coops. Twenty-four coops sought to operate in the United States of America. Only one did not collapse and that's because it never existed in the first place and that's in the State of Vermont. Our regulators did not take that proactive step to prevent the collapse of Health Republic and the consequence of that was great dislocation for health insurers, health insured individuals across the State of New York looking, scrambling to find new health insurance and many tens of millions if not hundreds of millions of dollars' worth of unpaid claims that resulted, again, because the agency's

involved were reactive, not proactive. We await a conclusion of the Health Republic crisis as well. It's also important for we in New York to understand the involvement of our agencies, the Department of Health, the Department of Financial Services, and the Attorney General so that we know what kind of input we can and should have with those agencies during the course of this process. It certainly is incumbent upon all of us, our regulators and those of us in the legislature to maintain a healthy and competitive insurance market and to maintain access to pharmaceutical and healthcare and health security for each and every individual. This hearing is an opportunity to evaluate the impact of this particular acquisition on New York markets, to review the State's role regarding this merger and the possible subsequent business organization and how the state can begin to proactively deal with the impact. We will have several witnesses today. We're going to ask the witnesses to limit their testimony to ten minutes and if at all possible to avoid reading verbatim from a written

statement. If you wish your statement to be considered your testimony, you may offer it and then give us a few word summary. I promise you it will be carefully read. I know the colleagues here are very diligent in that respect. All written testimony will be included in the record and given the same weight as oral testimony. We may this panel or any one of us may ask a witness to provide some follow-up information. We hope that you will be cooperative. We hope that we will if we do have additional questions that the responses that we get back from you are complete, accurate, and timely. With that, I want to thank you all for your participation and before we proceed to the first scheduled panel, I just want to make sure because I don't want to be critical where it's not necessary or appropriate. If anybody from the Department of Financial Services is here to testify, please come forward at this time. If there's anybody from the Department of Health to testify, please come forward at this time. If there's anybody from the Department of Law to testify, please come forward at this time.

Their absence and their continued lack of proactivity in this regard has been noted and will continue to be noted throughout this hearing and with that, we'll call our first witness and actually what we'll do is we will call a panel and that would the panel would include CVS Health and Aetna and we invite Melissa Schulman and Paul Wingle to come forward to begin our day. I'll give you each a chance to introduce yourselves as you see fit, but I will note that we have Melissa Schulman, the Senior Vice President, Government Relations at CVS Health and Paul Wingle, Vice President of Operations, Products & Technology of Aetna, Inc. Folks, I will remind you and this goes for every witness that although we will not ask you to raise your right hand and swear to a god or whatever else you wish to swear to, your testimony is under oath and is considered it should be truthful in every regard and to the extent that you are, that our questions are pertinent. I hope that your answers can be equally so and direct and responsive. So, Mr. Wingle, why don't you go ahead and introduce

yourself.

PAUL WINGLE, VICE PRESIDENT, OPERATIONS, PRODUCTS & TECHNOLOGY, AETNA, INC.: Sure. Thank you, Mr. Chairman. Thank you, Mr. Gottfried as well, Assemblyman Gottfried. Thank you for this opportunity to testify. I will do my best to be brief.

ASSEMBLY MEMBER CAHILL: Can you pull the microphone closer?

MR. WINGLE: Sure. Is this better?

ASSEMBLY MEMBER CAHILL: Maybe more just so that the system.

MR. WINGLE: I don't see a red light. Is that going?

ASSEMBLY MEMBER CAHILL: Yep.

MR. WINGLE: Okay. Well, again, thank you Chairman Cahill, Chairman Gottfried for this opportunity to testify. As Chairman Cahill mentioned, my name is Paul Wingle and I am the Vice President of Operations and Product and Technology at Aetna. I'm happy to be here to talk about the opportunity to transform the healthcare system through this planned

acquisition of Aetna by CVS Health. We have a longstanding history of serving New Yorkers and we're very proud of the fact that we have 1.1 million medical members here in New York in multiple different offerings, hundreds of thousands of people in employer plans whether they're self-insured or fully insured. We have folks in different lines of business across the state and we look forward to continuing to serve them. We serve them through robust networks. We have hundreds of thousands of, tens of thousands, excuse me, of provider organizations in our network. They're very important and will remain a vital part of the way we serve New Yorkers even through this acquisition. Actually, the acquisition will fortify those relationships. It's our goal through the relationship and through the vertical integration with CVS to better inform and arm our members with information that serves their own health aspirations and goals. So, we're very much looking forward to how we build together a consumer centric system at the local level and it

is that local presence that CVS enjoys and has built that makes this really exciting. The broad retail footprint that CVS has combined with our analytical capabilities, that network of physicians, hospitals, and medical professionals will create a new community-based model. It will help us learn and better serve the needs and health ambitions of customers. The consumer will be at the center of this system. We will strive to make healthcare simpler and easier to use. Our new company will learn about member's individual health goals and connect them to the tools, information, and resources they need to achieve a lifetime of wellbeing. Aetna cannot achieve this on its own. A valley-based consumer focus experience depends on having a significant presence in New York communities where our members live. That is what makes this so compelling. We'll use our data to identify opportunities for tailored and culturally appropriate interventions and our commitment to reducing racial and ethnic health disparities can be seen in several initiatives where meet members

where they are, provider focused diabetes pilot, a beginning right maternity program, a breast health ethnic disparity initiative, and a program to help minority communities manage their asthma and avoid the emergency room. Those are all part of what we do with our data, working through a provider organization, through our provider network, through those 87,000 providers we have in New York, 200 hospitals in our New York networks. I want to say as we talk about providers that there is no intention through this acquisition to make changes in our provider networks after the closing date other than the changes that would be part of normal business. You know, we constantly review the efficacy of our networks and that wouldn't change, but there's nothing that would result from this acquisition that would drive any of those design decisions around networks. Its consumers who are driving the demand for new models of care whether it's concierge medicine, tele medicine, digital health or other innovations that have been coming into this space. Our data integration and member

engagement will be the keys for driving value through this ideal and we have a track record of working to drive transformation and of better outcome for our members here in New York. Seventy seven percent of our membership, our medical spending here in New York is made through value-based reimbursement models. So, we believe we can't stop there though. Consumer centered approach means individualized care attuned to the members own lifetime aspirations for health and wellness and community-based healthcare providers are essential to that whole person approach to empower the members. The opportunity to build and drive that momentum to achieve patient centered care is at the heart of what we're doing through this acquisition. It will bring together two companies with innovative businesses and a sector that's undergoing change. The new company will offer a local experience that is simpler to use and built around consumers. Our value-based model will help consumers receive higher quality more affordable care while also addressing social and environmental factors that impact health.

It's worth noting here that 60 percent what affects health is based on where you live, your zip code. It is not based on your incidents of care or even your genetic code. So, being in the community to identify those needs and become a hub for assembling those needs is really critical and what we're really excited about through this combination. So, thank you for this opportunity to testify and we look forward to working with you in the Assembly and with regulators as each of us works to transform the healthcare delivery system.

ASSEMBLY MEMBER CAHILL: Thank you.

MELISSA A. SCHULMAN, SENIOR VICE PRESIDENT, GOVERNMENT RELATIONS, CVS HEALTH: Chairman Cahill, Chairman Gottfried, thank you very much for and other members of the Committee. Thank you very much for inviting us here today to talk about CVS Health's proposed acquisition of Aetna. As Chairman Cahill mentioned, my name is Melissa Schulman and I'm the Senior Vice President of Government and Public Affairs for CVS Health. Most of you know us as the local

pharmacy in your community, but we are more than that. We are a front door to the path to better health. We have long been at the forefront of putting patient first and improving the health of our communities. Over the past few years, we've taken bold steps to redefine ourselves as a healthcare company. We removed tobacco from our stores and we're promoting healthier food options, and importantly, we are waging a multifront fight against the opioid epidemic by limiting the time of prescriptions consistent with the CDC guidelines in order to help reduce the chance of addiction. We're also providing increased counseling and expanding access to safe, convenient drug disposal options. Over the last several years, we have donated 77 drug disposal boxes to police stations throughout the State of New York and we're now expanding our commitment by providing disposal boxes into our pharmacies. To date, we've already installed 49 of those disposal boxes in pharmacies, in our pharmacies here in New York. Our commitment to public health is central to our purpose and a

reflection of who we are as a company. 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 nations most pressing problems and a major source of financial worry for consumers here in New York. We're addressing this challenge comprehensively by negotiating lower drug prices and reducing out of pocket costs. We are giving patients, prescribers, and pharmacists expanded capabilities so they can evaluate prescription drug coverage in real time and identify lower cost alternatives with their patients. Our acquisition of Aetna singles our next bold step as a company. Our healthcare system is in many ways 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. Our vision is to create a new innovated healthcare platform that's easier to use, less expensive, and puts consumers at the

center of their care. I'd like to highlight a few ways we think this combination will benefit New Yorkers. Consumers are looking for more value, convenience, and help in making their choices in their everyday lives. By most of effectively coordinating patient's care, we'll provide consumers the information and resources they need to better manage their own health. We will expand opportunities to bring accessible healthcare services to consumers and compliment the care they receive from their physician so they have the support they need to follow their doctor's care plan. And again, I want to emphasize that we are complimenting the care and the care plan put in place by their physicians. For instance, we will modernize and simplify our communications to patients when their prescriptions are filled to help them effectively manage their medications to increase adherence and reduce the chance of costly medical complications. Today, one out of every two Americans lives with a chronic disease. We will be increasing our focus on both preventing and

helping patients manage their conditions. By combining pharmacy and medical information, pharmacists will be better able to help provide information from the doctor to the patient, at the pharmacy counter, and will empower patients to more effectively manage their health. We believe this combination will strengthen the relationship and improve the continuity of care between a physician and his or her patient. While a physician may see their patient a few times a year, the pharmacist will see that patient as often as once or twice a month. This provides a natural opportunity in the everyday life of that patient to reinforce the instructions and messages of the physician as the pharmacist is able to engage with patient to help prevent disease and coordinate care more effectively. Today an estimated 1.7 million New Yorkers has diabetes. This is a key area where we have an opportunity to reshape the delivery of care. Combining our resources and skill sets will enable us to better support and coordinate the care that consumers are seeking across

healthcare settings. Put simply, to make real progress on making healthcare simpler, more accessible and more affordable, we have to break down the barriers to better care. We know health can only improve if consumers are connected to support from their pharmacists and providers who live in their communities and understand their personal experiences. Our commitment to being a positive force in local communities is a central tenant to how we operate as a company and we are proud of the work we do with our local partners. For us, the combination with Aetna is the next step in our company's long running commitment to the healthcare of all Americans. We don't see it as more of the same but rather as a bold innovation that will reshape how healthcare is accessed and delivered starting first by putting the patient at the center of everything that we do. Building from that simple premise, we will create a new healthcare platform that is easier to use, less expensive for consumers, partners with local healthcare providers to deliver superior coordinated care. On behalf of our

16,000 New York State employees, I want to thank you for giving CVS Health the opportunity to describe our benefits of our combination with Aetna today. We are committed to working with New York State regulators and the Legislature to ensure consumers receive high quality, affordable healthcare. Thank you for your time.

ASSEMBLY MEMBER CAHILL: Thank you very much for your testimony. We've been joined today by Assemblyman Andrew Raia who is the I believe the ranking member of the Health Committee right, Dick?

ASSEMBLY MEMBER GOTTFRIED: Yes.

ASSEMBLY MEMBER CAHILL: And although I don't see her at the moment, I know she's been in and out Assemblywoman Michaelle Solages is also with us. I have a few questions but I'll defer to my colleague if you'd like to start. I guess he's going to defer back to me to start. Good. Okay. I will try to direct my questions to one or the other but if either of you has an answer to a question that appears to have been asked to the other please feel free to respond. This is a

big deal. This is transformational in healthcare in a way that many of us have not seen in the course of our lifetimes. Certainly, there has been some vertical integration in CVS. We've seen it with the acquisition of Caremark and a few other entities. We've seen the transformation of your retail outlets from essentially department stores with a pharmacy department to something more. It came to a focus on health. But this is moving over to the other side as well. This is engaging people who are not just walking through your door. This is engaging people who do not just have a contract with you directly because it involves the entire healthcare delivery system. In the, in the course of doing with this, dealing with this sort of monumental change has CVS paused to understand the gravity of the responsibility that you're taking on in terms of the healthcare delivery system and the health of each individual in the State of New York in this instance but in the country?

MS. SCHULMAN: Yeah, Chairman Cahill, we

see patients across our pharmacy counter every single day and I don't think that there is anyone more than our company and our pharmacists who take that relationship very, very seriously. We thought long and hard about this acquisition and we ultimately came to the conclusion that the system is broken, it's too fragmented, and this presented a unique and really quite frankly exciting opportunity for us to tackle a big problem with a big solution and by combining the -- our retail presence, our pharmacy expertise, Aetna's health plan expertise, and data analytics, we believe by bringing the pharmacy benefit and the medical benefit together that we're going to be able to do something very special and very important for patients and I cannot emphasize to you enough how serious we take our guiding principal which is helping people on the path to better health. It's the first and last thing that we think about. I referenced our decision to take tobacco out of our stores. As you can well imagine, that was a substantial financial hit to CVS Pharmacy, but it

was the right thing to do because it was the right thing for patients.

ASSEMBLY MEMBER CAHILL: The magnitude is something, the scale is really where this becomes critically important. What share of the market does Caremark have in pharmacy benefit management in the State of New York?

MS. SCHULMAN: We have I want to say about 40 percent, but I'm going to have to doublecheck on that for you.

ASSEMBLY MEMBER CAHILL: Forty percent so two out of every five people in New York State or two out of every five insured subscribers in New York State have their prescriptions administered through Caremark in New York State already. Correct?

MS. SCHULMAN: I bel-, if my math is correct then your math is correct.

ASSEMBLY MEMBER CAHILL: Right. And how many retail outlets does CVS have in the State and what percentage of the retail pharmacy outlets is that in the State of New York?

MS. SCHULMAN: We have -- just give me

one moment. Turn to it. I want to make sure I answer your question correctly. We have 563 stores in New York State. We have filled 58 million prescriptions and we process 135 million prescriptions. We have slightly under 2,000 pharmacists.

ASSEMBLY MEMBER CAHILL: You have slightly under 2,000 pharmacists did you say?

MS. SCHULMAN: That are CVS pharmacists.

ASSEMBLY MEMBER CAHILL: Got you. And you have $58 million dollars in prescriptions that you filled at CVS?

MS. SCHULMAN: No. We filled 58 million prescriptions.

ASSEMBLY MEMBER CAHILL: Fifty-eight million prescriptions and 135 what was that million number?

MS. SCHULMAN: One hundred and thirty-five claims that CVS Caremark processed.

ASSEMBLY MEMBER CAHILL: A hundred and thirty-five million claims? So, of the claims that you're processing, about 40 percent of them are also going to the CVS business correct, 58 of

135?

MS. SCHULMAN: No. Just because a claim was if I'm understanding your question correctly, you cannot assume that every claim processed by Caremark went through a CVS pharmacy.

ASSEMBLY MEMBER CAHILL: No.

MS. SCHULMAN: Okay.

ASSEMBLY MEMBER CAHILL: You're saying you had 58 million prescriptions filled.

MS. SCHULMAN: Through CVS Pharmacy. Yes.

ASSEMBLY MEMBER CAHILL: Through CVS Pharmacy. Most of them were probably insurance based.

MS. SCHULMAN: I don't know what percentage of those were insured or uninsured. I'm sorry.

ASSEMBLY MEMBER CAHILL: Alright. So, Mr. Wingle, the same question to you. What portion of business does Aetna have in New York State, what portion of your business is in New York State, what portion of health insurance is Aetna providing, and what markets are you in?

Mr. WINGLE: We can get you the numbers broken down by segment. I can give you some raw data about what our me membership looks like if that's satisfactory for the moment. We have 1.1 million medical members in New York as I mentioned in my summary testimony at the top. Those we have a hundred thousand seniors in our Medicare Advantage products. Those are rated four stars and better by the way. We have a small footprint in Medicaid Managed Long-Term Care. That's primarily in Long Island and some of the Boroughs of New York City. That's about 5,000 members. We have 800,000 members with dental coverage and we have 50,000 students at the 19 New York colleges and universities that offer our student health plans. In addition, in terms of our presence, probably in the New York economy, I'll mention that we offer -- we are present in three office locations in New York. We employ 1,500 professionals in New York in both office and work at home roles. Our network is extensive as I mentioned also at the top of the hearing with 87,000 providers and 200 hospitals

and in 2016 we paid $2.2 billion dollars in healthcare claims in New York.

ASSEMBLY MEMBER CAHILL: Do you know what percentage of the market share you have with health insurance in New York State with 1.1 million subscribers?

MR. WINGLE: We're ranked third overall in commercial business in New York.

ASSEMBLY MEMBER CAHILL: Just out of curiosity, who administers your pharmacy benefits now?

MR. WINGLE: We have a contract with CVS.

ASSEMBLY MEMBER CAHILL: You've been using Caremark as the PBS?

MR. WINGLE: Pharmacy benefits.

ASSEMBLY MEMBER CAHILL: Okay. So, what we're hearing here is that there's already a significant dominance in the market by both of you individually in different areas. Thank you. In different areas but that combined that will have a whole different effect. What do you expect to happen to your workforces in the State

of New York the several thousand people who work at the pharmacies, the several thousand people who work in your offices and?

MS. SCHULMAN: Chairman Cahill, we look at this transaction particularly in the State of New York as one of expansion, not contraction. There are no immediate plans after close to make any substantial changes in employment in New York. It is a -- New York State has been a primary state for CVS Health and we expect that to continue. We're very proud of our presence in New York and expect it to grow.

ASSEMBLY MEMBER CAHILL: Mr. Wingle?

MR. WINGLE: We don't anticipate changes because of the lack of an overlap in the capabilities that we're talking about here. Because this is a vertical transaction, we don't anticipate there is any duplication with the New York workforce.

ASSEMBLY MEMBER CAHILL: You both mentioned a number of approaches toward bringing efficiencies to the marketplace, bringing efficiencies and improvements to healthcare, can

you outline what you perceive some of them to be that are possible only through the merger that could not be done maybe with a contract or some other means?

MS. SCHULMAN: I think that when we're able to better combine the information, the pharmacy benefit information and the medical information, we're going to be able to impact people's healthcare differently. We will be able to better manage the transition for example from a hospital to the home and so--

ASSEMBLY MEMBER CAHILL: Explain why that is. Why is it that you're be better able to manage it as one entity as opposed to something you could do with a contract between parties?

MS. SCHULMAN: Because we're going to be able to develop benefit designs and plans that are more efficient and we'll be able to more directly interact with the patient in a way with information that we don't currently have now as two separate companies.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MS. SCHULMAN: We think it's the

transformational nature of the combination that is going to help us help somebody when they leave the hospital to make sure their medications for example are organized and what's in their medicine cabinet, what they're bringing home from the hospital is not overlapping or duplicative in a way that is potentially dangerous for the patient. One of the largest reasons for hospital readmissions is a pharmacy problem. This is going to give us the capability to manage that risk much better and by risk I mean the risk to the patient of they're being of a problem.

ASSEMBLY MEMBER CAHILL: Mr. Wingle, this is something I would expect you to be testifying to and not Ms. Schulman on behalf of a pharmacy. It would be something I would think an insurance company was already doing. Is Aetna already doing these things?

MR. WINGLE: We do do coordination of care. We do have active care management. I think we've had some models that we recently launched on this community-based approach on dealing with social determinants of health and

our early experience with those models is that it will be very beneficial to have a local coordinating hub, a local presence. As an insurance company, we're seen as the folks who are behind the card you present when you get sick. We want to be involved in the community helping people not get sick in the first place. So, as we launch these community-based models, we're working with social service agencies, we're looking -- we're working on food desert issues, we're working on all kinds of social determinants of health. As a national insurance company, we don't have all the sights and services that CVS does. This combination will really help us advance our goal to get whole patient care in the local community.

MS. SCHULMAN: I think one of the other things that we would want to emphasize is the ability for us to build out better technology for communication between the doctor's office and the pharmacist so as I think I mentioned in my opening statement, we will have the better technological capability to send messages to the

patient through the pharmacist. So, for example, if somebody has not come into their doctor for their next checkup, they haven't gone into get their blood test when they should, think particularly of a patient with diabetes, the interaction at the pharmacy counter gives us another opportunity to help remind the patient that that's something they need to do. The resources--

ASSEMBLY MEMBER CAHILL: Can I interrupt you for a minute cause I'm very concerned about some aspect of this? You know, I have a 91-year-old mom and she doesn't like it when I call her up and tell her I noticed you haven't been to the doctor and I'm her son. I'm pretty sure she wouldn't be too happy if CVS was calling her up and telling her she hasn't been to the doctor. What are you doing to assure and protect the privacy of individuals and the privacy of their healthcare data in this new proposed conglomerate? You're going to crossing bridges to create better data to use. Don't you also run the risk of releasing information to entities

that don't have a legal right to it?

