June 25, 2021

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: **Pharmaceutical Task Force, Project No. P212900**

Dear Sir or Madam:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to submit this comment to the Pharmaceutical Task Force, Project No. P212900.

NCPA represents America's community pharmacists, including more than 21,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and LTC settings. Together, our members represent a $74 billion health care marketplace, employ approximately 250,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America's most accessible health care providers, often serving as the only pharmacy in many rural and urban medically underserved areas. NCPA is uniquely positioned to understand the complexities and impact permissive antitrust enforcement has had on the healthcare sector.

NCPA and its members are directly impacted by the wave of consolidation that is transforming the U.S. healthcare system, which is now largely controlled by a dwindling number of vertically integrated for-profit companies. Several of these companies have affiliated pharmacy benefit managers (PBM) which handle pharmacy services for insurance plans. The PBMs are tasked with managing pharmacy reimbursement and establishing the drugs that are available under a plan. These vertically integrated entities engage in business practices which put our members and consumers at an economic disadvantage. NCPA believes that this consolidation, and the resulting impact on patients, demands vigorous antitrust enforcement, including for anticompetitive vertical transactions that have largely evaded scrutiny in recent years. NCPA submits this comment in regard to the appropriate general questions presented in the request for public comment.

I. U.S. Agencies with Enforcement Authority on The Task Force Should Consider Vertical Integrated Mergers Have Led to Decreased Competition

Over the past several decades, the U.S. healthcare system has undergone a transformational reorganization, with a small number of vertically integrated for-profit businesses now exerting

extraordinary influence on the quality of care that our most vulnerable populations receive. In the pharmacy sector, the three largest PBMs now control 77% of the market.[1] And each of these PBMs have merged with other, equally powerful companies in the healthcare value chain. In the past two years alone, CVS Caremark, which was already both the single largest pharmacy chain in the country and the second largest PBM acquired Aetna, the third-largest health insurance company in the country. Express Scripts, the largest PBM, was acquired by Cigna, another of the so-called "big-five" health insurers. Additionally, OptumRx is already affiliated with UnitedHealthcare, the single largest health insurer in the country. This surge in vertical consolidation has essentially created an oligopoly of integrated healthcare companies controlling nearly all aspects of healthcare. As one healthcare antitrust scholar observed, "the nation is only a few mergers away from having a very small contingent of vertically integrated middlemen responsible for insurance, benefit structure, and provider contracting across the entirety of public and private health care in the United States."[2]

Amid this rapid and accelerating consolidation, the federal antitrust agencies have focused their enforcement efforts almost exclusively on *horizontal* theories of harm – anticompetitive effects flowing from the loss of direct, head-to-head competition between the merging parties. For example, the U.S. Department of Justice (DOJ) successfully challenged the proposed mergers between four of the "big five" health insurers.[3] And the Federal Trade Commission (FTC) has brought a series of enforcement actions challenging proposed mergers and acquisitions involving hospitals, physician groups, pharmaceutical companies, medical device manufacturers, and other healthcare organizations.

At the same time, both agencies have consistently declined to exercise their antitrust enforcement authority over equally anticompetitive transactions involving primarily *vertical* combinations of large and dominant healthcare organizations. Indeed, even in mergers with significant vertical components, the agencies have limited their enforcement actions to the narrow horizontal aspects of those transactions. In CVS/Aetna, for example, the Department of Justice challenged only the combination of the companies' Medicare Part D prescription drug plans, failing to take any action to remedy anticompetitive effects stemming from the combination of a dominant pharmacy chain and PBM with one of the country's largest health insurers.[4] And the FTC cleared Cigna's acquisition of Express Scripts without requiring *any* relief.

As NCPA has emphasized in other communications during the review of these mergers, these and other major transactions are likely to cause serious anticompetitive effects, particularly for the

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[1] Fein, Adam. "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation." Drug Channels. April 6, 2021. https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html

[2] Thomas L. Greaney, "Navigating the Backwater: Vertical Mergers in Healthcare," CPI Antitrust Chronicle at 3 (May 2019).

[3] *See United States v. Anthem, Inc.*, 236 F. Supp.3d 171, 178-79 (D.D.C. 2017), *aff'd* 855 F.3d 345, 349 (D.C. Cir. 2017) (enjoining the merger of Anthem and Cigna following a challenge by the Department of Justice); *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 99 (D.C. Cir. 207) (enjoining the merger of Aetna and Humana following a challenge by the Department of Justice).