MS. SCHULMAN: And that is something we will not do. HIPAA will be -- we will be following HIPAA and the privacy and the protection of the patient's personal health information is paramount. We'll also be complying with all other federal and state laws regarding patient privacy and the exchange of data.

ASSEMBLY MEMBER CAHILL: And you think even with those restrictions you will be able to better use the data that you have and you will be able to pass it from one entity or one part of your entity to another to create these efficiencies and better quality of care?

MS. SCHULMAN: Appropriately so, yes, we do.

ASSEMBLY MEMBER CAHILL: So, if I'm insured by Aetna and I'm not using a CVS Pharmacy, how is that data going to be used? If I'm insured by Aetna and I choose as I would choose by the way all do respect to go to Nekos Dedrick's Pharmacy in Kingston, a local pharmacy,

to have my prescriptions filled, how would CVS, Aetna entity be using--

MS. SCHULMAN: Right.

ASSEMBLY MEMBER CAHILL: That data for the benefit of the patient?

MS. SCHULMAN: So, we don't envision the kind of technological innovations and improvements that we're talking about to only be about CVS Pharmacy. We want to empower pharmacists whether they're working in another chain, whether they're working in an independent pharmacy. We don't envision this as something that's only about CVS. This is the kind of innovation that we want to see happen in pharmacy because with all due respect to you and your mom, pharmacists continue to be the most respected profession. I won't pick up the phone when my insurance company calls, but I'll talk to my pharmacist. I don't -- I think there's a lot of people that are like me and so we want to make sure that that kind of counseling and behavior by the pharmacist is something that happens elsewhere but more importantly that pharmacists

are now actually compensated for that additional healthcare that they're providing.

MR. WINGLE: I want to add, Mr. Chairman.

ASSEMBLY MEMBER CAHILL: Please.

MR. WINGLE: If folks don't appreciate getting a call from their son about adherence, imagine when the insurance company calls to talk to them about adherence. We find that our best interventions are when we provide data to providers and we do that through our value-based contracts. We do that with doctors and with hospitals and this will allow us to also do it with the pharmacies in a more coordinated way. So, the people, the vectors that the patient trusts that they'll have the best information to provide the best counseling to the patient so it won't be Aetna on the phone, it will be the face to fact interaction with a pharmacist, a CVS pharmacist or another pharmacist or their doctor or their local hospital.

ASSEMBLY MEMBER CAHILL: So, I have a whole bunch more questions. I'm going to ask

three more and then pass it on to my colleagues and then if there's a need to come back, I will. Mr. Wingle, from Aetna's perspective, why CVS and Ms. Schulman from CVS's perspective, why Aetna?

MR. WINGLE: Well, it's because of the local presence frankly. We have long stated a goal of being more local, of moving away from being seen as the warranty card on somebody's health to being their partners in health and the best way to do that is to have the local presence that CVS offers and that's what excites us about it. We've moved through a few initiatives to get more local, but it's a start and the only way we can get there and get there quickly at the rate people expect and need with the state of our healthcare system is to plug into the CVS model with it's vocal presence and evolve with them in servicing the local community.

ASSEMBLY MEMBER CAHILL: The other question that I want to ask in the course of this I read the press release when the announcement was made. A significant portion of that press release was dedicated to a discussion of the role

Minute Clinics will pay. My colleague and I have a firm agreement that this is not going to become a hearing about Minute Clinics and it will not become a hearing about Minute Clinics, but it's the elephant in the room. You spent 25 percent of the press release talking about them so let's talk about them. Go ahead.

MS. SCHULMAN: So, Mr. Chairman, as you and I have talked about previously, we're very proud of Minute Clinics and what they do. In New York State, they are physician owned and compliant with current regulations. Minute Clinic is part of it absolutely. But there are a lot of places in the country where there are not Minute Clinics and that's why the role of the pharmacist and what we believe the pharmacist can do and the kind of interactions we can have across the pharmacy counter with improved technology is very much important to the key to the success to this so whether that interaction is happening in a Minute Clinic but more importantly if it's happening at the pharmacy counter where we know people are coming. That's

where they're going through their path of their daily life, that is the key to this. We want that daily interaction of the entity that's in the community.

ASSEMBLY MEMBER CAHILL: So, a key to this entire program is the development of Minute Clinics. In New York State, they're not permitted to be owned by the company. Does CVS plan to accelerate the development of physician-owned clinics in New York State or will you continue to simply be pursing legislative changes in that regard?

MS. SCHULMAN: So, as I just mentioned, Minute Clinic is important but there a lot of places in the country including in New York where there aren't Minute Clinics.

ASSEMBLY MEMBER CAHILL: Right.

MS. SCHULMAN: And so that is why I talked about the importance and the role that the pharmacist will be playing.

ASSEMBLY MEMBER CAHILL: My question was about the Minute Clinics, not about the role of the pharmacist would be playing. My question is

does CVS intend to pursue an expansion of Minute Clinics in New York physician run or do you intend to continue to pursue a change in the law to allow non-physician owned Minute Clinics?

MS. SCHULMAN: We are continuing to look at the legislative field and if there is legislation we will take a -- we will continue to take a look at it, but I don't have any immediate information about expansion plans in New York for Minute Clinic right now. I'd be happy to follow up with you.

ASSEMBLY MEMBER CAHILL: Okay. And Mr. Wingle, the -- it's not unheard of for an insurance company to have a retail presence in communities, clinical presence in the community if you will. It's been done mostly on a more local level than a state wide or a national basis. Why hasn't Aetna pursued this approach already? You have said you had three offices in New York. There are 1.1 million subscribers across the state. I don’t know how they're geographically distributed but why haven't you already set up these community-based facilities

in you believe them to be so entangled to your mission?

MR. WINGLE: I think it's a question of how quickly you can achieve that community presence and we're trying to accelerate of the change because we think the demand is great. If we were to attempt to do this on our own, we could never achieve the scale and the presence that CVS has today so that's why we want to join with CVS to get this done. We have in the past had our own insurer owned clinics, but this we think is the model that works best.

ASSEMBLY MEMBER CAHILL: I understand that you want to do this but why haven't you done it already? And if you have done it, why haven't we seen an expanded use of it?

MR. WINGLE: Well, as I've said, there's no way for us to achieve the kind of scale and the presence that CVS does on our own.

ASSEMBLY MEMBER CAHILL: Why haven't you developed it already? I understand you can't get to the scale that you can get to with a CVS merger but that's not my question.

MR. WINGLE: We yeah.

MS. SCHULMAN: If I could?

ASSEMBLY MEMBER CAHILL: If you want to answer for Aetna go ahead. You might be violating some antitrust laws but go ahead.

MS. SCHULMAN: See now you freaked me out.

ASSEMBLY MEMBER CAHILL: Yep. I don't think you're the appropriate person to answer an Aetna question at this point in time.

MR. WINGLE: So, as I've said, we've tried in the past and have worked with different models in the past.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MR. WINGLE: Some of our competitors as you've noted have had those models in the past.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MR. WINGLE: Some of our national competitors. As you may have seen, you know, some of our competitors are moving to acquire different practice types so this is something that's happening around the sector.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MR. WINGLE: So, this is our version of achieving that synergy too.

ASSEMBLY MEMBER CAHILL: And one final question before I pass it on and that is will you be seeking any legislative changes in New York other than the one we just previously discussed in order to implement your new business model?

MS. SCHULMAN: No.

MR. WINGLE: I'm not aware of any.

ASSEMBLY MEMBER CAHILL: Thank you. Mr. Gottfried.

ASSEMBLY MEMBER GOTTFRIED: Okay. In a way, this is a very exciting morning for me. In a way, it's very frustrating. The excitement is that, you know, I talk to a zillion people a year about health policy. I've read a lot of journal articles and other statements talking about the dangers of vertical integration in health policy in healthcare and all the down sides of that. This is the first time I've actually met not one but two people who say that vertical integration is the wonderful new thing that we should all be excited about. Greatest thing since night

baseball. I don't think I've ever met anybody who says that we would be looking forward to having our doctor and our hospital and our pharmacy and our physical therapist and our for-profit insurance company all being part of one big conglomerate. So that if you are in an argument with your insurance company and you want your doctor to fight with the insurance company on your behalf, don't count on it because your doctor works for them or works for the conglomerate that also owns them. So, have I been leading an overly insular existence? Are there people writing articles in the New England Journal or Health Affairs extolling the virtues of vertical integration and I've just somehow missed all of that? And if there are people who are not directly connected with for-profit insurance companies and large for-profit corporate providers who argue for vertical integration could you refer me to them?

MS. SCHULMAN: So, Chairman Gottfried, I can't comment on other mergers in other sectors of the healthcare industry or in other sectors at

all. Our acquisition of Aetna does not further concentrate healthcare sector, healthcare does not further concentrate in the healthcare sector. All the current actors are going to remain in the sector. So, Aetna will continue to op--

ASSEMBLY MEMBER GOTTFRIED: Let me interrupt. Horizontal integration deals with increasing concentration. Vertical integration is a differ kind of thing.

MS. SCHULMAN: So, we're--

ASSEMBLY MEMBER GOTTFRIED: Now I know that -- well, I think when Aetna achieves the ability or has the financial incentive or the mandate from their parent to drive more of their members to CVS and vice versa, that will lead to greater concentration even if greater concentration doesn't happen on the morning that the merger takes effect but again that's not what I'm asking about. I'm asking about vertical integration. Who out there that isn't -- that doesn't have a direct financial interest in promoting vertical integration who out there is in favor of it? Where are the journal articles

saying this is the direction we ought to be moving the healthcare industry?

MS. SCHULMAN: Mr. Chairman, there has been testimony and there have been articles that have spoken to your question and have been favorable and I'll be happy to supply those to you after the hearing.

ASSEMBLY MEMBER GOTTFRIED: Well, I would appreciate receiving those citations and I'll be interested in seeing what sorts of people write those things. You know, one of the -- there have been several scary things said today like without CVS, we could not achieve this scale of clinical presence and, you know, you're not going to be violating HIPAA, but I'll bet somewhere on the computer screen if people want to continue talking to their health insurer or their pharmacy, I'll bet there's going to be a button they're going to have to click that says if you want your prescription filled, you have to agree to our terms and conditions and three feet down in the fine print it doesn't appear on your screen there will be a HIPAA paragraph that says

we can send your information to anybody and anybody can send us your information. And I'm not sure I want to get a call from a pharmacist I've never met and do not know and did not choose and have that pharmacist or physical therapist or anybody else talking to me about all kinds of stuff about my insurance and my visit to the doctor six months ago and giving me all kinds of patient centered whatever that means recommendations and assuring me that their company wishes me well and as someone who once learned in law school that corporations for-profit corporations are not allowed to have the welfare of their customers as you said the first and last thing we think about but actually your overwhelming number one legal obligation is to maximize return to your stockholders and if you divert from that you can get hit with a whopping lawsuit from your stockholders. So that to me is what's scary about this but ultimately my family doctor and my hospital and my trusted pharmacist are all going to be a part of one big for-profit corporation whose job is to maximize return to

shareholders even while saying things like we seek to create a new community-based model that will enable us to learn and better serve the vital -- the health needs and ambitions of consumers and the consumer will be at the center of this system. We will strive to make healthcare simpler and easier to use. Yeah, you won't have to choose what doctor or hospital. You'll got to one that Aetna and CVS chose for you. That will be simpler. Our new company will learn about members' individual health goals and connect them to the tools etc. I hear stuff like that and apart from wishing it were in English, it really does scare the pants off me.

MS. SCHULMAN: Mr. Chairman, we work everyday to help people get and stay healthy and to provide more affordable access to healthcare. Patient's privacy and appropriate sharing of data will be paramount and we will be respecting all appropriate laws and regulations.

MR. WINGLE: I'd like to add as well that we will continue to have access non-CVS providers, non-CVS pharmacies. Our value as a

company is based on customers getting products and the access points they need and want and our customers expect to have the opportunities to see those other providers. You know, so we're going to maintain a broad network of options for our customers at access points for our customers through this combined entity.

ASSEMBLY MEMBER GOTTFRIED: But you already have restricted provider networks. You will now have even more of an incentive in certainly the pharmacy area to restrict that provider network or those provider networks even more narrowly because you will be serving the interests of your corporate owner and as you are as the combination of Aetna and CVS begins to make what are virtually ownership relationships with other providers, that will restrict consumer options even more and, you know, I agree with Kevin that this hearing is not about Minute Clinics but actually they're not the elephant in the room. The elephant in the room is the entities that are corporate controlled healthcare providers that are a whole lot bigger and broader

than Minute Clinics and to me that's what's scary here. And so, to I guess to turn that into a question, doesn't the vertical integration of your insurance company and your provider or a major provider conglomerate doesn't that increase the danger that our healthcare will be increasingly vertically integrated and not independent?

MS. SCHULMAN: Our business model would not work if it was Aetna only. CVS Pharmacy has contracts and relationships with other health plans, other PBM's. That would continue. The same with Caremark who has contracts with other pharmacies, with independent pharmacies, other chains, etc. and with other health plans. We currently in the Medicare Part D system have a prescription drug program SilverScript. We are also the PBM service provider for about 43 other Medicare Part D prescription drug plans. They compete against each other. We take the innovations and the improvements that we're able to develop at SilverScript and we then offer them to the other 43 other health plan clients. To

date, 83 percent of our other prescription drug plans in Medicare have a star rating of four or higher and so we don't envision this and it can't be just about CVS and Aetna. This is going to be more of a if you will open source model. Current Aetna patients as they do now have the ability to go to other pharmacies, will continue to have that ability. This is we need to have robust networks in order for our patients to get service where they are and where they want to get it.

MR. WINGLE: And we as a company have worked to diversify from being more than health insurance company. We also have invested greatly in becoming a data company to help drive improvements in member care, member adherence and to make those services available to companies other than Aetna. So, you know, we are trying to transform healthcare to be more than the financier of somebody's sick care. We are trying to become a company that works with data will all providers including with CVS to build tools and it's not to interrupt people's existing relationships with their providers. We want to

arm all the members' providers at the members' permission, to have this data and to drive the improvements that the patients need and want.

ASSEMBLY MEMBER GOTTFRIED: Your reference to with the members' permission but am I wrong in my understanding of how you achieve that member permission that it will be buried in terms and conditions that people have to click on in order to continue getting their prescription filled?

MR. WINGLE: It would go against our promise to make the system simpler and easier to use. We--

ASSEMBLY MEMBER GOTTFRIED: Well, actually, it would make it very simple and easy to use. Deal with us or leave. Simple choice.

MR. WINGLE: Well, our customers expect a variety of options and products and plans. We wouldn’t succeed as a company if we said our way or the highway.

ASSEMBLY MEMBER GOTTFRIED: You'll get there though but the but again specifically the patient consent to waive HIPAA will be buried in

terms and conditions that you have to click on or you can't get what you've come to the website for right? I am right on that.

MR. WINGLE: That's speculative about what will be. We are working to simply all of our interfaces with the consumer and display exactly what they'll get and what permissions are needed and what our products offer. We're working every day to simplify that process and to make it more transparent for the consumer.

ASSEMBLY MEMBER GOTTFRIED: Okay. I think I understand what you're saying.

ASSEMBLY MEMBER CAHILL: It's fun to be the good cop. We've been joined by Assemblyman Phil Steck and I mentioned before she was not in the room at the time. I know she was doing other important business. Michaelle Solanges is with us today. Thank you very much. We will now move to the rankers of the individual committees and we'll start with Mr. Barclay.

ASSEMBLY MEMBER WILL BARCLAY: Thank you Mr. Chairman and I just have a few questions and I don't care who answers the questions. Can you

just give me the framework how big is this merger on a national level?

MS. SCHULMAN: It's one of the larger.

ASSEMBLY MEMBER BARCLAY: Number dollar wise.

MS. SCHULMAN: It is I'm sorry. I'm going to have to double check. $69 billion.

ASSEMBLY MEMBER BARCLAY: $69 billion. And where does it stand as far as federal regulatory approval?

MS. SCHULMAN: We're currently under review at the Department of Justice and that is ongoing.

ASSEMBLY MEMBER BARCLAY: And what's the timeline?

MS. SCHULMAN: We've publicly stated that we expect the merger if approved to close in the second half of the year and that continues to be the timeline.

ASSEMBLY MEMBER BARCLAY: Okay. The more theoretical I guess question I have you talked a lot in your testimony about how this is going to help patient care I guess and insured

care, I haven't heard much of the cost savings as a result of this merger and usually when there's a merger, there's some sort of cost savings coming through for the company or the companies that are merging. Could you explain the cost savings that you envision in this?

MS. SCHULMAN: Sure. We think again the combination of the pharmacy benefit and the medical benefit is going to result in cost savings both for patients and for payers. We believe that we will have greater capability to address chronic care conditions which as you know I believe are around 80 some percent of the cost of healthcare today and if we can better manage those conditions, if we can help people be less likely to go enter into a medical emergency where they have to be in an emergency room for example those are going to result in cost savings and we believe that that's the savings that we'll see and those are savings that we'll be able to pass on.

ASSEMBLY MEMBER BARCLAY: Have those been quantified?

MS. SCHULMAN: There are studies. Anthem Today I have not yet had an opportunity to read it myself but Anthem Today I believe released a study. United Health Group has a study and there have been others and again happy to provide those to you afterwards.

ASSEMBLY MEMBER BARCLAY: I appreciate that. Do you see any other cost savings other than patient care that you envision in this merger?

MS. SCHULMAN: I believe we'll also see reduction in drug prices. We are hoping to be able to enter into again different and more innovative contracts. For example, value-based purchasing when we actually are able to have greater patient engagement and control of how the benefits done enable us to we think make those contracts be more productive. For example, if you think about it, when a drug is in a clinical trial, there's a whole network of people around making sure adherence is 95, 98, 100 percent right? Once that drugs no longer in clinical trial, that adherence rate can drop to as much as

50 percent. Again, lack of adherence costs the healthcare system today about $300 billion dollars. If we can help people stay adherent on their medications, lower both the medical costs and keep them on more affordable medications then we believe that is going to result in a reduction of costs and--

ASSEMBLY MEMBER BARCLAY: Well, what was that lower than medical costs? I think I understood your first point and I understand the second point about the pharmaceutical, yeah, making sure people are using the right drugs, etc., but then you said lower what was that? Lower medical costs?

MS. SCHULMAN: If people are staying, if people are adherent on their medication--

ASSEMBLY MEMBER BARCLAY: I understand that.

MS. SCHULMAN: Will hopefully keep them healthier which will hopefully lower healthcare costs. I'm sorry if I misspoke if I said medical instead of healthcare.

ASSEMBLY MEMBER BARCLAY: Okay. So, is

this set forth in any of the press releases or anything you put forth about explaining the merger, what the cost savings and how they rank in the cost savings were?

MS. SCHULMAN: I believe we put out materials to that effect.

ASSEMBLY MEMBER BARCLAY: Anything else?

MS. SCHULMAN: Not that comes to my mind sitting here immediately, but I'm happy to go back and look through our literature and if there's something that I think is even might slightly be of interest to you, I'm happy to get that to you.

ASSEMBLY MEMBER BARCLAY: Thank you. Just where is Aetna's geographic region in New York? Where is primarily your geographic region?

MR. WINGLE: Well, for our fully insured group businesses, we are across the state and for certain segments, we are concentrated. As I mentioned, we have that Medicaid Long Term Care agreement that gets us into Long Island and some of the boroughs and the city, but our commercial business is around the state.

ASSEMBLY MEMBER GOTTFRIED: Thank you. Thank you, Mr. Chairman.

ASSEMBLY MEMBER CAHILL: Thank you. Mr. Raia.

ASSEMBLY MEMBER ANDREW RAIA: Thank you, Mr. Chairman. I apologize for getting here late. I had 10:00 start on my calendar, but I had a moment to read through the testimony and I have some couple questions. Your testimony mentions that you're working regarding fighting the opioid crisis. Just exactly what are you doing on that front?

MS. SCHULMAN: I'm sorry. Could you have said that again?

ASSEMBLY MEMBER RAIA: The opioid crisis you mentioned that you're taking steps to help combat the crisis.

MS. SCHULMAN: So, we've addressed the opioid crisis in three different ways. The first thing we're doing is we're trying to get excess medication not going into the community.

ASSEMBLY MEMBER RAIA: How are you doing that?

MS. SCHULMAN: So, for example, what we have done is through Caremark is that we have put a first time opioid prescription limit to for seven days. Obviously for palliative care, cancer care, and other important exceptions, those exceptions are in but if it's your first time getting an opioid because you've been to the doctor for whatever reason, we want to limit that first prescription to seven days. The studies show that seven days is the tipping point to start to go into addiction. We're also trying to do that by getting excess drugs out of the community and that's through our increased presence of having disposal units both in police stations and now in our CVS Pharmacies. Our foundation has also contributed money to help with drug treatment programs. Again, a very important part of this equation. We also have been going into the schools. Our pharmacists voluntarily goes into the schools and do a program that we call One Bad Choice and our pharmacists meet with the students and they see a video vignette that has three sad unfortunate sad

stories. One is an individual who is now a paraplegic as a result of an opioid overdose. We also have family member who passed because of an overdoes and then we also have a recovering addict and so what we're trying to do is talk to the kids about what one bad choice means. We have touched over 300,000 students across the country. It's been very well received here in New York as well. It's an important program and again I want to emphasize this is something that our pharmacists do on their own free time. They're literally going to the schools knocking on the door and saying can we come in and do this. We also have programs within our pharmacy to make sure that we're catching any fraudulent prescriptions as well as if there are outlier prescribing patterns. We will block those prescribers from CVS stores.

MR. WINGLE: I would like to add if I could, Assemblyman. Aetna has a couple of tools at its disposal and has applied them to the opioid crisis. One of the tools we have in our insurance business is obviously preauthorization

where we apply it, how we apply it, to what ends we apply it. So, for example, we've removed prior authorization for medication assisted treatment programs like suboxone. We've also removed copays for those treatments and then there's the question of when we apply a preauthorization so for short or long acting opioid prescriptions, we require consistent with New York law, preauthorization, and a limit on that script. It's shown some early results. We've seen from 16 to 17 a nine percent increase in opioid prescriptions. The other thing we've done is we've looked at people who are in pain management or pain treatment programs and we've tried to find alternatives for them so we seen a 40 percent shift of our folks in pain management from opioid based to non-opioid based treatment approaches. So that's a significant shift and like CVS we've looked at the super prescribers. We've looked at the top percent of all the specialties of in our network and we've sent them the CDC guidance kind of a sentinel warning and said this his how we expect you to behave as one

of a thousand biggest prescribers in our network.

ASSEMBLY MEMBER RAIA: Alright. Thank you. You touched on it before with Assemblyman Barclay, but can you address the chronic conditions of what you're doing to help address that issue as obviously that is a huge cost driver.

MS. SCHULMAN: One of the things that we're doing is trying to use again both our digital tools and our pharmacist to help keep people adherent on their medication. We have new diabetes programs where we are giving folks digital glucose monitors to better keep track of what their levels are and if there are, there are opportunities in the Minute Clinic -- don't yell at me. There are opportunities in the Minute Clinic to help also people manage their chronic care conditions.

ASSEMBLY MEMBER RAIA: Alright. And my last question, you know, the concern that always arises with me and with others is that you're trying to substitute the role of physicians in the healthcare system. Can you clarify your

position and what your objectives are?

MS. SCHULMAN: We're absolutely not trying to do that. Physicians, pharmacists, we are partners and it is our job from the pharmacist's perspective to help support the patient care plan that the physician has put into place. We have many partnerships with health systems across the country where we work very well with providers and that is the important relationship between the physician and the patient is not one that we're trying to disintermediate or circumvent.

MR. WINGLE: It's our hope that the physician relationship will be fortified by the presence and by better informed patients who have help in adhering to their programs. I think our physician prescribed programs.

ASSEMBLY MEMBER RAIA: Thank you.

ASSEMBLY MEMBER CAHILL: Ms. Hunter.

ASSEMBLY MEMBER PAMELA HUNTER: Thank you. I just wanted to get a little more information relative follow up to what Assembly Member Barclay was asking about your presence in

New York so specifically outside of New York City. What does your presence look like either with CVS and/or Aetna?

MS. SCHULMAN: In terms of our retail presence, ma'am, or in terms of our corporate presence?

ASSEMBLY MEMBER HUNTER: Both.

MS. SCHULMAN: Yeah. So, in our corporate presence, we do have facilities elsewhere in this state and we have a large distribution center in Chemung, New York that employs about 600 people and our CVS Pharmacies are relatively dispersed across the state, but we're not everywhere which is why the independent pharmacies that are part of our network are so important.

ASSEMBLY MEMBER HUNTER: So, in Syracuse specifically, you've had several CVS Pharmacies that have since been closed up so is this something that we're looking to I guess open up again and have a new presence where the presence was gone?

MS. SCHULMAN: I'm very sorry. I don't

have information on that so I'd want to check into that and be able to come back to you. I wish I had an answer for you today and I'm sorry I do not.

ASSEMBLY MEMBER HUNTER: So, Mr. Wingle, you had mentioned reference to in your beginning opening statement about tailored and culturally appropriate moving forward and I just wanted to know what does that mean? I know you were talking about, you know, diabetes and, you know, we've had conversations about the opioid crisis, but, you know, what does that mean for tailored and culturally appropriate healthcare?

MR. WINGLE: So, so what we see is patterns emerging as we look at the data and as we become more of a data company, we see patterns emerging geographically and there's a strong alignment again to zip codes and the zip code alignment for certain conditions asthma and diabetes are also aligned to cultural, ethnic, and other factors. There's a strong alignment there so we need to partner locally to help folks in those communities adhere so what we do is we

work with the local providers. As I said earlier in my comment to the Chairman, it's different when the insurance company's calling and saying, you know, we need to get you your asthma medication so that we can help divert you from the emergency room so you can maintain and don't have an episode. But if we can work in the community and work through trusted providers in the community, then we find the adherence and the success are much greater. Same with we have a maternal program the Healthy Babies Program that I described. We all know that, you know, the rates of success with maternity are different. There are disparities and when we see those disparities in our data, we work with local providers in our network to talk to folks who are, you know, carrying a child and help get all the right interventions so that they stay healthy and they stay doing everything they can nutritionally and follow-up care to make sure that that pregnancy is successful.

ASSEMBLY MEMBER HUNTER: So, will this potential merger then expand into people who

don't have commercial insurance who have Medicaid?

MR. WINGLE: It can. I will note that we are not part of the main Medicaid program in New York. We welcome the chance to participate in the Medicaid program in New York. Our current Medicaid presence is limited to that long-term care program I mentioned.

ASSEMBLY MEMBER HUNTER: I guess it's some of my concern because obviously in Onadoga County we do have communities that are affluent, you know, and who are capable of having commercial insurance. Maybe they bought insurance on the Exchange, you know, and they don't have commercial insurance, but, you know, we do have a lot -- a large population of people who have Medicaid and it seems like all of the great things that we're talking about here are only able to be afforded to the people who are wealthy enough or have resources enough to have commercial Medicaid insurance.

MR. WINGLE: But insurance isn't our only product is I guess the point I'd say. We've

been building our capabilities as a data company to help manage population health and I think combined with CVS we could offer more.

ASSEMBLY MEMBER CAHILL: Mr. Wingle, can you move closer into the mic? You're talking and wavering?

MR. WINGLE: We could offer more in community services, not just insurance services.

ASSEMBLY MEMBER HUNTER: Okay. But would those services then somebody has to pay for this service that the people are going, you know, to be provided. Who pays for that? So, if you're talking about nonmedical I guess service, give me an example of some other type of service that would be provided.

MR. WINGLE: Well, we could offer community education and outreach programs. We could work with local community-based organizations. We have done things in some communities in Philadelphia. We're working on a housing initiative because a lot of health indicators are related to homelessness.

ASSEMBLY MEMBER HUNTER: So, Aetna

contributes to these services free?

MR. WINGLE: We have a foundation that provides some support. Yes.

ASSEMBLY MEMBER HUNTER: Okay. And what would this potential merger do to impact FBC's in a lot of these hospitals that see folks who get these emergency payments obviously because they're the hospitals.

MR. WINGLE: The DSH with a safety net. Yeah.

ASSEMBLY MEMBER HUNTER: Yes. Disproportionate care.

MR. WINGLE: Yes. DSH.

ASSEMBLY MEMBER HUNTER: The DSH payments. So how would it affect specifically federally qualified health centers who and many of them have their own pharmacies obviously, you know? Some of them do take commercial insurance, but many of them take Medicaid and also the hospitals who take the same population of basically indigent people who need access to quality healthcare.

MR. WINGLE: Right. So, there are a

number of financing systems that support those DSH hospitals, those disproportionate share hospitals. This acquisition, this combination has no affect that I can see on how that financing arrangement and how that support happens and again it is our intention and our hope that we can arm patients, you know, regardless of the program they are enrolled in. As I said though, here in New York, we're not currently a major Medicaid carrier although we'd welcome the opportunity to become one.

ASSEMBLY MEMBER HUNTER: And just a couple other questions. So, Melissa, you had made mention about digital tools for folks. So, what will you be able or how would this work for areas that don't have access to consistent broadband services in maybe rural areas or places that even in urban areas like mine that don't have the ability for people to have consistent use of the internet?

MS. SCHULMAN: So, what the studies have shown is that folks usually do have access and keep their cellphone even if they're is somebody

who moves around a lot. There cellphone is one of the constants and so a lot of the digital tools, the messaging we're referring to would come through this thing. You know, I wish I could solve the world broadband problems of the country. Believe me, I've a place like that myself. So, I understand what you're saying and it is something that would have to be part of the longer-term solution I think to the telecommunication situation. Unfortunately, I can't solve that.

ASSEMBLY MEMBER HUNTER: Yeah. I know. I think there's a lot of folks who do have their cellphones who actually hop on connectivity to areas that actually have Wi-Fi so that obviously might be a challenge as well. So, could you just describe a little bit about the structure? What would this look like so you're now a merged entity and the name of the organization is?

MS. SCHULMAN: I believe it is still going to be CVS Health.

ASSEMBLY MEMBER HUNTER: Okay.

MS. SCHULMAN: But Aetna will still have

the Aetna name and Aetna will exist as a company within CVS Health.

ASSEMBLY MEMBER HUNTER: Okay. And the 1,500 employees in the three offices that, you know, some folks work at home those will be expanded to places elsewhere. I'm just trying to get a feel for how does this work now that you're a statewide merged entity that is I think as we were referencing I guess cradled to grave. How does that work when all of a sudden now that you're this huge provider of everything from the point of service with the consumer to providing the pharmacy and the prescriptions to education, to having the conversation about insurance, how does that work? Like what is the structure of the organization?

MR. WINGLE: The 1,500 was an Aetna number. There's no changes happening to the Aetna footprint as a result of this combination.

MS. SCHULMAN: And some of the questions you're asking about the details in the structure are part of integration conversations that are currently ongoing. A lot of those detailed

decisions have not yet been made or I'm not privy to them.

ASSEMBLY MEMBER HUNTER: Okay. Thank you.

ASSEMBLY MEMBER CAHILL: Mr. McDonald.

ASSEMBLY MEMBER JOHN MCDONALD, III: Thank you. Well, good morning first of all. Thank you for being here. As you know, I'm a pharmacist too and I practice so I actually have a little bit of knowledge of what's going on in the healthcare field. It's interesting because many people have said oh you've got to be against this and I'm like, you know, I don't know yet. I really don't know. We really have to really fully understand the full of scope of what's trying to be put together and, you know, Melissa you mentioned some great points. You know, our healthcare system is growing. We have fortunately more people living longer so that means utilization is obviously going to increase. You know, not many people are terribly happy with their overall coverage because it's a complex system. We don't really understand it. You

know? When you say something like prior approval to somebody, you know, the red devil lights go on and they get very upset and, you know, it is frustrating. I know Rich would probably at this time this is a good time for single payer, but I'll leave that to another discussion. I think from my perspective and it's not just talking about pharmacy. It's actually talking also about physicians and nurse practitioners and physical therapy. I think it's a matter of the fact that number one now more than ever before government, federal and state are dedicating a tremendous amount of financial resources into the system. You know that. You participate in the majority of those programs. And we really have to have confidence that that money is being spent wisely which I think everybody's trying to do. And that we're really achieving the optimal goal which is greater patient health at the most affordable price. And that same token and I'm going to jump back and forth, you know, there are examples that come up that just, you know, even as one who practices on a daily basis, I scratch my head and

say what's going on. The whole PBM industry as you know and CVS is just one of the four major players that control 85 percent of the country's prescriptions has a large amount of energy around it. Let's put it that way. A lot of frustration. You'll hear later from I know like the independent pharmacists are here today about the fact that there's frustration when back when this merger announcement was made in the fall that dramatically within days reimbursement on many mental health generics dropped through the floor below anyone's ability to get, buy the product, and provide it to the patient and that was a good month and a half where and I can tell because I've looked at my own reports. You get reimbursed at six dollars or $60 for this prescription, all of a sudden, it's $15 and then magically after the Medicaid Inspector General reached out to CVS, the price went back up to $60 and I don't really expect you to explain that or defend it but you can see where just from one practitioner's eyes and there's been others that have been convincing about this, there's a

concern that if this merger goes through this could happen again. Not only to pharmacy whether it's independent or chain. It could happen in health systems. It could happen to physicians and nurses and I don't know if there's anything you can tell me today to assure me that that won't happen because as you mentioned, you are not planning any major changes except for what the normal customary changes are and the fear is these type of changes where a commodity is being reimbursed below what anybody can practically buy it at what can you say to me to assure that that's not going to happen again?

MS. SCHULMAN: Do you want me to specifically talk about the MAC reimbursement?

ASSEMBLY MEMBER MCDONALD: If you want to, you can yeah sure. Cause it wasn't just a New York State thing. It was an East Coast thing and Midwest but go ahead.

MS. SCHULMAN: No, I understand that and there were changes that were implemented, MAC changes that were implemented in 2017 that we believe were appropriate reimbursements to

pharmacies. MAC prices as you well know are subject to change and that can occur at least on a weekly basis if not more often based on several factors which is based on our best understanding of the marketplace, product availability, and purchase. What I can tell you is that in New York State where 57 percent of our network are independent pharmacists, independent pharmacists in New York are reimbursed more than CVS Pharmacies and I do not in any way, shape or form expect that to change.

MR. WINGLE: And Assemblyman--

ASSEMBLY MEMBER MCDONALD: I don't know if I agree with that.

MS. SCHULMAN: I understand that.

ASSEMBLY MEMBER MCDONALD: No. The only reason why and I can pull up document after document of plans where independent pharmacies and once again I'm not really trying to carry the pail for independent, but when I look at these documents and see plans administered by CVS where the patient actually gets a lower copayment at the independent pharmacy only because the

independent pharmacy is being reimbursed, it's a pass through plan and it costs them more to go to a CVS or to a Rite-Aid. I don't know if that's really an accurate statement. I don't know how in all fairness. I'm not trying to put you on the spot but to come out with a statement like that is kind of I don't know if I would be confident saying that because as you know, there are thousands of MAC schedules that are changing on a regular basis and to say that is not really, I believe accurate, but if you're confident in saying that, so be it but I didn't ask you to say that. You did say that.

MS. SCHULMAN: I believe that in New York State, CVS -- independents are reimbursed more than CVS Pharmacy is. And--

ASSEMBLY MEMBER MCDONALD: And I have documents to disprove that but that's okay. We're not going to -- that's not what the intention. I was trying to get to a more broader context with the fact is is that any healthcare provider is concerned about what I call predatory reimbursement. And to that point and you know

this is coming cause I shared this last week with others, during that process when reimbursements were dropped dramatically and once again they went exactly back to where they were 45 days later. Independent pharmacies were receiving letters from CVS saying are you tired for low reimbursements, is this the time to sell your pharmacy. Do you have a response to that?

MS. SCHULMAN: Sure. So, there's a firewall between CVS Caremark and CVS Pharmacy. And so, the right-hand side of the firewall where which was the CVS Pharmacy were sending the letters. They had no knowledge or insight into what was happening with the rates on the Caremark side.

ASSEMBLY MEMBER MCDONALD: Uh-huh.

MS. SCHULMAN: And the Caremark side had no idea that those letters were going. Two, it was completely unrelated.

ASSEMBLY MEMBER MCDONALD: Coincidence. Unrelated. Okay.

MS. SCHULMAN: Really sad coincidence but.

ASSEMBLY MEMBER MCDONALD: Yeah. It doesn't look good for anybody to be honest with you. I think we all agree that.

MS. SCHULMAN: Nobody will disagree with you on that.

ASSEMBLY MEMBER MCDONALD: Since you brought up the firewall that brings up a question. I'm going to give you scenario that I know happened. A patient was getting a prescription filled at a local pharmacy for diabetes medication and usually the pharmacy will call the patient. They call them to see one are you still alive, two how things going, and three, would you like a refill? Three days before it was due to be refilled because the plan has parameters. You can't fill it, you know, until 70 percent is utilized. You know this. This patient gets a call from CVS Caremark. Now she's never used CVS. She is a member of the New York State Empire Plan so the claims go through and process through the PBM subsidiary saying she's Mrs. So, and so. We'd like to fill your prescription. Would you like us to call your

doctor and get your prescription? And she said I really don't want to do that. Well, it's a lot less expensive. Now the copay was zero so I don't know how much cheaper it can get. But it was a lot less expensive to get it through the mail-order than it is to get home at your local pharmacy and she goes no I really don't want to do it. Then she's grouchy so she just hung up. Now, I contacted New York State Civil Service because they administer the program here on behalf of the patient and they said well they're not supposed to do that and I'm sure you're going to tell me they're not supposed to do that. But can you explain to me how a patient getting a prescription filled at an independent pharmacy that happens to have a process through CVS Caremark gets a call from CVS Caremark to ask her if she wants her prescription filled?

MS. SCHULMAN: I'm not sure myself and I'd have to look into that one specifically.

ASSEMBLY MEMBER MCDONALD: Yeah. Well, if you'd like to talk to the patient, it's my mother and she gets her prescriptions from my

pharmacy. And that's not the first time it's happened. I've had this particularly with SilverScript where they'll contact my patients on a Saturday afternoon saying you can get it cheaper through the mail which is listen if people want to use home delivery that's fine. That's not my beef. I think my concern particularly as our society ages is we have a lot of people that are confused because of the healthcare system and to have a stranger calling up and basically and I trust my mother. She's a pharmacist. She knows this to be in coerced to get their prescriptions filled. It doesn't build the confidence that I'm trying to see that you're trying to push through with this merger. The other question and Paul this is probably more for you I guess.

MR. WINGLE: Okay.

ASSEMBLY MEMBER MCDONALD: I share this with Members Cahill and Members Gottfried a couple weeks ago and I did a triple look. I usually do a double look. I did a triple look. I'm reading this article that came from Modern

Healthcare back on April 13th about the fact that Aetna is suing CVS Health over reimbursement of prescription medications. Feeling that they were filing false claims to Medicare kind of government programs. Do you have any comment or thoughts about that?

MR. WINGLE: That's actually a suit filed by an Aetna employee. It's not an Aetna suit.

ASSEMBLY MEMBER MCDONALD: Okay. So, you're probably not going to make comments on that right? My only point is is that in this situation it's the federal government that's getting potentially as alleged by I guess a former employee or is that a--

MR. WINGLE: No. That's, the employee's status—

ASSEMBLY MEMBER MCDONALD: Still working?

MR. WINGLE: Is protected under--

ASSEMBLY MEMBER MCDONALD: Okay.

MR. WINGLE: Under the law while the lawsuit works its way through.

MS. SCHULMAN: It's my understanding the government has chosen not to join that case.

ASSEMBLY MEMBER MCDONALD: That's accurate. That is true. Let's go back to the benefits and you referenced I think at one point like transitions in care when people are being discharged from the hospital and have a pharmacist to help with adherence. I think you referenced that earlier. So, you're familiar with DSRIP in New York State?

MS. SCHULMAN: I'm sorry?

ASSEMBLY MEMBER MCDONALD: Are you familiar with DSRIP that Medicaid redesign?

MS. SCHULMAN: I'm sorry. I am not.

ASSEMBLY MEMBER MCDONALD: Okay. Are you familiar with the PPS's the Perform Provider Systems here in the capital region like Alliance for Better Health or BHNYS [phonetic]?

MS. SCHULMAN: I am sorry. I am not.

ASSEMBLY MEMBER MCDONALD: Okay. So, they've been work--

MS. SCHULMAN: My colleague might be more familiar.

MR. WINGLE: I would have to look up.

ASSEMBLY MEMBER MCDONALD: As you might know, the state received I think it was probably $8 billion dollars from the federal government a couple years ago, four or five years ago to work on Medicaid redesign. Knowing that 40 percent of the people in New York State somehow qualify for some kind of Medicaid benefit.

MR. WINGLE: Uh-huh.

ASSEMBLY MEMBER MCDONALD: And unfortunately for a lot of different reasons, they usually consume the majority of healthcare dollars so it's best to put your resources into the high fires, right? The ones who drive up the most costs. So, when you're talking about the fact that, you know, we pharmacy, community, the provider community are going more engaged, I was just curious if you guys where one engaged in this large effort to redesign healthcare in New York State and what level of participation was going on? I know that I participate, you know, I said this publicly and--

MR. WINGLE: These are programs funded

through federal waivers.

ASSEMBLY MEMBER MCDONALD: It's actually a state -- the federal government provide -- well Richard can explain this better than I can, but the Department of Health is heading it up. It's being administered throughout all of New York State.