[4] Complaint, *United States v. CVS Health Corp, and Aetna Inc.*, Doc . No. 1, 18-cv-02340, at 1-2 (D.D.C., Oct. 10, 2018) (alleging that the proposed merger of CVS and Aetna would substantially lessen competition between CVS and Aetna for Medicare Part D Prescription Drug Plans in 16 geographic regions). The FTC's healthcare merger enforcement efforts have also been laser-focused on horizontal mergers, to exclusion of potential vertical anticompetitive effects. *See, e.g.*,); *St. Alphonsus Med. Ctr. V. St. Luke's Health Sys. Ltd.*, 778 F.3d 775, 782 (9th Cir. 2015) (challenging a health system's acquisition of a leading independent medical group solely on horizontal grounds, despite private plaintiffs alleging vertical theories of anticompetitive harm).

most vulnerable patients living in underserved areas.[5] Like the DOJ, the FTC's healthcare merger enforcement efforts have also been laser-focused on horizontal mergers, to the exclusion of potential vertical anticompetitive effects.[6]

A growing body of research evidence, including from current and former agency officials, shows that vertical consolidation in healthcare has led to increased prices without offsetting improvements in quality.[7] As one recent literature review (focusing on evidence from hospital-physician vertical integration) explained, empirical evidence undermines the theoretical underpinnings for a laissez-faire approach to vertical merger enforcement:

> Rapid consolidation in health care markets has sparked renewed interest in understanding the effects of vertical integration. . . . [W]hile neoclassical economic theory suggests that vertical integration in most circumstances cannot increase prices, alternative theories suggest integration may serve as a vehicle for firms to achieve competitive advantages and foreclose rival competition. . . . [T]he literature we reviewed finds that *vertical integration generates higher prices, higher spending, and ambiguous changes in quality*.[8]

While the empirical evidence, research, and data is most well developed for vertical integration among healthcare providers, the reality is that nearly all aspects of the U.S. healthcare system exhibit high and increasing levels of concentration. A dwindling number of vertically integrated companies now dominate virtually every level of the healthcare sector: the three largest PBMs collectively control approximately 80% of the market;[9] the two largest pharmacy chains

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[5] *See, e.g.*, NCPA CVS /Aetna Comment at 3; National Community Pharmacists Association Statement for the Record, United States House Subcommittee on Antitrust, Commercial, and Administrative Law Hearing: "Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets," at 1 (March 7, 2019) [hereinafter "NCPA House Statement"], available at: http://www.ncpa.co/pdf/ncpa-statement-healthcare-consolidation.pdf; Letter from Ronna Hauser to the Federal Trade Commission Regarding Comments to the Federal Trade Commission's (FTC) 21st Century Hearings, Doc. ID: FTC-2018-0076 at 2-3 (Nov. 15, 2018) [hereinafter "NCPA 21st Century Competition Letter"], available at: https://www.ftc.gov/system/files/documents/public_comments/2018/11/ftc-2018-0076-d-0018-162492.pdf.

[6] In challenging the proposed acquisition of an independent medical medical group in Nampa, Idaho by the leading health system in the area, the FTC focused exclusively on a narrow horizontal overlap in adult primary care services without addressing potential vertical anticompetitive effects alleged by rival hospitals. *See, e.g., St. Alphonsus Med. Ctr.* 778 F.3d at 782.

[7] *See, e.g.*, Thomas G. Koch, Brett W. Wendling, Nathan E. Wilson, Fed, Trade Comm'n Bureau of Economics Working Paper No. 337, "The Effects of Physician and Hospital Integration on Medicare Beneficiaries Health Outcomes" at 5 (July 2018) (finding that "[o]verall. . . vertical integration rarely leads to better outcomes, and sometimes leads to worse outcomes . . . [these] results indicate that vertical integration is not associated with improvements in health, despite the fact that the literature has found it to be associated with increased expenditures"); Hannah T. Neprash and J. Michael McWilliams, "Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence," 82 Antitrust Law Journal No. 2 551, 553 (2019) (reviewing literature and finding that "[i]n total, the literature suggests that consolidation among healthcare providers, whether horizontal or vertical, does not, on average, result in welfare enhancing efficiencies."); *id.* at 577 (noting that researchers have yet to find conclusive evidence supporting claims that physician-hospital integration will consistently reduce redundant and wasteful care or improve quality through care coordination."); Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospoital Ownership of Physician Practices is Associated with Higher Prices and Spending," 33 Health Affairs No. 5, 756, 762 (2014) (finding that "hospital ownership of physician practices leads to higher prices and higher levels of hospital spending," and that "a one standard deviation increase in the market share of hospitals that own physician practices was associated with significant increases in prices and spending of 2-3%.").