MR. WINGLE: Uh-huh.

ASSEMBLY MEMBER MCDONALD: Some of the tools that you talk about about inoperability, sharing information is all through other resources like the SHIN-NY that we have in New York State so I'm trying to figure out--

MR. WINGLE: It's part of the larger federal push around patient centered medical home.

ASSEMBLY MEMBER MCDONALD: Yep.

MR. WINGLE: Yes.

ASSEMBLY MEMBER MCDONALD: Yeah. Yeah.

MR. WINGLE: And largely through Medicaid as the venue.

ASSEMBLY MEMBER MCDONALD: The feeling is that there's, you know, there's a--

MR. WINGLE: Yeah.

ASSEMBLY MEMBER MCDONALD: Your Medicaid recipients do drive a lot of costs and therefore let's work with a population that the government is actually funding more of versus the commercial.

MR. WINGLE: It's a yeah. There's a public analog to a lot of work we've been doing through value-based contracting.

ASSEMBLY MEMBER MCDONALD: Uh-huh.

MR. WINGLE: And one of the tools in value-based contracting is to have a better data between the payer and the provider.

ASSEMBLY MEMBER MCDONALD: Uh-huh.

MR. WINGLE: So, we have a commercial version of that that I think the federal governments been interested through waiver activity in getting the states to innovate around the same idea of whether it's, you know, value based contracting or patient centered medical home. It has different names, different iterations.

ASSEMBLY MEMBER MCDONALD: Uh-huh.

MR. WINGLE: But, you know, as I mentioned before, when it comes to Medicaid specifically in New York, our presence isn't as large as we might like it to be, but we'd be happy to support those efforts where we can.

ASSEMBLY MEMBER MCDONALD: Melissa, CVS is very much involved in the Medicaid business, what is their performance in the PPS's?

MS. SCHULMAN: It's my understanding that we do participate in some of these programs through out managed Medicaid, but I am not.

ASSEMBLY MEMBER MCDONALD: Yeah.

MS. SCHULMAN: Deep on the details at all and so I don't unfortunately I cannot answer your question.

ASSEMBLY MEMBER MCDONALD: The only reason I bring it out is the fact that, you know, Alliance for Better Health here in the capital region and BHNYS which is the Albany Med behemoth. They're very actively engaged with it. I follow their newsletters. I go to their meetings. They'll be a nice workshop Wednesday morning here at the Capital Center. I've never

seen CVS involved. So, I'm trying to figure out when you're saying here's what we're going to be doing, I'm assuming that it's already going on and I'm trying to just understand, you know, once again this is all about trying to build some confidence and faith behind what you're talking about but actions are important too.

MS. SCHULMAN: I agree and again unfortunately, I'm not as familiar with that as I would like to be sitting here right now.

ASSEMBLY MEMBER MCDONALD: Uh-huh. Yeah.

MS. SCHULMAN: So, if I can make a commitment to you that we'll come back and talk to you about that, when I--

ASSEMBLY MEMBER MCDONALD: Love to.

MS. SCHULMAN: And I can bring the folks in who are actually knowledgeable.

ASSEMBLY MEMBER MCDONALD: That would be great.

MS. SCHULMAN: Again, I am--

ASSEMBLY MEMBER MCDONALD: I know. Just it's a big company. You got a lot going on. I

get it. I get it.

MS. SCHULMAN: I would have preferred to have been able to answer.

ASSEMBLY MEMBER MCDONALD: I know. I know. So, my last question you mentioned adherence to medications which is true and you mentioned the star ratings which for those of us who practice healthcare we know what they are and it actually brought up this question cause I've always been harping about this in my pharmacy. It's great to say you're refilling prescriptions for people and they are getting 80, 85 percent adherence, but the reality is is that are they actually taking the medication. Right? I mean, you know, anybody can fill a prescription and drop it off at someone's doorstep. It's a matter of are they actually taking it. And this actually probably goes towards your mail order or home delivery service. You guys have like an auto refill program?

MS. SCHULMAN: I believe we do. Yes.

ASSEMBLY MEMBER MCDONALD: Alright. Do you know how it operates? Is it something where

like I do with Medifast. I click auto delivery every month and every 30 days or every 90 days they just send the prescriptions.

MS. SCHULMAN: I believe it's every 90 days.

ASSEMBLY MEMBER MCDONALD: Okay. So, is there any patient interaction? Is somebody on the phone talking to them or is it just automatically filled?

MS. SCHULMAN: I am not familiar with the actual mechanics.

ASSEMBLY MEMBER MCDONALD: Yeah. The I can tell you from the pharmacists that work for me who actually have parents that are former GE retirees that have Caremark that you have to click on the box and you're in and every 90 days it shows up at your doorstep. The problem is trying to get out and trying to disable from that because let's face it as we've talked about people get hospitalized. Please do become nonadherent and my concern in leading up to this and hopefully this is something you can take back home is that like I said it's great to say we

filled the -- we have 100 percent adherence. We filled the prescriptions every 90 days. I can tell you, I could bring pictures, I can have you come to my pharmacy and I can show you $50 -- $60,000 of unused medication that were never touched because of auto delivery programs. And my concern is this and, you know, data is important and analytics is important and all those things, but the biggest challenge in healthcare some days is human behavior and if you just send things to people's doorstep, first of all I don't believe there's confirmation by the patient that they've actually received the prescription. I think it's a UPS guy saying yeah, I dropped it off Thursday afternoon at 2:30 in the afternoon. We have no real certainty that the patient actually got the prescription. We actually have no certainty the patient was still alive cause it takes usually a month for that information to navigate through systems depending on the pair source. But I would argue that a large amount of our concern in healthcare also falls with waste and auto programs like that

definitely if not managed properly can promulgate waste and I would think that that's something we want to be extremely mindful of all of us.

MR. WINGLE: Assemblyman, I think this is actually a good illustration of how this combination will work very well because we'll be able to bring the picture of other claims. So, if the member is presenting if they're say diabetic and they're presenting at the emergency department.

ASSEMBLY MEMBER MCDONALD: Uh-huh.

MR. WINGLE: You know, over and over again, we'll have the relationship to understand that even though the script may have been filled, something isn't happening there and we'll be able to compliment that with our nurse and our care management infrastructure so bring the both pictures together how is this, is this member adherent. Maybe it looks like they're getting their scripts filled, but we're seeing on the claims side on the medical side something that indicates they're not really compliant with their care plan here. We can bring that together.

ASSEMBLY MEMBER MCDONALD: And that's it's an exciting time when you think about I like Melissa you mentioned earlier about the technology and what's going on. You know, I can tell you within the last month, Hixny which is the SHIN-NY of the Capital Region now has allowed provider alerts so if my patient at the pharmacy or Dr. Steck's patient at the medical practice goes into the ER and is discharged to the ER, we are getting real time alerts so we too as providers are getting that information with their consent by the way I will add.

MR. WINGLE: Yes.

ASSEMBLY MEMBER MCDONALD: That's good stuff and I think my only comment as I really do try to keep an open mind but I've got to mention some of the little -- this is only a small list of things I've seen. Is that we had to make sure that we really have a strong provider panel because at the end of the day it's still one on one care that makes the difference.

MR. WINGLE: Right.

ASSEMBLY MEMBER MCDONALD: And, you

know, to leave everything -- the data is good to identify problems, but it's still gets back to person to person communication.

MR. WINGLE: And I'm thinking specifically of an example here in New York that I was reading about in prepping for this, this opportunity. There was a member who had shown up I think 16, 17 times at the emergency department. We said there is something really going on here. We have, you know, we have the nurse, you know, kind of alert and it was a value-based agreement, right? We were working with a provider here in New York. So, we didn't call up as the insurance company and say, you know, are you taking your drugs. We said, you know, nurse practitioner, doctor, specialist, this is what we're seeing, can you work with us to outreach this patient and make sure they stay out of the emergency room and it worked.

MS. SCHULMAN: And if I remember the incident you're talking about, what they found is the individual actually had a wool allergy and wore wool sweaters because she wanted to keep the

thermostat down to save the money, there was wool carpeting, wool fabric on the furniture so actually it was her environment that was exacerbating the allergy which was then leading to the increased emergency room use.

ASSEMBLY MEMBER MCDONALD: Right.

MS. SCHULMAN: So, the ability to have somebody go into the home and interact directly probably was life altering for this woman.

ASSEMBLY MEMBER MCDONALD: Yeah. Absolutely.

MS. SCHULMAN: It was an allergy.

ASSEMBLY MEMBER MCDONALD: Yeah. Thank you.

MS. SCHULMAN: I think that's the one you're talking about.

MS. WINGLE: Yeah.

ASSEMBLY MEMBER CAHILL: Assemblyman Steck.

ASSEMBLY MEMBER STECK: We can yes, thank you. So, I'd like to ask the gentleman from Aetna approximately since 1986 on average how much have what percentage has Aetna's health

insurance premiums increased since 1986?

MR. WINGLE: I don't have an aggregate number. You know, we can look segment by segment at what that looks like.

ASSEMBLY MEMBER STECK: Would it be fair to say it's at least 200 percent since 1986?

MR. WINGLE: I don't have the number off the top of my head.

ASSEMBLY MEMBER STECK: That's pretty consistent for the industry, though right? Two hundred percent or more.

MR. WINGLE: I don't recall what the total number is.

ASSEMBLY MEMBER STECK: So, this is all the discussion of diabetes has been very, very interesting to me because I happen to be a diabetic so I've been in this system and I want to raise my experiences with health insurers and CVS cause I have CVS Caremark and what I've experienced. So, I from the very beginning of being diagnosed has used a test kit called Freestyle Light which is made by Abbott Laboratories. My insurer this year, I've had the

same insurer probably for ten years suddenly switched to a different test kit. They won't pay for Abbott anymore because they deem it not medically necessary. They think all test kits are fungible, interchangeable. But consistently, the results of the new test kit are about 60 points higher and they did some research on this and I found out two things. First, that the that this was widely reported by users, that this particular test kit produced high results and secondly, Consumer Reports had rated the test kits and the Abbott Laboratory's test kit which my doctor obviously knew is a very good one and has among the most accurate results. The one my insurer substituted that they probably made some deal with is at the very bottom of accuracy of results. So, what's the point of this? The point of this is going back to Dick Gottfried's point. When instead of really covering a lot of different options that are prescribed by a physician, the insurer is allowed to force you into things which can prove harmful to your health. So, if you're diabetic also emotionally

and all of a sudden, you're getting test results that are 60 points higher, you're coming to two conclusions. One, I've got a big problem or two, the that the that I need to be taking more medication so I think the latter point illustrates a danger of combining an insurer with a pharmacy in essence because once there is no incentive to make sure that the doctor's recommendation which has worked extremely well is followed. The incentive, the more medicine I take the more money the pharmacy makes so I think this it illustrates a danger in this merger. What's your thought on that?

MR. WINGLE: I'd say first of all that when it comes to how we at Aetna look at what services or what products or what treatments or medications are offered, it's all through our medical peak medical officer's review. It's all--

ASSEMBLY MEMBER STECK: Yes. And you can appeal and it can take a long time. I want to -- I am going to appeal this. I have so long to appeal. I'm sending back the package with

that test kit and saying you can have it cause it's useless to me.

MR. WINGLE: Uh-huh.

ASSEMBLY MEMBER STECK: But I'm well aware that you have medical directors who blast what you do and yet the blessings of those medical directors are not being reflected in the best possible treatment for the patient.

MR. WINGLE: Our medical review process is rigorous and--

ASSEMBLY MEMBER STECK: They all are.

MR. WINGLE: Positive. It's positive for us so, you know, we defer to our clinicians on the best treatment and the one that they believe based on peer review studies are going to be most effective for our members.

ASSEMBLY MEMBER STECK: Well, they clearly and this insurer clearly was not familiar with an independent study of the test kits so maybe the medical who's not an endocrinologist I'm quite sure maybe that medical director thought all test kits are alike. They're not so now I'll focus a little bit on my experience with

the Caremark side on the same issue. So, one of the most widely prescribed drugs for diabetes is metformin and there are different formulations of metformin. I was doing extremely nicely and all of a sudden my blood sugars are not good, I'm getting heart burn in the evening, and I was trying to figure out what's going on and after working with my doctor he hadn't seen the physical medication but somewhere along the line, CVS had substituted Caremark had substituted the traditional generic metformin in it's more original formulation which is less expensive for the timed release medication which is what I was taking and the failure to have the timed release medication adversely affected my health in terms of higher blood sugar and two, gave me heartburn in the middle of the night which I had never had before. Now, I certainly know and John had indicated, it's the same problem that you will say Caremark's not supposed to do this, but they do and my concern again is to Chairman Gottfried's point is the more power you give over to this giant pharmacy emerged now with a health

insurance provider that there will be more abuses of this kind, not less.

MS. SCHULMAN: So, the substitution should have been clinically equivalent and I'm sorry that you had that experience. I can't unfortunately speak to those details, but again, I'm happy to go back to our chief medical officer and get some more detail on that and we--

ASSEMBLY MEMBER STECK: Someone can say it's clinically equivalent, but it was certainly not in my case and after discussing it with my physician, he -- it didn't take him long to figure out what might be the problem so clinically, he seemed to be a lot more aware of the differences between the two formulations than your staff.

MS. SCHULMAN: I understand.

ASSEMBLY MEMBER CAHILL: You done Phil?

ASSEMBLY MEMBER STECK: Yes.

ASSEMBLY MEMBER CAHILL: Oh, okay. Are there any other panelists that haven't asked questions that would like to?

ASSEMBLY MEMBER GOTTFRIED: Ms.

Schulman, when I think it was Mr. McDonald was asking the question about the letter from CVS which kind of sounded like, you know, gee nice story you have here. Wouldn't it be terrible if something bad happened to it? And you assured him that there was a firewall between the PBM part of CVS and the pharmacy part of CVS. But isn't the whole point of our testimony here this morning that we're going to be working to term down those fire walls so we can have patient centered, individualized, blah, blah, blah care and everybody will tell everybody everything they know and there will be total communication and like will be wonderful.

MS. SCHULMAN: The firewall that I was referring to in that example is a firewall around business sensitive information and so the decision of the folks who look at pharmacy purchasing would have had no inside into the business information as to what was happening with the reimbursement on the Caremark side.

ASSEMBLY MEMBER GOTTFRIED: And is there a law that provides for that?

MS. SCHULMAN: There is our policies and our procedures. It's part of a commitment that we made to the FTC when CVS and Caremark came together. It is part of our code of conduct. It is part of our training. That's where that's what that's based in. There are also computer safeguards that information's not inappropriately shared when it comes to business sensitive information as well. There's additional training. There are essentially waiting periods so people can't be employed in one side and then be employed in the other without essentially a cleansing period. We have a number of procedures around this.

ASSEMBLY MEMBER GOTTFRIED: But people at Aetna will know exactly which patients are going to a non-CVS pharmacy. People at the CVS PBM will know which patients are going to a non-CVS pharmacy. CVS will know which of their patients are insured by somebody other than the insurance company that pays its dividends to CVS. What firewall is going to make any difference in whether all of the components that are now all

reporting to the CEO of CVS, what firewall is going to prevent all those components from working together to maximize the power and profit of CVS?

MS. SCHULMAN: The information from other health plans to Aetna or Aetna's information to other health plans will not flow that way. There are, there will be and there are protections around that.

ASSEMBLY MEMBER GOTTFRIED: The CEO of the conglomerate is going to know everything. And all of the people I mentioned are certainly going to know who went -- who is covered by something other than Aetna and everyone will know who got the -- who is getting their prescriptions filled by somebody other than CVS. How can they not know that and how can they not think about that when they are making decisions?

MS. SCHULMAN: So, everyone won't know. There as again the claims data and information from one health plan will not be insured with other health plans including Aetna. There were restrictions around that currently.

ASSEMBLY MEMBER GOTTFRIED: No, no, no. I'm talking about sharing what Aetna knows with CVS. And by the way, what will stop CVS from saying to Aetna, here's a list of 40 million prescription fillers in New York who aren't covered by you.

MS. SCHULMAN: Aetna's current patients go to other pharmacies, currently today go to other pharmacies than CVS including independents, other chains, etc. That will not change and we're not going to require that that changes.

ASSEMBLY MEMBER GOTTFRIED: Well, Aetna decides who -- what pharmacies are in its network.

MS. SCHULMAN: So, if Aetna--

ASSEMBLY MEMBER GOTTFRIED: So, if when Aetna is designing its network, are they going to like redact the name of the pharmacy from the?

MR. WINGLE: No. No. Representative, we'll -- Assemblyman, Chairman, we are designing products with the networks that our customers and our plan sponsors want and expect and we would lose significant parts of our business if we were

for many of our clients to say we were only offering an exclusive network so we will design the networks that help our plan sponsors to deliver the benefits to their employees that they want and need and so that's how it will be kept separate by consumer demand. We will continue to meet the expectations of the members for access points other than CVS if they want them.

ASSEMBLY MEMBER GOTTFRIED: Every time I hear about a provider who is being excluded from someone's network or a consumer who is in a sense that their provider is being excluded from a company's network, at some point somebody tells me oh it's in our interest to have wider and wider provider networks. Why would we do such a thing? But insurance companies keep doing exactly that and having narrower and narrower networks. Do they not know that that harms their business or does it really not harm their business to gradually have a narrower and narrower network and just gradually rope people into settling for that?

MR. WINGLE: We have customers who

prefer networks that are more select because they want the efficiencies that come with that. We have customers who want networks with broader access points and we have both products on the shelf today and we'll have both products on the shelf tomorrow.

ASSEMBLY MEMBER GOTTFRIED: Would it shock you that I have never in my life met a consumer who expresses happiness that their insurance company is restricting them to a narrower network?

MR. WINGLE: The point of network design is to achieve the greatest efficiency because the other big complaint that folks have--

ASSEMBLY MEMBER GOTTFRIED: Oh, I'm sure it's to achieve maximum efficiency.

MR. WINGLE: It's consumer centered, Mr. Chairman, in that people also are very concerned about costs as well at the same time so we offer more affordable options based on the most efficient providers and if folks want access to a broader array of providers, then we offer that product as well. It's up to the plan's sponsor

to decide what design they want to offer on the shelf. Some offer both side by side and the members of the group select the plan with one network design or the other and that's part of the choice of open enrollment for those employees.

ASSEMBLY MEMBER GOTTFRIED: And all they have to do is pay a lot more.

MR. WINGLE: Well, if the cost of care underlying the plan is higher, then the premium reflects that cost of care.

ASSEMBLY MEMBER CAHILL: We have been joined by Assemblyman James Skoufis and I understand he has a question.

ASSEMBLY MEMBER JAMES SKOUFIS: Thank you Chairman and I'm sure that was a total accident. Good morning. I apologize that I'm a little bit late so I don't know if someone has asked this question or approached this question and if they have I'm sorry for being repetitive. I don't profess to be an expert in exactly how this works, but this seems problematic to me. There are many walk-in clinics especially in New

York City at CVS's. Is that correct? I mean I've seen a number of them.

MS. SCHULMAN: I believe there are 23 operating in New York State.

ASSEMBLY MEMBER SKOUFIS: Twenty-three. Okay. So, let's say at one of those 23 someone walks into one of the clinics. They are given a prescription. They walk -- they're told you can walk right down the hallway to hand in that prescription and fill whatever medicine they're looking for by the CVS Pharmacy from this CVS walk-in clinic and then the price for that drug is dictated in a large part by CVS Caremark, the PBM that you operate. You own or operate every piece of that chain from the walk-in clinic to the pharmacist and the price in getting the medicine. Doesn't that seem like a conflict?

MS. SCHULMAN: The clinic is actually in New York State is owned by a physician first. Secondly, what the patient is told is, they can get their pre--

ASSEMBLY MEMBER CAHILL: Direct your voice to the mic.

MS. SCHULMAN: I'm sorry. The clinic in New York is owned by a physician, but when that patient is handed a prescription, they are told they can fill that prescription wherever they would like.

ASSEMBLY MEMBER SKOUFIS: Do you have any statistics as to how many fill it elsewhere besides the CVS they're in already?

MS. SCHULMAN: Not at the tip of my fingers, but I'd be happy to get back to you.

ASSEMBLY MEMBER SKOUFIS: I'd love to see. I have to imagine just by virtue of convenience a large proportionate, disproportionate number of those patients are just walking down the hallway to the CVS Pharmacy. So, that aside, you don't see any problem with owning or operating or having at least a role in every piece of that chain?

MS. SCHULMAN: Our central purpose is to try to provide more affordable healthcare for patients. That's what I've stated earlier today and that's what we're focused on.

ASSEMBLY MEMBER SKOUFIS: So, your

answer is a no, you don't see any problem with that?

MS. SCHULMAN: I'm not qualified to give that a yes or a no answer.

ASSEMBLY MEMBER SKOUFIS: Okay. You know, as someone representing CVS not being able to answer no to that certainly raises a red flag. I think any objective person who looks in and sees this process just it's commonsense that this is inherently a conflict of interest. Owning, operating, or having a role in all three pieces of that chain from start to finish but so I continue to have major problems with the Aetna acquisition. Oh, and that's the piece of course. How could I forget? You know? The insurance company that's reimbursing the pharmacist whose prices are dictated by CVS Caremark now is owned by CVS as well as Aetna. At least those patients who have Aetna so.

MS. SCHULMAN: So--

ASSEMBLY MEMBER SKOUFIS: This seems crazy to me quite frankly and I was hoping that maybe there was some piece of information I was

missing that you can provide some piece of mind but clearly you haven't and I'll continue to have these concerns. Thank you.

MS. SCHULMAN: I can what I can tell you is that currently Aetna is 12 percent of our business so there are many other actors in the healthcare system involved potentially in that transaction. It's not all Aetna if that's helpful to you.

MR. WINGLE: And Assemblyman if I might, I think one of the virtues of this alignment is in our current relationship, you know, our costs are revenue to the PBM. Together, we'd be able to look at the whole patient and ensure that the costs are being managed together so it's not an over the fence transaction of we're seeing claim to medical activity related to nonadherence or other pharmacy issues. We'd be aligned together and our interests would be aligned together around ensuring total cost of the whole patient are managed to be more affordable.

ASSEMBLY MEMBER SKOUFIS: Okay.

ASSEMBLY MEMBER CAHILL: Thank you very

much. I have a couple of follow-up questions. Ms. Schulman, you testified that one of things you're doing at CVS to deal with the opioid crisis has to do with limiting prescriptions to seven days. Did I hear you correctly when you said that?

MS. SCHULMAN: That what Caremark has done is for naive opioid prescriptions if they're not for compassionate care, cancer, other important exceptions for the first fill, we're trying to limit that to seven days. As you may know, there are a number of states that have enacted legislation to that effect as well.

ASSEMBLY MEMBER CAHILL: Right. So that was my question. I thought that was a legislative or a regulatory arena as opposed to a practitioner from the pharmacy point of view that.

MS. SCHULMAN: So, it's on the--

ASSEMBLY MEMBER CAHILL: So, under what authority are you doing it where it is not statutory?

MS. SCHULMAN: So that's under the, it's

under the Caremark side so it's a prescription management tool. I think we're now up to over 20 some odd states that have a dispense -- have that prescription limit.

MR. WINGLE: Same goes with our prior off policy, Mr. Chairman. We are compliant with New York State requirements for that. There may be a national policy. In our case, it talks about an initial script of seven days, but I believe the New York rules vary. We've adapted and amended the policy to comply with New York law.

ASSEMBLY MEMBER CAHILL: Thank you. And sir, you've indicated that Aetna would I think these were your words, welcome a chance to participate in Medicaid.

MR. WINGLE: Uh-huh.

ASSEMBLY MEMBER CAHILL: Did the State tell you, you couldn't and you wanted to?

MR. WINGLE: If there's a bid opportunity for Aetna to come into the Medicaid business here, we'd evaluate it and we've expanded Medicaid recently as a company. We've

had great success in bringing our tools to Medicaid programs and if there's an opportunity in New York and it makes sense based on the RFP or the RFI, we'd certainly take a look at getting in.

ASSEMBLY MEMBER CAHILL: Haven't there been numerous opportunities to participate in the Medicaid program in New York?

MR. WINGLE: I'm not certain of what happened to those or why we didn't end up bidding on them or.

ASSEMBLY MEMBER CAHILL: Maybe you can get back to us and let us know why.

MR. WINGLE: Yes, we will.

ASSEMBLY MEMBER CAHILL: And that brings me to two other areas. The Health Exchange.

MR. WINGLE: Uh-huh.

ASSEMBLY MEMBER CAHILL: I've read across the country that Aetna has been pulling out of Health Exchanges and in fact you didn't pull out of New York cause you never came to the Health Exchange in New York. The Health Exchange was a means by which I think most people who are

believers in the Affordable Care Act saw the expansion of access to health insurance for those who were on the margins of being able to afford health insurance. What was Aetna's thinking in not participating in the Health Exchanges where you didn't and what is the thinking about those places where you've decided to pull out?

MR. WINGLE: Well, first of all, we hope and advocate for the Affordable Care Act to become more stable and it's a challenge now that it isn't as we're seeing new rate actions and some of the continued instability in the market which makes it hard for us to reengage in the Exchanges. When we began our involvement in Exchanges, we were one of the larger carriers. We decided though to make a measured multi-year approach initially participating in 2014 in 17 markets. That participation shrank over time as we experienced losses and then finally after experiencing over $800 million in losses, we decided to suspend our participation. But we will continue to evaluate how that market evolves and may make later decisions about how to engage,

but there's so much instability at the moment. It's hard to talk about a commitment today.

ASSEMBLY MEMBER CAHILL: Eight hundred million dollars in losses on what revenue figure?

MR. WINGLE: Four billion.

ASSEMBLY MEMBER CAHILL: Four billion. So, you were seeing $800 million in losses over a course of how many years?

MR. WINGLE: That's the total of our participation.

ASSEMBLY MEMBER CAHILL: So, three years, four years, five years?

MR. WINGLE: Yeah. Nearly four years. Yeah. Four years.

ASSEMBLY MEMBER CAHILL: Four years.

MR. WINGLE: Actually, I'd say we did we're 14, 15, 16, 17, and 18. Now we don't have any exchange of business.

ASSEMBLY MEMBER CAHILL: You have no more exchanges?

MR. WINGLE: We have no more exchange business.

ASSEMBLY MEMBER CAHILL: And what was

the thinking about not entering the Exchange in New York in the first instance?

MR. WINGLE: Well, when we initially partipate, there is significant start-up costs. Our initial bias was toward federally facilitated market places cause that was one solution that served multiple states so our technology lift was and expenses would be lower by focusing on those states first.

ASSEMBLY MEMBER CAHILL: Got you. One of the things that I think is most important in this whole discussion is that when an entity enters into the area of healthcare in New York State we place upon those industries whether they be pharmacies or pharmacy benefit management companies, health insurance companies, hospitals, medical professionals and the whole range, we place upon them a greater responsibility than we do for a lot of other businesses that take place in New York State. We care about the auto glass industry, but we don't place upon them the responsibility for the care of somebody's car, just the replacing of the glass in a responsible

way. And that responsibility goes beyond the transactional circumstance. It goes to the system itself and therefore when health insurance companies go before the Department of Financial Services to seek rates, those rates are often times tempered against affordability in a way that doesn't exist for other kinds of insurance. When discussions about the quality of the product are in the realm of the administrative area, we go deeper and ask questions even beyond statutory authorization in New York State about the size and the configuration of networks and so on and so forth. One of the other things that happens and this has been a longstanding tradition in New York State since there has been health insurance is that if one company starts to waiver a little bit, the other companies step in and pick up the slack. We had a company waiver in New York State a few years ago called Health Republic and what was Aetna's role in picking up the slack on behalf of those customers in New York State?

MR. WINGLE: We were proud to take on a significant chunk of business from the Health

Republic collapse. It was a very compressed, very constrained time. It was disruptive for those members we know, but it was a two-week sprint from November 15th before those new benefits had to take effect on the 1st. That continuation of a benefit had to take place on the 1st of December. Over that two-week period, we enrolled 800 small groups and representing about 7,200 members as I recall from Health Republic.

ASSEMBLY MEMBER CAHILL: That's 7,000 lives.

MR. WINGLE: Yeah.

ASSEMBLY MEMBER CAHILL: And how many of those renewed in January?

MR. WINGLE: I don't recall the renewal numbers, but we can get them for you.

ASSEMBLY MEMBER CAHILL: Okay. A couple of housekeeping issues that I'm concerned with. Before we get to that, one last question about Minute Clinics. There are 9,000 locations in United States for CVS correct? Give or take.

MS. SCHULMAN: 1,100 I believe.

ASSEMBLY MEMBER CAHILL: No, 9,000 CVS locations.

MS. SCHULMAN: We say we're in 10,000 communities so a little bit more.

ASSEMBLY MEMBER CAHILL: Okay. 10,000. 1,000 Minute Clinics. One out of ten. What are the demographics of the communities where those clinics are located across the United States?

MS. SCHULMAN: It's diversified.

ASSEMBLY MEMBER CAHILL: Can you get me more specific information about the demographics of the communities in which those clinics exist?

MS. SCHULMAN: Sure. Yes.

ASSEMBLY MEMBER CAHILL: And if you have any current published plans. I'm not going to ask you to give away business secrets but if you have any published plans on the expansion of those clinics, if you can provide us with that information as well. That would be very helpful.

MS. SCHULMAN: Certainly.

ASSEMBLY MEMBER CAHILL: I know you got rid of cigarettes and that's a good thing. Did it cost you a lot of money to get rid of

cigarettes?

MS. SCHULMAN: Two billion dollars.

ASSEMBLY MEMBER CAHILL: Two billion dollars. And are chips, soda, and Snickers next?

MS. SCHULMAN: We have moved them to inconvenient places in the stores, but I do not believe that we are removing them.

ASSEMBLY MEMBER CAHILL: You're not removing them?

MS. SCHULMAN: No, we're not. At this time that I am aware of.

ASSEMBLY MEMBER CAHILL: Okay.

MS. SCHULMAN: I may be very careful for any lawyers for our company that may be listening.

ASSEMBLY MEMBER CAHILL: Or any distributors of Snickers. Right?

Ms. SCHULMAN: I will have a problem if we can't go get my candy so.

ASSEMBLY MEMBER CAHILL: If you can't. Yeah.

MR. WINGLE: Just keep the Kit Kats in the stores. I'll be alright.

ASSEMBLY MEMBER CAHILL: We all have our favorites. Right? Couple of really housekeeping issues but one is going back to a question I think that was asked by Mr. McDonald. I know he asked you about a false claims act, a false claims lawsuit that existed. There was also another lawsuit Gillian [phonetic] Washington v. Aetna that resulted actually from I think it was one of these hearings where there was testimony by a medical director of the company that claims were being denied without the medical director reviewing the actual records in the case. You wish to offer any illumination of that to show their action?

MR. WINGLE: Yes. Absolutely. So, the what came out of that that deposition activity was out of context. In fact, the judge in the case that's going on around this admonished the attorney for the other side for taking that quote out of context and the medical director involved in that deposition has added an addendum to clarify the record and to provide that additional context of what he meant. It is Aetna policy, it

is Aetna training that every piece of relevant medical information is reviewed by a physician as part of a decision about the medical care particularly if there's any concern about an adverse decision coming down. So, it is absolutely part of our training and our compliance and our requirements that the physician make that determination and again in that particular case, I think even the effect of what happened with that plaintiff attorney doing what he did was he ended up delaying the whole trial and I think the judge again was very firm on the bench against how we thought we were misused in that effort.

ASSEMBLY MEMBER CAHILL: Again, in the area of housekeeping, who else is reviewing the transaction across the United States? We know there's a federal review. What agencies in the federal government are reviewing the transaction?

MS. SCHULMAN: So, at the federal level, it's the Department of Justice. Each state has its own procedures. In most states, it is the Department of Insurance. In New York here as you

know it's DFS and the Department of Health.

ASSEMBLY MEMBER CAHILL: Uh-huh. And is it being reviewed in all 50 states at this time. Are there active views and hearings being held?

MS. SCHULMAN: It depends on what the individual states' rules are. There are a change of ownership reviews going on in 28 states.

ASSEMBLY MEMBER CAHILL: In 28 states. What is the timeline in terms of the next step? We know a December announcement and a few other things have occurred. What is the actual timeline, estimated time of arrival of the new CVS HA? CVS Health Aetna.

MS. SCHULMAN: We it's our expectation at this time that the deal if approved will close in the latter half of the year.

ASSEMBLY MEMBER CAHILL: Latter half of this year?

MS. SCHULMAN: Yes, sir.

ASSEMBLY MEMBER CAHILL: Okay. One of the things that you've discussed is the importance of -- you both discussed it from your own perspectives and thank you for that of

getting a piece of the other's business in terms of being able to better deliver the product. What about buying hospitals and buying medical practices? Is that down the road for you too?

MS. SCHULMAN: That is not in our current plans.

ASSEMBLY MEMBER CAHILL: Why not? If you want to be in the middle of healthcare, don't you think you ought to have doctors and hospitals?

MS. SCHULMAN: Our expertise is pharmacy.

ASSEMBLY MEMBER CAHILL: Yeah.

MS. SCHULMAN: And our retail presence so we want to build off of that expertise.

ASSEMBLY MEMBER CAHILL: Yeah.

MS. SCHULMAN: And joining with Aetna and their health plan expertise, we feel gives us the best opportunity to make a difference.

ASSEMBLY MEMBER CAHILL: It seems that one of the things that we know about particularly the hospital network in New York State and elsewhere in the country, is that it's sort of on

the ropes that finically a lot of hospitals are struggling to get by and part of that reason, certainly not all of it but part of that reason is that there has been some cherry picking that's taking place in terms of the care that's being given by private entities that is no longer being provided by hospital-based settings where maybe the higher profit area to cover some of the costs at the lower profit seems to me that you're talking about taking some of the more higher profit areas of the healthcare business and leaving the lower cost areas to other entities. What if and this is a very real what if and maybe you don't have to answer it now, what if in the course of doing that nature of business you've created an instability with the remaining institutions that they are no longer around to provide that care? Has this new entity given any thought to the impact on the overall system as you seek not just to as you've indicated several times integrate data and improve access to care but also make money which is what if you don't do then you don't get to come back and testify ever

again.

MR. WINGLE: I can help with this one, Mr. Chairman, if you don't mind. I think our emphasis on value-based contracting is a big part of the answer. Remember as I mentioned in New York, 77 percent of what we pay in New York is now through value-based contracting. If you're paying by procedure or by service, you end up with that challenge of the people can go anywhere and maybe the referrals are sending, you know, people to places where, you know, there's some economic incentive or advantage to doing that. If you're doing value-based contracting, you're setting a global budget and you're managing a population together. You're using your data with the provider's system to manage the population and to the extent that that population stays needs metrics around keeping healthier and improving population health, then you're achieving, you know, something that's good for the consumer, good for the provider, and good for us as the insurer behind that arrangement. It's when you get to volume or procedure-based

approaches to comp that I think you end up with more of that cherry-picking dynamic we're trying to move away with from that and we've done a great deal of that here in New York.

MS. SCHULMAN: We currently have partnerships with hospitals and health systems across the country. To us, those are partnerships. We don't want to weaken that. We want to strengthen that. You know, I started off a little while ago with that we that CVS Health was the front door to healthcare, so is the doctor's office, so is the hospital. It's the pieces of the healthcare continuum. We need to be working together to strengthen each other all in the goal of getting a better health outcome for the patient.

ASSEMBLY MEMBER CAHILL: Before we close up, is there anything that you have not been asked that you wish you were or anything you wish to amplify of what you've already talked about?

MS. SCHULMAN: Nothing comes to mind but thank you.

MR. WINGLE: Certainly, if anything

comes up after this hearing, I know we will be happy to take those answers, have any meetings or discussions or follow up that you require.

ASSEMBLY MEMBER CAHILL: That is the next question I was going to ask before I give you back your freedom was if indeed we have additional questions or seeking additional information, can we count on you to provide a quick--

MS. SCHULMAN: Absolutely and I know there have been a few--

ASSEMBLY MEMBER CAHILL: Accurate response.

MS. SCHULMAN: Commitments I've made in response to the questions about additional information that I didn't have and will be following up individually with the members of the Committee as well.

MR. WINGLE: The same.

ASSEMBLY MEMBER CAHILL: Well, thank you very much. You've endured over two hours of questioning and you've done it with a great deal of eloquence. I hope you understand that the

difficult questions provided you with an opportunity to provide information to questions that exist here and amongst our constituencies and that the easy questions gave you respite from the difficult questions. Thanks.

MS. SCHULMAN: Thank you.

MR. WINGLE: Thank you very much.

ASSEMBLY MEMBER CAHILL: Now before we go to our next witness because we extend this courtesy to agencies every time and maybe their long weekend is over and they're here and they want to testify, is there anybody here on behalf of the Department of Health who wishes to come forward and testify? Is there anyone here on behalf of the Department of Financial Services who sees fit to address the legislature on this very important issue at this very critical time or have they chosen not to do so? Just checking. Okay. Thank you. In that case, we're going to invite Dr. Charles Rothberg, the Immediate Past President of the Medical Society of the State of New York to come down and testify. Dr. Rothberg.

CHARLES ROTHBERG, M.D., IMMEDIATE PAST

PRESIDENT, MEDICAL SOCIETY OF THE STATE OF NEW YORK: Thank you, sir.

ASSEMBLY MEMBER CAHILL: How are you?

MR. ROTHBERG: I'm well. And yourself?

ASSEMBLY MEMBER CAHILL: Again, I'll remind you that while we're not swearing you in, your statements are expected to be truthful and under oath.

DR. ROTHBERG: Absolutely, sir.

ASSEMBLY MEMBER CAHILL: We would also ask that you speak directly into the microphone and if you have a prepared a statement, we would like to offer the opportunity to go forward with it at this time.

DR. ROTHBERG: Very good. First, I want to thank you, Chairman for convening this hearing because this is a tough issue and when you go to a cocktail party, you try to explain to people why your concerned about this, it's a little padanting. Hearings like this I think will help us to dive deeper and hopefully the public will understand why this is a great concern. I also want to thank Chairman Gottfried, the other

Members of the Assembly, the two Andrews who well I guess they will come back. So, good morning. I'm Dr. Charles Rothberg, Immediate Past President of MSSNY. I have long observed that our legislature and our regulators are both deliberate and deliberative on matters of healthcare, an important reason that New Yorkers have the best healthcare and an important reason I'm so proud to be a New Yorker. Thanks for the opportunity to contribute today. My perspective has been formed in a matter of very few health stakeholders as I've been interpedently practicing ophthalmology for more than 30 years in addition to my work in organized medicine. I serve on the medical staff of our community hospital which remains one of the very few independent hospitals in New York State. Although certainly I'm not an economist, I'm going to ask that during my remarks, we view this proposed business and healthcare transaction in a way that an economist might. As a clinician, I feel that too often as though I'm operating downstream and I use the word downstream both as

a metaphor and an economic term, downstream from an industrial polluter what an economist call negative externalities and I will point out that negative externalities abound in healthcare. I'll explain how this relates to the CVS/Aetna merger shortly. I would also ask that we view this merger with regard to its impact upon consumers, my patients and your constituents. This proposal is a vertical integration, the kind that economists say produces business savings from supply chain efficiencies, but savings that in my estimation are rarely realized by the consumer. Despite similar impacts to the consumer, vertical mergers are too often not scrutinized in the same way as horizontal ones are. And vertical ones are very, very hard to undo. I'd like to share a conversation I recently had with the dean of one of our state medical colleges. In discussing his vision of excellence in healthcare, he distinguished his hospital from the other health systems in the region and he remarked that one choosing to get their healthcare from Walmart could always choose

the other health system and it seems ironic to me that since that conversation took place, Walmart itself has announced it seeks to enter into the space. I'm deeply concerned in listening to the testimony before mine that entities talk about scale but offer little specifics about innovation. I'm here to ask the governor to protect the vital public mission of our healthcare system. I'm going to stray a little bit from my prepared remarks because you do have them and make some observations about what I've heard here today because these things deeply concern me and I hope that you share my interest. With regard to Minute Clinics, the Ms. Schulman stated that they're physician owned. She stated that more than once. I'm not sure that ownership is the issue before us but how they're operated and I think that the Assembly should be considering who is delivering the care in those entities and in my community, there's no physician anywhere near them. I would like to remind the Assembly and the Chair people of the adverse business practices of insurers in general

and Aetna has a record of its own that we should be reminded of. You pointed out Chairman Cahill about Aetna not having a presence in the Exchange and they've since withdrawn from other states where they did have a presence, but also in the last 20 years on two occasions, they let go hundreds of thousands of subscribers so I would urge people to examine that and draw inferences to the dedication to their subscriber pool. They talk a lot about data and the power of data, but I would argue that the power of data is based upon how it is used and I'm reminded of Ingenics which is a subsidiary -- was a subsidiary of a different health insurer than the one that was here today but they use data in a very adverse way and that New York State I'm proud to say our then attorney general, our governor took action to reverse the misuse of the data and how it was missupplied to people and caused them to have unexpected and surprise cost that was not borne by the insurer even though that they had paid extra premiums so that they would have that coverage. The market power of the combined

entity that you're receiving testimony today has the power to give poor deals to other insurers and maybe to exclude new entrance to the insurance market which has been a struggle here in New York. It's was a struggle I think for the Affordable Care Act's market and it's been a struggle in general. The market power of this combined entity might make it hard or impossible for entities that don't also have the same combination of PBM providers and insurers to enter the market. The opioid epidemic. Certainly, this is something of great interest to the legislature and to me as a physician and we all have been touched by it even in our families and in our communities but what you heard today was not leadership. It was merely following the law. If we're going to combat the opioid epidemic, we need a multipronged collaborative approach and we need innovation, not just entities that say that they comply with the law. The gentleman from Aetna testified that he sees no direct effect of his merger on the other players in the provider pool here in New York and