[8] Brady Post et al, Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality, 75 Medical Care Research & Rev. 399, 418 (2018).

[9] Fein, Adam. "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation." Drug Channels. April 6, 2021. https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html

command a 50-70% share across the country's largest markets;[10] and the four largest commercial health insurers account for more than 80% of the country's commercial health insurance business, with the majority of local markets dominated by no more than two insurers controlling over 70% of the market.[11]

As one prominent healthcare antitrust scholar explains, this makes these markets especially vulnerable to anticompetitive transactions and conduct: "The health care sector . . . exhibits *textbook conditions of a market susceptible to consumer harm*. Provider, payer, pharmaceutical, insurance, and intermediary management markets exhibit key pre-conditions for harm from vertical mergers: Most are highly concentrated, exhibit durable barriers to entry, and have historically performed poorly."[12]

II. The Task Force Must Look to the Significant Impact Consolidation Has Had on Small Businesses and Consumer Pricing

Previous permitted mergers in the healthcare sector by the DOJ and FTC have negatively impacted community retail pharmacies throughout the United States. As companies in the healthcare sector vertically integrated – with the justification of economic benefit for the consumer – each merged entity has only increased its market power and influence. This consolidation and increased market power allows the entity to steer patients away from community pharmacies to large corporate pharmacies owned by the PBM by excluding community pharmacy from the preferred Medicare Part D networks.

That means that the millions of senior consumers who have chosen to fulfill their prescriptions at one of the 21,000 small businesses pharmacies must now pay a higher copay if they do not want to disrupt the relationship they have built with their pharmacists and their pharmacy staff. Seniors participating in these Part D plans are economically coerced to obtain their prescriptions from PBM owned chains.

In addition to disrupting a trusted, long-term relationship with a local pharmacist, seniors may have to travel long distances to avoid out-of-network or higher tier co-pays, or they are forced to use mail order pharmacies which frequently offer less specialized access or opportunities to communicate issues directly with the pharmacist. This behavior continues despite community pharmacies being consistently rated higher by consumers than large corporate pharmacies in independent consumer surveys.[13] This relationship disruption has never been so stark as during the pandemic when many seniors were self-quarantining and had fewer transportation options.

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[10] Thomas L. Greaney, The New Health Care Merger Wave: Does the 'Vertical Good' Maxim Apply?, 46 J. Law, Medicine & Ethics 918, 921 (2018).

[11] *Id.*; *see also* L. Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. on the Judiciary, 114 Cong. 5 (2015) *available at*: http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[12] Greaney, supra note 2 at 2 (emphasis added); *see also* Greaney, supra note 10 at 921.

[13] https://www.consumerreports.org/pharmacies/consumers-still-prefer-independent-pharmacies-consumer-reports-ratings-show/

In exercising their market dominance, PBMs offer community pharmacies "take it or leave it" contracts with low reimbursements that often do not cover ingredient cost and professional dispensing fees, while offering PBM-owned pharmacies a more advantageous deal. For example, CVS Caremark, operating as a PBM, was reimbursing their affiliate pharmacies, CVS retail pharmacy and CVS Specialty pharmacy, at higher rates for the same drug product than independent pharmacies.[14]

This double whammy of patient steering and low pharmacy reimbursement places community pharmacies at an unfair competitive disadvantage, drives up costs for consumers, and deprives patient choice for their Part D drugs. Ultimately, these community pharmacies suffer economically, which then the corporate pharmacy use as leverage to acquire the struggling community pharmacies and reduce competition in a particular market. **They reduce payments to pharmacies and then send a letter offering to buy that pharmacy due to economic difficulties**.[15] Not only does it deprive patients of a choice, it further augments market share for the PBM-owned pharmacy chain.

Because of these continuing behaviors by PBMs, there continues to be serious competitive concerns about these transactions which have not been addressed by the DOJ or the FTC to date, including the potential negative impact on patient costs, patient access, and quality of service. And while these mergers have been advertised to the public as creating efficiencies and reducing costs, rising drug costs continue to be an issue for patients – particularly seniors on Part D, who have to subsist on a fixed income.