one of the things that's vitally important to our community is a safety net that we have whether it be safety net hospitals or the safety net that we have as practicing physicians provide and I would argue that the pair mixes is extremely vital to the survival of our safety net so even if they're not actively involved in the Medicaid pool for example, that portion of our pair mix is very important to support the infrastructure in our communities. Any disruption of any component of the pair mix will have consequences on how we deliver the care, the delivery system and the safety net in particular and I want to point that out and be very mindful of that. And lastly, population health. Large entities seem to like to use that word and, you know, it struck me that these people don't really understand how we do things here in New York. Population health is a discipline that of course is very, very important. It should guide some of our policies, but all too often it doesn't always intersect ideally with the individual's needs or the individual's health and Mr. Steck pointed that

out I thought better than I could because he related it a personal vignette where population health dictated something that was very adverse to his care. And again, to strengthen the kind of people that would resort to those kinds of innovations concerns the physician population. I want to return to my prepared remarks and just point out a couple of things that I would like to emphasize. We're very concerned that the [unintelligible][02:29:13] of this transaction will facilitate or accelerate the arms race that's currently underway in healthcare whereby the other healthcare stakeholders such as the other insurers and hospital systems are competing with each other who can gain the best leverage so that they're not left out. I want to point out that the U.S. Department of Justice together with attorney generals around the country have successfully brought litigation to block proposed mergers of health insurance companies including Aetna themselves because these mergers would have resulted in market concentration in New York's health insurance market particular downstate

where I practice. I would like to point out that we believe that the consequences of vertical mergers be no less profound than the horizontal mergers that were successfully proposed by the attorney general. Certainly, these kinds of mergers have not demonstrated kind of cost savings that these folks are promising. No reason to think that this one would either. It's my understanding CVS already owns 500 retail stores, Caremark is the second largest PBM in the country. According to AMA testimony at a judicial committee hearing in Congress, CVS has the status of being one of the nation's two dominant pharmacy chains in a highly concentrated market. Drug sales attributed to CVS are 25 percent of the market share and together with Walgreens, the two chains represent 50 percent of drug sales. Twenty eight percent of specialty pharmacy market is attributed to CVS and Walgreens gets another ten percent. We are very concerned that these proposed transactions could exacerbate the already fragile nature of New York's healthcare delivery system in a number of

ways. What is particularly ironic is the significant limitations placed on physicians to start an antikick back laws that limit our ability, the ability of physicians to have an ownership interest in another aspect of the healthcare system but yet we're granting or considering the granting of these privileges to less responsible or less New York based entities. So, the concerns that I have are on a number of fronts. We're concerned that these transactions will reduce choice of pharmacy for patients, become very hard for pharmacies that are not affiliated with CVS or Walmart. We're worried about prior authorization hassles and how they increased handily over the last eight or ten years. That physicians spend something like 20 -- almost 15 hours a week processing these prior authorizations which is two business days. That physicians spend an average of two hours doing this administrative paperwork for every hour they spend with the patient and we should also make note of the fact that PBM's are not regulated by the State of New York despite the enormous

involvement these entities have in development of the prescription drug plans including which drugs will be considered preferred which will be placed on higher cost sharing tiers. These decisions are too often based on the financial deals made with drug manufacturers and wholesalers and they don't always lead to cost savings. And this was highlighted in Wall Street Journal over the last week that discussed Caremark's tactics with the Ohio Medicaid Managed Care Program. As you know, a proposal on last year's state budget to require PBM's to register with New York was not adopted in the final budget. I believe some steps have to be taken to regulate their practices including prohibiting the gag clauses which is a nice step. Much more needs to be done. I mentioned briefly before about the adverse effect this would have on insurance competition and new entrants into the insurance market. What I didn't mention that I'd like to bring up is the effect on physician owned medical homes. We're concerned that these transactions will place additional pressure on the New York State Legislature to approve

legislation that it previously rejected in terms of corporate owned retail clinics staffed by nonphysicians that would likely drive many more independent physician practices out of business which in turn will endanger the medical homes that these practices provide for many folks across New York State. The enormous scale of these merged entities could create significant financial incentive for these companies to develop cost sharing structures in a way that incentivizes use of corporate clinics at the expense of the traditional ones. Thank you. Certainly, there would be significant pressure to have prescriptions written at those clinics to be filled in the store pharmacy. With regard to the Walmart Humana merger which is not the focus of this hearing but that can have a great impact too because they're very big in the Medicare Advantage space and this could drive many of our seniors to be getting care at alternate and suboptimal outlets. I would call attention to some of the AMA data from their testimony at the February 27th hearing that I referenced. They're

kind of the expert on some of the issues about anticompetitive practices, the high degree of insurance consolidation, the high degree of PBM market consolidation, pharmacy consolidation. The merger may be anticompetitive because it allows CVS Aetna the third largest health insurer to control PBM services of Anthem, it's competitor, the second larger insurer. In addition, the American Antitrust Institute made some comments that I would call to your attention in my prepared remarks that we submitted, but one of the things that they pointed out was that despite the barriers to entry, you know, for other insures and what not that in the healthcare space a bad decision that we make from a regulatory point of view can result in poor health outcomes and even death and that's why these decisions that we make are just so vitally important. In conclusion, I want to thank you again for permitting us the opportunity to testify on this issue while we understand that the FTC and the U.S. Department of Justice will have primary jurisdiction over the matter of CVS

Aetna and Walmart Humana, it must also be approved by the New York State Department of Financial Services and as such the New York State Legislature could be helpful in identifying and highlighting impediments to patient care, the pharmacy and physician care settings that will inevitably result from these proposed cross-section, cross sector mergers of health care behemoths. I would add a final note. Recently, there were public comments from the Aetna CEO that his business is presently in the business of selling a warranty card that if it breaks, that is if you get sick. Aetna will indemnify you and he seeks to change the model by means of this transaction to focus on health and wellness and to leverage CVS retail presence to do that and I can't get over these questions that I have to ask. One, why has he not done more in the past and why does he need a retailer to promote what he should have been doing all along and two, as this is a business proposal where the promotion of wellness itself a [unintelligible][02:36:37] would at all impact the cost drivers of

healthcare which my understanding is things like end of life, chronic disease and the pharmacy itself. Again, we are extremely concerned that the major consolidation of the healthcare industry this merger would represent. It is our experience at the Medical Society patient care and physician's ability to deliver this care are never improved when these consolidations occur. Thank you again for providing the opportunity to comment. Happy to answer any questions if you wish.

ASSEMBLY MEMBER CAHILL: Thank you. I will point out that we have not received your written statement so if you can provide it to us that would be very helpful.

MR. ROTHBERG: Absolutely. I apologize.

ASSEMBLY MEMBER CAHILL: Thank you. Thank you. Dick, you want to start up?

ASSEMBLY MEMBER GOTTFRIED: Yeah. Similar question to one that I put to the Aetna and CVS people, on the subject of vertical integration, you know, and I noted that they were the first people I had ever met who had anything

good to say about vertical integration, what is the run of opinion in the physician community on vertical integration? Are there physicians out there saying gee, I not only want to practice as an employee of a large organization rather than as a small practitioner or in a small practice, but it would be really great if an insurance company could own the entity that employed me. Are there physicians out there championing at the bit for that to happen?

DR. ROTHBERG: Did you want a one-word answer or do you want me to embellish that a little bit? They are not banging down our door to tell us let's facilitate this and I think tehre's a healthy skepticism. My understanding and again, I'm not an economist is that vertical integration – well, let's look at industries that have had vertical integration. When was the last time you ever paid less for a new car than you had before? Yet horizontally integrated companies like consumer electronics you always get a better deal on your current TV than you got on the last one so I would urge people to look at

vertical integration at least from the consumer standpoint as not always being a very favorable thing. From the physician's standpoint, we do have vertical integration in healthcare. We have health systems and the promise of health systems in New York and also around the rest of the country was that there would be efficiencies in economies that would result in better outcomes. I'm not sure that we have ample evidence that that's universally true. I think that there are physicians who work in vertical integrated systems and sometimes they enjoy some of the benefits of integration which include and I'd like to distinguish the terms clinical integration which I know a bit more about than vertical integration and sometimes that's, you know, handled very, very nicely through the system. I think that that's still very different than a pair being involved than a provider in a vertical integrated model because the pair essentially has a very, very different mission than say a health system. So, my answer to you is I don't think that the physician community is

embracing this as the only solution or even the best solution.

ASSEMBLY MEMBER CAHILL: Thank you. Doctor, I have a couple of very specific questions about your personal experience and that of the -- your colleagues who you represent here today. Have you or your colleagues entered into contractual arrangements with Aetna and what is that experience been like?

DR. ROTHBERG: I'm not sure I understand the question. Am I a provider for Aetna?

ASSEMBLY MEMBER CAHILL: An Aetna provider.

DR. ROTHBERG: I believe I am.

ASSEMBLY MEMBER CAHILL: And what was the nature of the transaction that led to that? There was a provider relations representative came to visit you and handed you a contract and said would you like to be part of this network or your group got a contract and you were part of a group?

DR. ROTHBERG: I'm a solo practitioner. I work as a clinician. I have another provider

that's a nonphysician but an independent provider that works with me and that's been our model for over the last ten or 15 years so. The Aetna contract as I recall predates Aetna. There used to a firm called U.S. Healthcare and they were like the first--

ASSEMBLY MEMBER CAHILL: They were what?

DR. ROTHBERG: U.S. Healthcare.

ASSEMBLY MEMBER CAHILL: U.S. Healthcare.

DR. ROTHBERG: And they were the first HMO I believe that came to Suffolk County which is where I practice and I was a young physician at the time and I joined them back then. Since then, they were acquired by Aetna and, you know, we have a patient pool. I imagine that the relationship has been satisfactory. I've renewed, they've renewed. I don't recall having any interaction with representatives of their company in terms of contractual issues.

ASSEMBLY MEMBER CAHILL: I would be interested if on behalf of the New York State Medical Society we could get information about

the experience of providers and their entering into contracts and actually dealing with Aetna in particular. But equally important to me and you mentioned a Walmart possibility. I think that is a proper subject of this hearing. We're not here to pick on CVS and Aetna per say. This is a phenomenon that I think we have to get out in front of instead of waiting for it to hit us over the head so the issue with other insurance companies is equally important as are the issue with other providers of healthcare. But sticking to the one that's before us today with specificity, have you dealt with CVS and Caremark as a professional or members of your association dealt with CVS -- your Society dealt with CVS or Caremark in a professional?

DR. ROTHBERG: Nothing specific. Again, I'm a provider and that's, you know, what informs my -- a lot of my experiences is my own personal experience.

ASSEMBLY MEMBER CAHILL: Uh-huh.

DR. ROTHBERG: In our community, there not Caremark because I have -- I'm very troubled

by the whole notation of PBM's because of the lack of transparency and I'm a little disappointed that the conversation earlier today didn't focus a little bit more on how untransparent their operations are and how little the insurance industry itself calls the PBM's responsible for their activities. There seems to be this notion that that's not--

ASSEMBLY MEMBER CAHILL: You say how the insurance company does not hold them accountable?

DR. ROTHBERG: The people that collect the premium.

ASSEMBLY MEMBER CAHILL: Yes.

DR. ROTHBERG: So, in the example this morning would be Aetna but I don't wish to vilify them. I think they operate in this regard similar to their peers. But I think that they carve out the whole notion of pharmacy to this PBM and the PBM works like the wizard in The Wizard of Oz behind a curtain where we don't see it and the results of that are not accountable to us as providers, to you as New York State, and ultimately the people who pay the premiums. It's

not an arm's length, it's more than an arm's length transaction and I believe that that is in no small part contributes to the rising problems that we have with drug costs and availability and any number of things and I think that the insurer or the person collecting the premium ought to be a little bit more responsible for those activities. But I don't have direct, you know, I write a prescription. The patient takes it and gets it filled.

ASSEMBLY MEMBER CAHILL: Right. I want to come to another aspect of what you just said. Not necessarily from the perspective of the payor but the whole question about the regulation of PBM's and so forth but we'll get to that at the very end. Are there any health plans with which you deal that you are not a contracted provider? Are you an out of network provider with any health plans?

DR. ROTHBERG: The answer is yes. I--

ASSEMBLY MEMBER CAHILL: Explain that experience.

DR. ROTHBERG: Again, I'm an

ophthalmologist so my experience is not -- we accept most plans so if I've gone out of network with a particular plan it's because of an inability to come to contractual terms.

ASSEMBLY MEMBER CAHILL: Okay.

DR. ROTHBERG: Typically, they try to resist paying the out of network claims. They -- in New York, we've done a pretty good job I think of facilitating that where we keep the patient out of it since the out of network law came in. It's not a really important part of my practice and I don't wish to name the company that I left, but it's about six percent of my practice.

ASSEMBLY MEMBER CAHILL: Okay. So again, on behalf of the membership preps, you can provide us some additional information about experiences that providers have had when they've been out of network in dealing with a company particularly as that company grows stronger and stronger through integration vertical or horizontal.

MOE AUSTER, SENIOR VICE PRESIDENT AND CHIEF LEGISLATIVE COUNSEL, MEDICAL SOCIETY OF THE

STATE OF NEW YORK: Well, I will say there has been recently--

ASSEMBLY MEMBER CAHILL: First before you say anything, tell us who you are.

MR. AUSTER: Moe Auster. I'm the Senior Vice President and Chief Legislative Counsel for the Medical Society of the State of New York. I will say just in getting to that point, we've had experiences where one insurance company in particular one downstate area did a wholesale dropping of physicians from their network and with little opportunity to appeal that determination. Now, certainly, they make decisions like that all the time, but we're certainly concerned with this proposed transaction that based upon what their model is and what they're looking to do that you could have a further marginalization of community physician-owned practices.

ASSEMBLY MEMBER CAHILL: The last question that I want to ask you at this point and may have a follow-up. Are there and I'm guessing one of them already. Are there any suggested

legislative changes you think we should be considering in advance of the advent of a merged entity of this nature whether it be CVS, Walmart or anybody else that's going to take over health insurance companies. Is there anything you think we should be doing legislatively? I'm going to guess one of the things you think we should do is more carefully regulate PBM's.

DR. ROTHBERG: Well, I think I've already stated that so yes.

ASSEMBLY MEMBER CAHILL: Right.

DR. ROTHBERG: But I'd also ask you to look again at some of the collective negotiation legislation.

ASSEMBLY MEMBER CAHILL: Collective negotiation legislation.

DR. ROTHBERG: Like you've seen over the years. The okay. Chairman Gottfried sponsors the bill on that. That's not a shameless plug. We're very proud of it.

ASSEMBLY MEMBER CAHILL: It's a fine bill.

DR. ROTHBERG: Yes. And the issue is is

that I think that there are some people in the legislature that look at that with, you know, some trepidation because it evokes when you hear the work collective people think of it in other industries but here it would be very highly regulated by the State on their State's Action Doctrine and it would provide physicians, the kinds of people like me with the ability to have some meaningful negotiation with these very, very large stakeholders who unabashedly talk about their scale and this would give us at least some ability not necessarily that we would want to collectively negotiate with them but some ability that they would negotiate on a level playing field with us for fear or concern that it would invoke the provisions of a law like that. It would just give some of the, some meaning back to the kinds of contract things that you were talking about when you asked your first question.

ASSEMBLY MEMBER CAHILL: Without going too deep into the weeds on Minute Clinics, you indicated that it is not your experience that the Minute Clinics are in fact run by physicians.

What exactly did you mean by that portion of your testimony?

DR. ROTHBERG: Okay. So, there are several industries in New York State that a licensee has to--

ASSEMBLY MEMBER CAHILL: Right.

DR. ROTHBERG: Technically own. An optical store is such as example and I've had some experience personally with that and so a store can't actually own that in New York State. It's a prohibition against corporate ownership of these clinics so what they can do I don't know if that's what they're doing in this instance is they can get a licensee to operate that clinic. But if you go into the Minute Clinic seeking care, you're not going to meet a physician.

ASSEMBLY MEMBER CAHILL: Uh-huh.

DR. ROTHBERG: It's going to be some other provider.

ASSEMBLY MEMBER CAHILL: And that's under the existing law you're talking about where.

DR. ROTHBERG: That's what's happening

in New York and I wanted to make sure that that was very clear because the Ms. Schulman gave the impression that, you know, you went there and you saw a doctor.

ASSEMBLY MEMBER CAHILL: Uh-huh.

DR. ROTHBERG: And I want to make it very clear that that's not what's happening and I don't believe that's their model around the country.

ASSEMBLY MEMBER CAHILL: Anything else that you wanted to add to the record that wasn't part of your testimony? You're going to provide us with the written testimony Moe?

MR. AUSTER: Yes. Oh, yeah.

ASSEMBLY MEMBER CAHILL: Alright.

MR. AUSTER: Yeah. Yeah.

ASSEMBLY MEMBER CAHILL: That's good.

MR. AUSTER: Yeah. Yeah.

ASSEMBLY MEMBER CAHILL: Anything else you want to add other than your what you?

DR. ROTHBERG: I really think that I'd like to think that I spoke for that the issue speaks for itself. I think that your group was

really incisive and I was very pleased by the kinds of questions because I think they represent the kinds of concerns that our patients would have even if they have not yet articulated them.

ASSEMBLY MEMBER CAHILL: I just want to doublecheck. Any questions? Doctor, thank you very much for your testimony. I will ask that if we have some additional questions, that you or your representative provide us with a timely and accurate and complete response.

DR. ROTHBERG: I would be delighted.

ASSEMBLY MEMBER CAHILL: Well, my pleasure and thank you very much.

DR. ROTHBERG: Thank you very much.

MR. AUSTER: Thank you.

ASSEMBLY MEMBER CAHILL: Moving right along. We now have a representative of the Pharmacists Society of the State of New York. I'm not sure exactly who it is that's coming forward. I have to find that document. Kathy Febraio.

KATHY FEBRAIO, EXECUTIVE DIRECTOR, PHARMACISTS SOCIETY OF THE STATE OF NEW YORK:

Correct. Thank you.

ASSEMBLY MEMBER CAHILL: Is that how you say your name?

MS. FEBRAIO: That's how you say it.

ASSEMBLY MEMBER CAHILL: Cool. Okay. Great. So, you we have your written statement. Thank you for an extensive statement with multiple addenda and we would be happy to take your testimony and if you would be willing to answer a few questions that would be great. Everything you say is you are swearing to the truth of the statements that you're making even though we are not putting you under oath. Is that understood?

MS. FEBRAIO: Absolutely.

ASSEMBLY MEMBER CAHILL: At the end of your testimony, we may ask for additional information from you and I would ask that you be willing to provide that information in a timely and complete and accurate fashion.

MS. FEBRAIO: Of course.

ASSEMBLY MEMBER CAHILL: Terrific. Thank you. Go ahead with your testimony.

MS. FEBRAIO: Okay. Thank you for holding this hearing. It is of great importance to pharmacists across the state and across the country. The Pharmacists Society of the State of New York is the voice of more than 2,300 New York community pharmacies and their patients where an important voice on this issue is the outcome is going to invariably impact those who rely on their local neighborhood pharmacies. And we want patients to be able to choose the care that's right for them and that fits in their circumstances. As detailed in our written testimony, PSSNY opposes the proposed question of Aetna by CVS Health. And this is based on their historical behavior. Aetna has a history of excluding many community pharmacies from its preferred status Part D pharmacy networks and has resulted in the CMS sanctions against the company in both 2010 and 2015 for misleading seniors about pharmacies that were in network. So, Aetna's precedent for steering these vulnerable patients toward their own preferred status pharmacies is an example of how vulnerable

patients can be treated in this new vertical integration. These patients rely on the relationships with their pharmacists and to be told that they had to change pharmacies in order to afford their medications is unnerving. The information is not always complete and accurate that is sent to these patients but too often the patients don't know that or don't know the questions and the nuances within these letters to understand that. CVS Health in addition to being the nation's largest pharmacy chain owns one of the three largest PBM's and together they control nearly 85 percent of the market. Aetna is the third largest health insurer with revenues of more than $60 billion dollars. In the PBM arena, CVS Health is the second largest entity controlling 34 actually they claim 40 percent this morning of the entire market in reporting first quarter revenues of this year of $32.2 billion dollars. We believe that bringing the insurance company and its pharmacy benefit manager together inhouse is tantamount to the fox watching the hen house. There is little

incentive to control costs and if you're unfamiliar with a PBM they are the functional middleman. They set the pricing and the reimbursement for the pharmacy and on the other side they set the pricing for the health plan. The pharmacy cannot talk to the health plan about what the pricing is and vice versa. The only person who knows the difference between those two prices is the PBM. And the person who retains that money is the PBM. CVS has come under national scrutiny for its questionable cost control measures. Last week, the Wall Street Journal wrote that in Ohio CVS appears to be billing the State for far more than what it is paying pharmacies driving up taxpayer costs and CVS is also attempting to drive independent pharmacies out of business and expand its retail market share. Recently in Arkansas where my counterpart of the Arkansas Pharmacists Association, they were able to obtain insurance explanation of benefits data for Medicaid patients. They found that CVS Caremark billed Medicaid plans more than twice as much on average

as what their CVS Pharmacies got paid. And that data from fully insured commercial health plans show that CVS paid itself more than $60 more on average per prescription than the independent pharmacies. So, for an organization that talked considerably about data this morning, it's very concerning that these numbers can be unfolded and unfound but only through extreme means and measures to get to the data. These reimbursements are funded off the backs of pharmacies, the patients, and the taxpayers. PSSNY members report similar concerns and our own research of a CVS Health sponsored employee plan available online revealed that CVS has been setting prescription prices for itself and other national chains significantly higher than the reimbursement it pays to smaller regional chains and independents. Such practices result in squeezing out community pharmacies and deteriorating their overall financial health. According to the National Community Pharmacy Association, gross profits of community pharmacies since 2007 through 2016 have fallen

from 23.2 percent to 22.1 percent while total revenue over the same period barely changed from $3.6 million to $3.619 million per store. The script count over the same period of time fell on average from 61,502 scripts to 59,746 in a community pharmacy per year. However, overall prescriptions dispensed grew from 3.7 billion to 4.487 billion. We believe many of those other scripts are moving to mail order. So, adjusted for inflation total revenue between 2007 and 2016 has fallen and so although the number of community pharmacies may not have dramatically changed, it's in the face of booming prescription volume and the overall financial picture of these independent and local pharmacies is deteriorating. We don't know how much longer they can sustain this or what will happen with this vertical integration to increase the rapid change. PSSNY can also confirm that after suddenly decreased generic prescription reimbursement rates on October 26, 2017 which Assemblyman McDonald referred to, CVS followed this activity with prospecting letters offering

to purchase independent stores recommending they do so due to declining reimbursements that ironically were created by another branch of their company. PSSNY believes that both CVS and Aetna have not only been not part of the solution but are the problem in rising healthcare costs. The merging parties have stated that the proposed transaction will create efficiency and save hundreds of millions of dollars and put the patient front and center. However, our history has demonstrated that this acquisition will only serve to benefit CVS and Aetna stakeholders. As has been demonstrated in the past, the merger will not result in greater choice, access, or affordability but in fact the opposite. For these reasons, PSSNY opposes the merger of CVS Health and Aetna. Thank you.

ASSEMBLY MEMBER CAHILL: Thank you very much. Really appreciate your testimony and I apologize for having to miss the beginning of your oral testimony, but I assure you I've read and will reread your written testimony which I think is part and parcel of what you have had to

say here today. You've made some points about the relationship with Caremark and you heard the representative of Caremark say essentially that those are anomalies, that's not the way they do business. Can you address that particular concept?

MS. FEBRAIO: We have consistently heard from our pharmacies that they feel they're being squeezed out of the networks, that they are being under reimbursed, and that this is part and parcel of the business model.

ASSEMBLY MEMBER CAHILL: Uh-huh. And tell me about what is the business relationship between a pharmacist and Caremark? Do you have to enter a separate contract with them or are they automatically they're just a payer to you?

MS. FEBRAIO: What happens is the pharmacy can enter into a network contract in a couple of different ways. They can directly negotiate with the PBM or they can contract--

ASSEMBLY MEMBER CAHILL: You mean in this case it would be Caremark?

MS. FEBRAIO: Caremark. Correct.

ASSEMBLY MEMBER CAHILL: Right.

MS. FEBRAIO: Or they can utilize the services of a pharmacy service administrive organization. We call them PSAO's and what they do is they negotiate a contract and then offer it to multiple pharmacies so they would all be under one contract. There could be hundreds or thousands of pharmacies under an individual contract.

ASSEMBLY MEMBER CAHILL: Generally speaking, you'll become a provider through Caremark because of a contract that you've entered into with an insurance company, right? Is that generally the way the arrangement operates?

MS. FEBRAIO: No. You're entering into a contract with a pharmacy benefit manager and they're entering into contracts with health plans on the other side.

ASSEMBLY MEMBER CAHILL: So, the PBM is telling the health plan what pharmacies are available, not the other way around?

MS. FEBRAIO: Correct.

ASSEMBLY MEMBER CAHILL: Okay. You've indicated in your written testimony and I think you touched base on it here that Aetna has been involved in a number of different disciplinary actions particularly by CMS, in fact, a disproportionate number of disciplinary actions by CMS and you also indicated that they have been similar types of issues with Caremark. They both seem to revolve around discussions and representations about the network.

MS. FEBRAIO: Uh-huh.

ASSEMBLY MEMBER CAHILL: To what do you attribute this particularly on the part of Aetna the issue about network with Aetna. Why would they have a stake right now before this merger takes place in misrepresenting the network?

MS. FEBRAIO: I can't speak to why they take these actions.

ASSEMBLY MEMBER CAHILL: I realize you're not going to speak on behalf of Aetna but.

MS. FEBRAIO: We have far more experience, direct experience with Caremark and PBM's.

ASSEMBLY MEMBER CAHILL: Yes.

MS. FEBRAIO: But we routinely see letters going to patients and they'll be vague letters saying the pharmacy you recently visited is no longer in the network never naming the pharmacy.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MS. FEBRAIO: The patient is left to assume which pharmacy are they referring to and then further on in the letter they'll recommend several other pharmacies they can go to instead and we've had many of our members need to contact the PBM to say am I in the network, am I out of the network? They shouldn't be hearing from their patient whether they may be in or out.

ASSEMBLY MEMBER CAHILL: Right.

MS. FEBRAIO: What typically happens is they're not out but the patient thinks they are. They then have to go on an educational campaign with to retain their patients based on an incomplete letter, incomplete information and we just find that this is a standard tactic that they use.

ASSEMBLY MEMBER CAHILL: So, the nature of independent retail pharmacies is changing as well. I mean we certainly know that--

MS. FEBRAIO: Correct.

ASSEMBLY MEMBER CAHILL: CVS took cigarettes out but they still sell Tide. When I my first exposure and I think the first exposure of most people my age to a pharmacy was that's where you made and you had a soda fountain and that would be how we would go there and, you know, the pharmacist would be over in his or her booth probably his booth at the time, but there would be somebody else who would provide at the soda fountain maybe a banana split or something. Most of your entities I'm guessing don't have soda fountains anymore although I do know of one and I highly recommend people go visit it. Are there -- is there an evolution in terms of what a pharmacy is offering or are there retail clinic equivalents in the independent pharmacy world to the Minute Clinic that CVS touts?

MS. FEBRAIO: Well, what a lot of pharmacies are doing now is exploring the

possibility of clinically integrated networks and that means that multiple local pharmacies can group together under another entity and offer services to patients so they may decide that they are going to do adherence programs for diabetes patients in much the way CVS explained but by doing so collectively they can go to payers and to healthcare, other healthcare providers and offer more access and more exposure to patients in a larger geographic area. So, independent pharmacy is absolutely evolving and there are very entrepreneurial. There we do have a pharmacy who offers a farmer's market within his pharmacy providing the wellness of appropriate nutrition along with medications. We find that there are very unique situations and they're trying to keep up with the times and service their patient and provide unique services and ironically in the last couple of weeks we started to hear from some of our members that they're seeing contracts from PBM's that are telling them you can only do delivery to 10 percent of your patients. Who are they to tell them they can't

deliver to their patients? But that's an entity, that's a piece of the business that PBM or a PBM who owns a retail outlet or a mail order outlet wants to take over so they start to put these entities are trying to survive in a uphill battle and every time they take a step forward or do something unique, the PBM tries to take it back. Every time this body tries to pass legislation, they come up with a new business process that works itself around it. You have a MAC appeal law in place which we greatly appreciate. It gives a pharmacy the ability to appeal an underwater reimbursement on a generic drug. Many states have been passing these bills. Well, now PBM contracts are moving towards what are called generic effective rates which means if within your book of business, you don't have a certain percentage of generics dispensed, sometime based on volume, sometimes based on dollar value, then we're going to take money back from you and you're MAC appeal law is useless because you can appeal all you want. They can even give you money back but at the end of the quarter if you

didn't make that meet that effective rate in your contract, they're taking money back again. And this is what they do. We push and push and get legislation passed and then they just have people because it's happening in so many different states and they're watching and they're waiting. They're to move as soon as it hits a critical point to their business.

ASSEMBLY MEMBER CAHILL: I won't ask too many more questions cause its getting late and we have many more, we have two more witnesses after you. Do you have any suggestions on what we should be considering legislatively in view of the potential of a vertically integrated healthcare/health insurance delivery system or are there any other changes that you would recommend at this particular time that we should be considering legislatively with or without this merger taking place?

MS. FEBRAIO: We firmly believe in the regulation of the pharmacy benefit managers. You're taking an entity that exists today with minimal or no regulation, incorporating them into

another entity where even more curtains can be pulled across and less can be seen so we believe that is absolutely necessary and to enforce any other existing laws that you've created to have a place to go when those laws are not being followed.

ASSEMBLY MEMBER CAHILL: Just on a side question. Is the independent pharmacy industry expanding, contracting, changing, or staying the same?

MS. FEBRAIO: It's staying the same in number of stores but as I've explained their financial health is deteriorating.

ASSEMBLY MEMBER CAHILL: Is the location of independent pharmacies different than it used to be? It used to be on Main Street.

MS. FEBRAIO: They are in a wide variety of places and different geographies, different needs and that's where they are.

ASSEMBLY MEMBER CAHILL: I've seen the emergence of independent pharmacies in sort of health centered buildings, complexes that have been built for the purposes of providing one stop

shopping for all kinds of healthcare with related or unrelated entities and that's where independent pharmacies have been coming up. I've also seen some independent pharmacies pop up in underserved communities but then disappear just as quickly as they popped up. I'm not quite sure what that phenomenon is about. But I can tell you for sure that no new pharmacies have opened in my community that have soda fountains so.

MS. FEBRAIO: Correct.

ASSEMBLY MEMBER CAHILL: So, thanks so much for your testimony.

MS. FEBRAIO: Thank you.

ASSEMBLY MEMBER CAHILL: John? Dick?

ASSEMBLY MEMBER GOTTFRIED: No. No. Phil?

ASSEMBLY MEMBER STECK: Yes. Maybe you can explain to me I'm not sure there's any known explanation for this but I'm enjoying this whole discussion of diabetes since they brought it up. It costs to buy without insurance FreeStyle Lite test strips 100 count about $60 online. I've seen it as high as $160 at CVS. Today, it's

$130. Why is it so much more expensive to buy it at CVS than simply getting the product online?

MS. FEBRAIO: I cannot speak to CVS's pricing policies, but I will caution you to make sure that your test strips are not black-market test strips that we've seen expanding considerably in the last several years.

ASSEMBLY MEMBER STECK: They are $50 from Canada.

MS. FEBRAIO: Talk to John McDonald. He can help you better understand the test. You picked one that's a little bit different than just your average medication. Test strips are a different animal and have some serious concerns about their sourcing.

ASSEMBLY MEMBER CAHILL: Are you done Phil? Thank you. Mr. McDonald.

ASSEMBLY MEMBER MCDONALD: Okay. There you go. I just want to actually you brought something up in your comments with Mr. Cahill I just wanted to follow up on. You mentioned how now there is a trend toward GER generic equivalency ratio, and just to be clarified so I

make sure they understand. Pharmacists aren't able to issue prescriptions, are they?

MS. FEBRAIO: They aren't able to?

ASSEMBLY MEMBER MCDONALD: They are not able to issue prescriptions.

MS. FEBRAIO: Correct.

ASSEMBLY MEMBER MCDONALD: So, if a doctor writes for a brand name, the pharmacist required to dispense the brand name. Correct?

MS. FEBRAIO: That is correct. Yes.

ASSEMBLY MEMBER MCDONALD: Okay. And this stuff tells into the whole MAC appeals which actually I have to say this this chart which I was referencing some of the pricing is very impressive because we got into a discussion with Melissa about the MAC pricing and the thousands of different schedules. So, when you had mentioned that to Member Cahill about how when a pharmacy as part of a PSEO net contracts that PSEO contracts with Caremark to provide prescriptions, does the pharmacy have any idea of what the MAC schedule is going to be or the MAC prices?

MS. FEBRAIO: Absolutely not. There's no specific reference to the list itself in the contracts other than what the parameters are for making changes as to when they can change them and so there's no -- you do not not know what you're going to be reimbursed when you sign that contract and it can change weekly as I believe CVS stated itself.

ASSEMBLY MEMBER MCDONALD: Conversely, brand names pretty much have a rough idea of what you're going to get reimbursed, what the discounts going to be and things like that?

MS. FEBRAIO: Sure. Yes.

ASSEMBLY MEMBER MCDONALD: So, when you look at GER, the average GER's run 80, 81 percent right now so that means 80 to 81 percent of every prescription dispensed should be a generic. So, would it be fair to say that most pharmacies on 80 to 81 percent of their prescriptions because they fall under MAC have no idea what they're going to get reimbursed every single day?

MS. FEBRAIO: Correct. Very good point.

ASSEMBLY MEMBER MCDONALD: Okay. Thank

you. Sir.

ASSEMBLY MEMBER CAHILL: Well, thank you very much for your testimony. We appreciate you coming here today and we may have some additional questions. We'll put them, we'll get them to you as quickly as we can. If you could respond completely, accurately, and quickly that would be our request.

MS. FEBRAIO: Absolutely. Thank you very much.

ASSEMBLY MEMBER CAHILL: Thank you so very much. Thank you. Because we're switching panels here I thought it would be appropriate to find out if the Department of Health or the Department of Financial Services has decided to participate with the other branch of government or if they are solely responsible to themselves. We should remember when it comes budget time that they don't think they need us and we should remember that when it comes time when they want to have reason to have testimony here maybe to plant a story in the New York Times so is anybody here from the Department of Health or the

Department of Financial Services? Hearing no one I would like to invite our next group down. We have a panel of consumer representatives. Chuck Bell, the Program Director for Consumers Union and Amanda Dunker, Policy Associate with Community Service Society of New York. Folks I will remind you that although we are not swearing you in, your testimony is expected to be truthful and that it is in fact under oath. And that we may have some additional questions for you afterwards and if you would be kind enough to agree to provide a complete, accurate, and timely response of those questions, we'd be very appreciative. So, and thank you for taking your time to come here today. Who wants to start?

AMANDA DUNKER, POLICY ASSOCIATE, COMMUNITY SERVICE SOCIETY OF NEW YORK: Do you want me to go first? Okay. So, I am a Policy Associate with the Community Service Society of New York, but I'm submitting my testimony on behalf of the health.

ASSEMBLY MEMBER CAHILL: I'm having a great deal of trouble hearing you.

MS. DUNKER: Oh, sorry. I'll move the microphone closer. So, I'll be submitting testimony on behalf of the Healthcare for all the New York Coalition which is a statewide group of over 170 consumer organizations.

ASSEMBLY MEMBER CAHILL: Okay

MS. DUNKER: And I did submit written testimony as I came in. I apologize for not getting it to you ahead of time, but your offices do now have a copy of the written testimony.

ASSEMBLY MEMBER CAHILL: Uh-huh.

MS. DUNKER: So, I'll just run through four different concerns that we have. Some of them are things that have people have brought up earlier. So, the first concern that we have on behalf of consumers is that the merged company's insurance division will potentially have access to data of millions of consumers as the prices its rivals pay for perspiration drugs. As a pharmacy chain that has a PBM, it doesn't really present a lot of problems for the market that CVS has so much data on consumers. If CVS Caremark is allowed to absorb and run an insurance plan

without safeguards, they potentially will have an unfair market advantage by gaining access to information about it's competitor's pricing strategies. Generally, it's a huge problem in the healthcare market, but there is so little transparency about prices. As consumers, we advocate for greater transparency on prices at all levels of the healthcare market. So, a way to counteract any potential adverse effects from this situation where CVS Caremark Aetna has access to information about its rivals that they've told us again and again as a trade secret they closely guard that information. No one is allowed to see that information, we think that that could potentially be a benefit consumers if that in fact means that now everybody will have access to that information. So, if the merger is allowed to go through, we would like the federal government and the state to think about how we can impose regulations or legislation that would then loosen up that information to the public, not just to Aetna. A second concern that we have is that the merger could create new incentives

for Aetna to limit the providers as members may use. We heard earlier that, you know, they are saying right now their intention is not limit Aetna's members ability to use different pharmacies and different walk-in clinics. That intention that they have right now is not legally binging in any way and the benefit that the merger is supposed to have for their shareholders probably depends on their limiting Aetna's member's ability to use rival walk-in clinics and rival pharmacies. The way that insurance companies do that is by imposing financial penalties on consumers and so we are concerned that this merger will create a new network problem for consumers to navigate. As we've discussed earlier during this hearing, navigating in and out of network providers is a huge issue for consumers in New York. It's very challenging. It's very disruptive. The provider networks change a lot even in the middle of the year. We're very concerned about this new angle through which an insurance company like Aetna would be able to impose limits on the providers

that its members use. A third concern we have which could have both positive and negative effects actually so in the area of pharmacy benefit managers, we think the effects of a merger like this is unpredictable. So, insurers higher PBM's in part to negotiate with drug manufactures. They negotiate with those manufacturers for rebates. This creates an incentive for them to accept high prices because the higher the prices they accept to start with the bigger the rebates they can negotiate and the public and even the insurance companies that hire these PBM's do not have good information about the size of those rebates and how much of the rebate that the PBM actually keeps for itself. So, the merger between Aetna and CVS because of the Caremark PBM that CVS owns and operates it removes some competition from the PBM marketplace. That competition could be a force for alleviating some of that incentive that the PBM's have to accept higher prices because of course Aetna right now can say Caremark you are not doing a good job giving us good prices. We

are not getting good value from this service we've hired you to provide and we're going to go with somebody else or we're going to create our own PBM. The question is whether competition in the PBM market actually can exert that discipline over the PBM's because the PBM market is already so consolidated. So, there's only really three big PBM's. Caremark is either the biggest or the second biggest. It's about 25 percent of the market nationally. I don't know this loss of competition from Caremark and CVS now owning Aetna would have such a big effect that we would expect to see price changes. What it could do is be an example of insurance companies moving away from this model of external PBM's which actually could be beneficial to consumers. It is not clear at all that the existence of external PBM's to manage these rebates and pharmacy benefits is beneficial to insurers or to consumers and a lot of experts believe that they're the cause of rising prices. They are at the very least it's unlikely that they're helping keep prices down. So, this change where the insurance company and

the PBM are one in the same are not sure what effect it would have because there are so many problems already with a PBM market. We don't think this change would have a huge effect. Our final concern with the merger is has to do with the medical loss ratio requirements. Medical loss ratio requirements are imposed federally and New York State also has its own medical loss ratio requirement. The ratio is a limit on how much of its revenue an insurer can spend on anything other than medical care. So, it's a way that insuring premium increases are tied to actual costs of care and not just profits or things like advertising or high administrative costs. The structure of the medical loss ratio already creates some incentives for insurers to create higher prices because it's a ratio so if the entire pie gets bigger, you know, they are still only keeping 15 percent for profit and administration but you know the pie is bigger so that 15 percent is bigger. However, we do believe in the medical loss ratio has an important consumer protection and a merger

between a provider such as the Minute Clinics and the PBM adds insurers as 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. However, the medical loss ratio mechanism for keeping costs down would that those higher prices that they're paying that would be higher medical spending and so that would be allowable under the medical loss ratio. Even though no additional care would be provided to Aetna members, Aetna would be able to say that costs for medical services have gone up and thus their premiums would be allowed to rise. When there's a separation between providers and insurance companies, insurance companies play an important role in keeping prices down despite some shortfalls of the medical loss ratio strategy. If they were the same, that incentive and that relationship changes to the point where there's no reason for Aetna anymore to negotiate lower prices with CVS or its Minute Clinic providers because all of the profits are going to

the same corporate entity regardless. So, in closing, I'd just like to thank both of the Committees for holding this hearing. We feel really strongly that public discussions like this are the best way for us to protect consumers. It is disappointing that more representatives from the government did not come, but we feel that this hearing is a good start and we hope that there will be more opportunities like this for public discussion on such an important issue.

ASSEMBLY MEMBER CAHILL: I'm sorry. I didn't hear that last thing you were just saying. No, I heard. Thank you so much. Chuck?