In addition to the foregoing, anticompetitive vertical mergers in the healthcare industry can have dire consequences for patients and the healthcare providers these patients depend on. Vertical consolidation can harm competition in myriad ways, including:

- *Unfair and anticompetitive conflicts of interest*. Vertical integration of PBMs with pharmacy chains and other companies in the pharmaceutical supply chain create conflicts of interest ripe for anticompetitive conduct. Each of the largest PBMs own mail order pharmacies and specialty pharmacies. PBMs also contract with all other retail pharmacies to form pharmacy networks which compete with the PBM-owned pharmacies, but often with a lower reimbursement rate for non-affiliated pharmacies. PBMs regularly design plans, including plans with preferred networks, that require, coerce, or incentivize patients to use a PBM-owned pharmacy option over another retail pharmacy. This is especially true regarding the fast-growing area of so-called specialty drugs in which the three largest PBMs also control 62% ($109.5B) of the specialty pharmaceutical marketplace.[16] Moreover, when a PBM contracts with a retail pharmacy, PBMs have wide latitude in setting requirements for a pharmacy to be included in a network: the PBM determines how much the pharmacy will be reimbursed, which drugs will be covered on

[14] Arkansas Department of Insurance Limited Scope Examination of Pharmacy Benefit Manager (July 27.2020), https://ncpa.org/sites/default/files/2020-10/ark-doi-pbm-mmc-examination.pdf;
[15] Redacted CVS offer to purchase letter to community pharmacy owner

[16] https://www.drugchannels.net/2021/05/dcis-top-15-specialty-pharmacies-of.html

the plan formulary, the day supply that the pharmacy can dispense, the patient co-pay, and many other factors.

- *Anticompetitive exploitation of competitively sensitive information.* Because the major health insurers and PBMs necessarily have information on the reimbursement rates paid to pharmacies and other providers included in their networks, the vertical integration of competing providers creates the opportunity for this confidential information to be exploited to gain an unfair competitive advantage, which cannot be fully addressed through firewalls or other purported safeguards.

According to the report by the Florida Pharmacy Association and American Pharmacy Cooperative, Inc.,[17] patients are being herded to pharmacies owned by or affiliated with the PBMs. Conveniently, those pharmacies are authorized to dispense so-called specialty drugs, which are among the most expensive. In fact, the report shows that payments to these affiliated pharmacies "far exceed" the cost to dispense the drugs and that pricing policies are set differently, often to the advantage of affiliated pharmacies. The report exposes "many examples" of "how MCOs and PBMs appear to be using their control in managed care to incrementally shift dollars to their affiliated companies." For example:

- Average reimbursement for high margin generic drugs was $93.84 per claim versus $1.58 per claim on all other generics, disadvantaging those pharmacies not given access to the high margin drugs by the PBMs.

The experience of NCPA and its members confirms that vertical transactions that the agencies have cleared have caused significant anticompetitive effects, in these and other ways. Continued vertical healthcare consolidation could further impede competition and foreclose any meaningful entry into the market, leading to fewer choices and higher healthcare costs. For example, it is not uncommon for Medicare Part D ("Part D") sponsors and their PBMs to limit or deny access to local community pharmacies in their preferred networks. Instead, these networks are often limited to a smaller number of select pharmacies and regularly exclude community pharmacies even when such pharmacies are willing to accept the terms and conditions of a Part D sponsor's network. As a result, seniors' choice of pharmacy is limited and their access to quality care is hindered, especially in underserved areas. However, the opening of preferred networks to any willing pharmacy willing to participate on those terms does not necessarily mean costs will increase as increased competition will drive down prices.[18]

III. **The Task Force Needs to Study Pharmaceutical Rebate Harm**

The Centers for Medicare and Medicaid Services (CMS) grants Part D plan and PBMs significant latitude in designing their formularies, which is a list of the prescription drugs the plans will cover. There are few requirements mandated by law other than the required coverage of six protected

[17] https://cdn.ymaws.com/www.floridapharmacy.org/resource/resmgr/docs_2020_legislative_session/fl_master_master_5.0_delieve.pdf
[18] Eisenstadt, David M. "How H.R. 4577's Any Willing Pharmacy Provision Could Leave Drug Prices Unchanged." August 6, 2014.

classes and some procedural aspects about how a formulary must be designed. Otherwise, each Part D plan or PBM can design their formulary as they see fit.

Because placement on these formularies often drive patients to consume a particular drug, and therefore the economic success of that drug, PBMs know pharmaceutical manufacturers are coerced into offering rebates to PBMs to place their products on the PBM's list. These placements come at the expense of competing therapies and generics – which can be more economical for the patient. This creates a wall around a particular product – at the expense of the patient where they are forced to pay a greater share of the cost of the more expensive drug.[19] This is known as a "rebate wall."