CHUCK BELL, PROGRAMS DIRECTOR, CONSUMERS UNION: Hi. I'm Chuck Bell, Programs Director for Consumers Union based in Yonkers, New York. We're the house division of Consumer Reports. Chairman Gottfried, Chairman Cahill thank you so much for having this hearing. I have about 25 minutes worth of material in my statement, but I will summarize. We share a lot of the concerns about the potential economic damage to consumers that could be caused by this merger and Consumers

Union has been a strong supporter of active antitrust enforcement to promote and preserve competition in all parts of the healthcare marketplace and so for example, we've supported antitrust enforcement relating to hospitals, medical practices, health insurers, and drug manufacturers. We've also called for greater transparency and oversight of PBM's. So, a merger between CVS and Aetna will have a major impact in every part of the healthcare marketplace. We've heard this morning how they have a foot in the door with their clinics, their walk-in clinics. They have like an equivalent of a steel-toe boot in the door with CVS Caremark PBM and so combining these two giants together will create an even bigger giant and will combine them into a new corporate structure straddling more market sectors and creating new and potentially far reaching profit maximizing incentives so that what did not make business sense for them separately, now makes sense for them as a combined enterprise. And, you know, to the extent that these incentives do drive

positive efficiencies, those could potentially be good for consumers and good for the overall economy and these are the parts of the proposal that Aetna and CVS will absolutely highlight. But we have seen in experience and my testimony goes on to some length to say that a lot of times these efficiencies are not passed along to consumers in communities partly because healthcare is a broken market in may respects and we don't have competition, we don't have price transparency. A lot of times those gains of any efficiencies are going to go upstream to the investors and owners of the merged company. And then another problem is sometimes the efficiencies will be implemented on the back of consumers by reducing customer service, reducing competition and choice and so for us an overriding issue really is this issues of competition, choice, and cost and we have the most expensive healthcare system in the world as you know and it's getting more expensive all the time and we're not starting from zero when it comes to healthcare goliaths. The market share

for the four largest insurance companies in the United States which include Aetna and Cigna went from 74 percent in 2006 to 83 percent in 2014. And similar the three big PBM's have, you know, 75 to 80 percent of the market. We also have Cigna and Express Scripts another big PBM merging. We already have the existing combination of United and Optum which is merged so as the American Antitrust Institute has pointed out, you will have three payer PBM organizations that could have significant control over our marketplace so this would be a pretty unprecedented situation if it moved forward. So, we support an extremely thorough investigation by the Department of Justice. We don't presume that this transaction is at all in the public interest and we want them to, you know, engage in vigorous discovery and get the facts and make sure that consumers would not be harmed. And the similar thing is, you know, at the State level we want the Department of Financial Services and the Department of Health to do everything they can to scrutinize the transaction and use the full

extent of their power to either block it or impose condition, appropriate regulatory conditions that are consistent with their authority. They have done this type of thing in the past with the Anthem Cigna merger in particular. They took an active interest in that and so we know it's possible for them to do it. But the threshold question for us is really the national concern that this would have a major impact on consumers' ability to access affordable healthcare. They would have less ability to vote with their feet and go to another health plan and shopping for health plans is something that consumers do. They look at the costs and services provided by different health insurance companies. It's a little easier to do that than it is with prescription drugs. And so, any diminishment of competition in that area could be very damaging. New York has had more competition than many other states that have just one or two plans. And I wanted to also just point out that we conduct regular surveys of retail pharmacies at Consumer Reports and we conducted one in April

called Shop Around for Lower Drug Prices. We conducted a secret shopper survey of 150 pharmacies in six metro areas nationwide and we found the cost of the standard market basket of five commonly prescribed drugs was the highest at CVS at a rate of $928 as opposed to $866 at Rite-Aid and about $750 at Walgreens, $66 on an online pharmacy, $105 at Costco and $107 at independent individual pharmacies so just from that small marketplace sample, you can see this is a company that offers very high retail drug prices that are paid by some people who are uninsured and not able necessarily to get the benefit of discounts. So, for these reasons, you know, we hope that this merger will get extensive scrutiny both from the federal regulators and from the state regulators and so we are happy to keep working with you as it moves forward and I will continue to submit our concern to New York State agencies.

ASSEMBLY MEMBER CAHILL: Thank your panelists. Very enlightening both of your testimonies. Really important to hear from you the folks who often times are purported to be

represented by other entities. Sometimes the insurance companies come in and tell us how they are the advocates for the consumer. Sometimes the medical profession comes in and tells us that. Certainly, the hospitals tell us that but truth of the matter is you're your own advocates and you do a great job. One of the things that we've heard time and again is that this merger will reduce costs. The implication is that that will reduce the cost to the consumer. Is there any evidence that in the past when there has been integration either with or a merger where one company acquired another or where a business changed their line of business such as CVS acquiring Caremark that those costs have been passed on to consumers?

MR. BELL: You know, there are I mean I think the short answer is yes, there have been some particularly vertical mergers that have delivered benefits to consumers not necessarily in the healthcare sector as much but typically, you know, people and antitrust regulators are much more concerned about horizontal mergers.

For example, when Anthem and Cigna or Aetna and Humana tried to combine, I think though there is new thinking about the problems of vertical mergers because what you have is companies that are using a foothold in one or more markets or two or more markets as a springboard to achieve leverage in those other markets and so there's been a number of vertical mergers particular telecom mergers that have been rejected by antitrust regulators and so we don't presume there are people who say that these generally have positive benefits and the problem is I think a little bit too that with it's hard to dismiss completely the idea of disruptive innovation in the healthcare sector because we do lack coordination. We lack high touch with patients. Many existing practices don't have convenient hours. You know, we have all kinds of issues that are not really being addressed by the current delivery system and delivery reform that was started or regenerated. You know, a couple of years back under the Obama administration is stalling and slowing down and so we're not

changing the healthcare system fast enough to deliver the value that consumers need but going the other way on that though I think we're extremely worried about corporate consolidation. We've had a lot of consolidation of hospitals and physician practices. We have more and more of the healthcare system that is going into investor owned hands and I think its hard to be confident that that those big goliaths are going to be overseen effectively either by New York State or the federal government. It's difficult to have any type of effective regulatory oversight these days with the Congress voting to overturn eminently sensible rules that were developed by federal agencies. And you also get to this question of should these large healthcare companies have some types of public service obligations similar to what utilities have. I mean you raise the issue of should a large merged company if you only have four companies dominating 80 to 90 percent of the health insurance market nationally, should they have some obligation to participate in individual

marketplace or in Medicaid or Medicare and so I think these questions will come to the floor more and more cause this dynamic of large financial capital coming into healthcare is a long-term challenge that we face in New York State.

ASSEMBLY MEMBER CAHILL: It's interesting your comments are in one hand sort of fatalistic like this is going to happen and if it's going to happen we should be prepared in a way that's different than we are today; however, it appears that the federal level at least it's going in the exact opposite direction that it should happen if there's going to be "marketplace" solution that it has integration or merger as part of its -- one of its key components. Do you think it's inevitable?

MR. BELL: No. No. I what I'm saying is I think that the financial pressure from investor owned companies it's an atmospheric condition. It's a reality and I think, you know, there are companies outside the healthcare space that see that it is not operating at the peak of efficiency and that there's a lot of built in

inefficiency. Now whether they have a solution or not is something we have to examine very carefully. But for example, I've seen that Amazon is applying for pharmacy licenses in a number of states so we may see more things like that. I think the state is right to scrutinize and try to be prepared and develop more analytical capacity actually to watch out for these things and figure out how we are going to respond.

ASSEMBLY MEMBER CAHILL: So, in this without calling it an inevitability just a very fertile area for this to occur, I mean you take nearly one out of every five dollars in the economy, you know, Willy said it best. Why do we go to rob banks, because that's where the money is, right? And healthcare is where the money is and people -- entities are gravitating toward that industry seems to get as much of that pie as they possibly can. Not suggesting that that's the only motivation but certainly if you're a shareholder owned company that has publicly traded and your first and primary fiduciary

obligation is the generation of profits then it be silly to dismiss that as one of the motivations. The economies that can be brought about I think I read in your written testimony there is some concern that not all the economies are going to come from improving outcomes. Can you elaborate on that a little bit?

MR. BELL: What I think it comes down to, you know, a fact-based investigation the Department of Justice will do because they will as we point out they will look at the number of clinic locations. They will look at what are the impacts of Aetna merging with a PBM rather than creating its own PBM. You know, as a large insurer Aetna would have actually the opportunity to bring more competition in that horizontal marketplace and that would be given up if the merger takes place so they need to look, you know, closely at these different specific issues of, you know, where are the metropolitan markets that are most affected, how much, you know, some states like New York have more insurance competition than others so there's a lot of

issues that they have to drill down through and it's actually pretty hard as an outsider. We have, you know, what Wall Street analysts tell us, you have sometimes consultants generate when they, you know, consultants work for the merging company and they create all kinds of business plan documents and suggests there's all kind of efficiencies, but the regulators really have to delve into that and kick the tires and investigate the factual basis for those things.

ASSEMBLY MEMBER CAHILL: Ms. Dunker, you raised a couple of very interesting points. One in particular that I'd not really considered and that is the potential manipulation of the MLR, the medical loss ratio. That is, you know, it's an awkward way of saying the amount of money that an insurance policy goes to actually pay for healthcare. At least it is now right?

MS. DUNKER: Uh-huh.

ASSEMBLY MEMBER CAHILL: Because there is a wall between that 80 some percent and Aetna 100 percent. What are some of the concerns about how the MLR can be manipulated?

MS. DUNKER: Well, so if you take the example of the Minute Clinic or a pharmacist at CVS so, you know, they talked about medication management has a new service that for some reason they feel they need to merge to provide. But anything, any rate that they pay to a pharmacist for something like medical medication management would go on the medical side of the ledger, right? So, if they raised that rate that they are paying to their own CVS pharmacist really high, well then, you know, they are able to tell New York State's regulators, medical costs went up a lot this year for some reason. DFS, the public we don't have information about the rates that they pay individual providers. We have no way to see what they are paying their own providers versus other providers. So, they would be able to raise the rates that they're paying to their clinics or their pharmacist say that medical costs have gone up because they are paying more for medical costs, but they are paying more for medical costs to themselves because they only use clinics and these

pharmacies.

ASSEMBLY MEMBER CAHILL: So, the wall comes down. Just a question for the two of you and you can add if you would be kind enough to answer individually, what if any legislative changes should we enact in New York State to prepare for the contingency, not just the CVS Aetna possibility but all of the mergers and all of the discussions that are taking place for consolidation in the health industry? Is there any specific legislation we should pursue? Is there any recommendation you have for the regulators because I know they're not here but somebody's going to tell them that we talked about them today and be great for them to great for us to tell them that we also had some suggestions for them?

MS. DUNKER: Sure. I have two thoughts -- oh sorry.

MR. BELL: Go ahead.

MS. DUNKER: So, I think first our prior approval like our rate review process we're really happy about the fact that we have a public

prior approval law in New York so I think that's one avenue through which the State could think about coming up with some proactive ways to head off the problems we've talked about today. Rate review is something that I've done for a few years and a problem we see every year is that the applications either I think that they follow the law probably to the letter but not the spirit. I don't think that the public for example are community groups that we help write letters in response to the rate applications gets enough information in those applications to really understand what's going on with the rates. So, I would say that starting by looking at our rate review and our prior approval law and seeing if there's a way where we could extract better information from those insurance companies and those rate applications is a good start and I would say particularly, you know, if this Aetna CVS merger goes through Aetna will deserve special scrutiny the next time it asks to increase rates in New York. And another bucket I think of solutions would be better network

regulations and, you know, that's something we talked about not just with regards to this merger but overall. I think it's the biggest problem that consumers have is that it's too hard to navigate their networks. At the very, very least, I wish that New York could have either a law or better regulations that would hold insurance companies accountable for giving people correct information about networks. Right now, it is very easy for consumers to go to their own provider because they got the wrong information off of the insurance website or from the provider and while our surprise bill law does help consumers sometimes with that situation, it does not always help them and so I think that insurance companies can provide better information to consumers and that New York should start making them do that.

ASSEMBLY MEMBER CAHILL: You think we should more strenuously regulate network adequacy?

MS. DUNKER: We do but, you know--

ASSEMBLY MEMBER CAHILL: I know you

talked about accuracy.

MS. DUNKER: Even better information would be a good start but yes we do think that there should be stronger regulations about networks. We would like people to have more out of network options. We -- networks are a huge problem from start to finish.

ASSEMBLY MEMBER CAHILL: From the consumer perspective if you can just briefly state the concerns over data and the privacy of that data and the use of that data by an integrated entity.

MS. DUNKER: Uh-huh. I mean I think the examples some of the Assembly Members have brought up today that are particularly egregious are good examples of what can happen where, you know, you want to fill your prescription at one pharmacy and then you get a phone call somehow from another pharmacy and you're getting sales calls at your house. You know, they aren't supposed to do that but they do as was said earlier. With HIPAA, I'm sure that CVS and Aetna will follow HIPAA as much, you know, to the best

of their abilities, but even, you know, the most consumer friendly organizations sometimes have HIPAA breaches. It's just a matter of technology, you know, changing all the time and it's very easy for privacy breaches to occur and the more data that's aggregated to one entity, the more serious the repercussions of those data breaches are.

ASSEMBLY MEMBER CAHILL: Thanks. Chuck, you have anything?

MR. BELL: Yeah. I just wanted to build on the point that Amanda made that I think we should probably hear from the DFS whether they have adequate existing authority to investigate an issue such as the use of money for health claims where you are referring people to your own facilities for immunizations or tests or treatment. How would we disentangle the Aetna's or the merged company's involvement in sending people to their own provider network versus the broader provider network and so I think that's something that in California we testified that the State should take a more active role in

making sure that we're disentangling those two things?

ASSEMBLY MEMBER CAHILL: Let me ask you. You said you testified in California. What was the forum?

MR. BELL: Well we submitted comments to the Department of Managed Care. It's actually in my footnote number two.

ASSEMBLY MEMBER CAHILL: Department of Managed Care in California and they conducted a hearing on the CVS Aetna merger?

MR. BELL: Yes. Yes. They basically saying we want to make sure that the medical loss ratios are going to be valid and not skewed by these types of activities so that could potentially be imposed as a condition of the merger, but we're concerned at Consumers Union that the overall impact of the merger being maybe so negative that whatever conditions the State imposes are not going to really be very protective of consumers. So, for us the threshold question is whether it's in the public interest to begin with.

ASSEMBLY MEMBER CAHILL: Too big to regulate?

MR. BELL: Yeah.

ASSEMBLY MEMBER CAHILL: I don't know and I apologize if you mentioned PBM regulations.

MR. BELL: Yeah. I was going to add also PBM transparency and oversight I think that would be extremely worthwhile for the State. I mean there are many employers probably could get a better deal by going to buy their drugs at Costco or Walmart instead of buying them through their PBM. Because there's such a lack of transparency, employers don't know if they're getting a good deal and its also true, you know, that we don't know whether the State is getting a good deal so I think it would be very important to expand State's oversight over those issues.

ASSEMBLY MEMBER GOTTFRIED: Yeah. On the PBM question, you know, I've had a bill for a number of years which has occasionally passed the Assembly to require a fiduciary relationship between a PBM and its health plan clients and provide for transparency and like. We just

introduced a second bill that has those PBM provisions plus a licensure provision. But it occurs to me that, you know, fiduciary relationship and transparency starts to lose its meaning when the insurance company that is nominally the client of the PBM is actually the sibling of the PBM and so you're -- you've got, when you've got that built in conflict of interest transparency kind of loses its productive value.

MR. BELL: Right. I think yeah. I think it's also extremely challenging as a political matter because these are entities with formidable lobbying power stop a bill--

ASSEMBLY MEMBER GOTTFRIED: Yeah.

MR. BELL: Like that and so there is a concern with the high level of concentration in the PBM industry itself that they're going to make it impossible for other entities to come in and compete with them and they make kind of create a race to the bottom by eroding the formularies and choices that consumers have because they can get away with it and they have

the economic power to do that. One other point would be I think it's important for the Assembly and the Senate like whenever we have issues related to antitrust and potential healthcare consolidation to invite the views of the public and to try to be very cautious about clearing a pathway to further consolation and one example of that is the authorization of Fidelis to convert to a for-profit health insurance company because now they can become a target for acquisition by some large out of state insurer. Maybe not immediately.

ASSEMBLY MEMBER GOTTFRIED: Uh-huh.

MR. BELL: But in three to five years or seven years and then we'll have even more consolidation of insurance companies in the United States so that would be an example where I wish we would have had the opportunity to have public hearings and more regulatory scrutiny before that--

ASSEMBLY MEMBER GOTTFRIED: Uh-huh.

MR. BELL: Transaction was approved.

ASSEMBLY MEMBER GOTTFRIED: Thank you.

ASSEMBLY MEMBER HUNTER: I just have a quick comment and it seems with your background as far as consumer advocacy and, you know, I've listened to all the testimony today and it seems like a good chunk of the population of the people in New York State this is not anywhere near what they will ever be able to access and so while we heard communication relative to wanting to make it easier and access and affordable, I feel like we need to be honest in saying it's for all of the people who can pay for that because a huge portion of people in New York and I can say specifically where I live this is not something that's going to be accessible for them and while we've had conversations about Minute Clinics for several years here in the Assembly, it's always relating to episodic care relative to a bee sting or a flu shot which you can get those at pharmacies right now and, you know, we hear well data tells us and analytics tells us and we know by zip code well we should know then by all that data and analytics that and by zip code usage that episodic care in an impoverished

neighborhood is not the same episodic care in Westchester. You can't replicate the same model and expect the same result and so when you're talking about community outreach and education and all the other, you know, coupled things that, you know, happen as far as universal care for people, doesn't provide me comfort knowing that a foundation handles the access, you know, for the community engagement as part of the kind of the foundational process of the organization. Not the stakeholder but, you know, we put some money away and it makes us to feel good to go and, you know, talk to the poor people about, you know, stopping smoking. That's not going to be acceptable quite frankly, but if that's what we're really talking about and if that's what we're going to do then we should just say it but I think, you know, relative to what you can be helpful, you know, doing relative to this, you know, this is the federal government and we can puts on the AG's office and the DOH and DFS and say come and talk to us and move this forward and the federal government could, you know, go

forward and do whatever they're doing, you know, right now is that, you know, where you are at grassroots level I think more people need to understand how this impacts them in their everyday life because we're talking up here and that's not where it reaches people. When you're having stories of John's mother and Phil's diabetes, you know, that's like real and so I just feel like if there's a way that you all in your capacity as the consumer advocates are able to get this information out there to them in a more, you know, realistic way how you can touch them I think I would ask for you to be able to do that. Thank you.

MR. BELL: No. Absolutely. I very much agree and I think we've been concerned, you know, even pharmacies are not present in many low-income neighborhoods as Chairman Cahill was pointing out, but I think this is also should be seen as a wake-up call for the mainstream healthcare system where many institutions don't have convenient hours and they're not present in low income and minority communities. We have our

federally health qualified health centers, but I think that the economic problems created by the merger will very much be felt by low income working class people all across New York State so it is very important to tend to them for that reason.

ASSEMBLY MEMBER CAHILL: I have one follow up and that is have either of your organizations or your coalition any members of those organizations been called upon by the Department of Health or the Department of Insurance to discuss the CVS merger?

MS. DUNKER: Not to my knowledge.

MR. BELL: Yeah. Not at this point.

ASSEMBLY MEMBER CAHILL: Thank you. I have a tradition when I conduct a hearing is that the last witnesses get to pick from some treats that I have. Now I have to apologize in advance. We picked the M&M Mars Company and the Hershey Company which together in spite of the recognizability of their name do not represent 40 percent of the market share of candy in the United States. However, we sent our staffer to a

CVS and this was not the only candy they had to offer. It was just the easiest candy to get. It was right there at the register when you walked in the door so I offer you your choice of M&M's, Reese's Pieces or a Snickers bar for enduring the testimony of others and being the last people to testify here today and I thank you very much for your testimony.

ASSEMBLY MEMBER GOTTFRIED: But no beef jerky.

ASSEMBLY MEMBER CAHILL: No beef jerky.

MR. BELL: Thank you so much.

ASSEMBLY MEMBER CAHILL: Thank you. That concludes the hearing -- well before we conclude because it's entirely possible that maybe the Department of Financial Services and the Department of Health is not afraid of the State Legislature and is here prepared to testify. So, I'd like to give the Department of Financial Services and the Department of Health an opportunity to come forward and offer their testimony and their reassurance that they're on top of this in advance that they are not waiting

for a merger to come to New York and then react to it by trying to make up for lost time. Is anybody from the Department Financial Services here to testify? Anybody from the Department of Health here to testify?

ASSEMBLY MEMBER GOTTFRIED: But if they were here they'd get the candy.

ASSEMBLY MEMBER CAHILL: If they were, we would have a -- they would get a Snickers bar. Well, thank you so much and I thank you all for your patience. That concludes this hearing.

(The public hearing concluded)

CERTIFICATE OF ACCURACY

I, Julia Zappi, certify that the foregoing transcript of the Committees on Insurance and Health on June 4, 2018 was prepared using the required transcription equipment and is a true and accurate record of the proceedings.

Certified By

Date: June 21, 2018

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