In fact, the FTC report to Congress on PBM behaviors notes that rebate walls "may give payers strong incentives to block patient access to lower-priced medicines, whereas absent rebates a lower-priced equally effective product would tend to take sales from the higher priced incumbent product.[20]" There is no transparency into the rebating process and consumers and government authorities are left in the dark with the false promise they reduce premiums.[21]

Rebate driven games can wreak havoc on the costs for the patients – as the coinsurance is based upon the list price rather than net price of a drug – requiring seniors to pay more out of pocket for their prescriptions. Additionally, PBMs have an incentive to select higher priced drugs for their formulary in order to capture greater rebates at the expense of less expensive competing drugs and therapies or generics. All of this behavior increases the price of drugs by thirty cents for every dollar[22], increases the economic advantage of corporate operating pharmacies, and further squeezes the community retail pharmacy out of the market.

IV. The Task Force and U.S. Enforcement Agencies Should Not Use Theoretical or Speculative Efficiencies to Assess Harm

As several antitrust scholars have observed, one of the primary explanations for the agencies' lax approach to vertical mergers has been the *assumption*, based largely on neoclassical economic models, that vertical mergers generally yield significant procompetitive efficiencies.[23] Without evidence that a proposed merger is likely to generate significant cost savings or other benefits *that will be passed on to consumers*, the agencies should not presume that theoretical or speculative efficiencies will offset an otherwise anticompetitive transaction. Importantly,

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[19] https://www.drugchannels.net/2019/02/how-health-plans-profitand-patients.html

[20] https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-report-rebate-walls/federal_trade_commission_report_on_rebate_walls_.pdf

[21] https://www.pcmanet.org/pharmacy-benefit-managers-continue-to-keep-medicare-part-d-premiums-affordable/

[22] Medicine Spending and Affordability in the United States: Understanding Patients' Costs For Medicine. IQVIA Institute for Human Data Science

[23] Greaney, Supra note 10, at 919-920 ("Questioning the 'vertical, good' assumption") (citation omitted); Steven C. Salop, "Invigorating Vertical Merger Enforcement," 127 Yale L.J. 1962, 1962 (2018) (criticizing Chicago School and laissez-faire economic assumptions that have lead to insufficient scrutiny of vertical mergers); *see also* Letter of Diana L. Moss, President, American Antitrust Institute, to Makan Delrahim, Assistant Attorney General, Antitrust Division, United States Dep't. of Justice, Regarding Competitive and Consumer Concerns Raised by the CVS-Aetna Merger at 3 (Mar. 26, 2018), available at: https://www.justice.gov/atr/page/file/1132431/download (highlighting "well founded concerns about the effectiveness of past conduct remedies in vertical mergers" and "growing skepticism over whether vertical mergers deliver the efficiencies claimed by their proponents.").

economic theory and real-world experience show that the degree to which any cost savings are actually passed on to consumers depends on the degree of competition in the market.

Using the CVS/Aetna merger as an example, despite claims of enhanced efficiencies and other purported procompetitive benefits, Consumer Reports determined that CVS pharmacies often have the highest retail prices, which were found to be *400% higher* than independent pharmacies' retail prices for the same prescription drugs.[24] As patients' out of pocket costs and premiums continue to rise, while quality and service standards are not reflected in the increased prices, the agencies need to be as skeptical of efficiencies claims in vertical transactions as they are in horizontal transactions.

V. **Conclusion**

Ultimately, consolidation in the healthcare sector has exacerbated harm to both patients and community pharmacies. The continued reduction in reimbursements from PBMs, combined with the steering of patients to PBM-owned pharmacies have brought a wave of pharmacy closures, with approximately 2,000 community pharmacies lost over from 2017 to 2019[25] and increased costs to consumers.

NCPA greatly appreciates the opportunity to share our views on issues with the Task Force. NCPA is committed to working with the FTC and other stakeholders to resolve these issues in a manner which promotes competition and ensures the best healthcare marketplace for independent pharmacies and patients. Please do not hesitate to contact me at (703) 838-2648 or doug.hoey@ncpa.org or Matthew Seiler, NCPA's Vice President and General Counsel, at (703) 600-1221 or matt.seiler@ncpa.org to further discuss how NCPA can be of assistance to the Task Force.

Sincerely,

B. Douglas Hoey RPh, MBA
CEO, National Community Pharmacists Association

[24] Lisa A. Gill, Shop Around for Lower Drug Prices, (Apr. 5, 2018), *available at* https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/.
[25] IQVIA, DDD – Drug Distribution Data (last visited Feb. 20, 2020) (showing the number of U.S. retail pharmacies dropped from 58,706 in December 2017 to 56,788 in December 2019)