NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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February 18, 2020

Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC–5610
Washington, DC 20580

Department of Justice
Antitrust Division
450 Fifth Street NW, Suite 4100
Washington, DC 20530

Re: Federal Trade Commission and Department of Justice's Draft Vertical Merger Guidelines

Dear Sir or Madam:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to submit this comment on the Draft Vertical Merger Guidelines ("Draft Guidelines") released by the Department of Justice and Federal Trade Commission on January 10, 2020.

NCPA represents America's community pharmacists, including over 21,000 independent community pharmacies. Together they represent a $76 billion health care marketplace, employ 250,000 individuals on a full or part-time basis and provide pharmacy services to millions of patients every day. As a result, 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. NCPA believes that this consolidation demands vigorous antitrust enforcement, including for anticompetitive vertical transactions that have largely evaded scrutiny in recent years. NCPA submits this comment to explain how and why the agencies' approach to vertical merger enforcement should be strengthened beyond what has been outlined in the draft guidelines.

Largely unchecked by antitrust enforcers, vertical consolidation in healthcare has yielded significant anticompetitive effects without promised improvements in cost or quality

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 care that our most vulnerable populations receive (or fail to receive). In the pharmacy sector, for example, the three largest pharmacy benefit managers

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(PBMs) now control 76% of the market for prescription claims.[1] And each of these PBMs has merged with other, equally powerful companies in the healthcare value chain. In the past two years alone, CVS Health (which was already both the single largest pharmacy chain in the country and the second largest PBM) acquired Aetna Inc., the third-largest health insurance company in the country, and Express Scripts (the largest PBM) was acquired by Cigna, another of the so-called "big-five" health insurers. And the third major PBM (OptumRx) is already affiliated with the single largest health insurer in the country (UnitedHealthcare). This surge in vertical consolidation has essentially created an oligopoly of integrated healthcare companies controlling nearly all aspects of the healthcare and pharmacy supply chain. 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 Department of Justice successfully challenged the proposed mergers between four of the "big five" health insurers.[3] And the 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 Health/Aetna Inc., 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

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[1] Adam J. Fein, "CVS, Express Scripts, and the Evolution of the PBM Business Model," Drug Channels (May 29, 2019) *available at* https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.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).

emphasized in other submissions, these and other major transactions are likely to cause serious anticompetitive effects, particularly for the 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], 8, 9, 10 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]

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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 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], 8, 9, 10 *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: Hospital 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).

While the empirical evidence is most well developed for vertical integration among healthcare providers (where data is more readily available), 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 and pharmaceutical supply chain. According to public sources: the three largest PBMs collectively control 76% of the market;[9] the two largest pharmacy chains command a 50-75% share across the country's 14 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] Furthermore, the three largest specialty pharmacies are all owned by vertically integrated PBM insurance companies and control 59% of the country's specialty pharmacy prescriptions.[12]

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."[13]

Healthcare consolidation requires reinvigorated and reimagined antitrust enforcement policy rather than a continuation of the status quo

Given the evidence of anticompetitive harm from vertical consolidation, NCPA believes that the federal antitrust enforcement agencies should be considering fresh approaches to tackling concentration in the healthcare sector. Unfortunately, the draft guidelines largely restate conventional analytical approaches that have largely failed to protect competition and healthcare consumers. The stated goals for these guidelines – to "describe how the federal agencies review vertical mergers," based on the agencies' practice "*over the past several decades*" – misses the point.[14] The agencies' laissez-faire approach to vertical mergers has allowed transformational consolidation in the healthcare system, despite mounting evidence of the resulting anticompetitive harm. In NCPA's view, this demands a fundamental reshaping of the agencies' vertical merger enforcement paradigm.

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[9] See footnote 1.

[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] Adam J. Fein, "The Top 15 Specialty Pharmacies of 2018: PBMs Keep Winning," Drug Channels (April 9, 2019) available at https://www.drugchannels.net/2019/04/the-top-15-specialty-pharmacies-of-2018.html.

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

[14] Press Release, FTC and DOJ Announce Draft Vertical Merger Guidelines for Public Comment (Jan. 10, 2010), https://www.ftc.gov/news-events/press-releases/2020/01/ftc-doj-announce-draft-vertical-merger-guidelines-public-comment; *see also* Draft Guidelines § 1 (explaining that the Draft Guidelines outline *current* vertical merger enforcement policy).

Fortunately, there is precedent at both agencies for critical reassessment of analytical approaches leading to reinvigorated antitrust enforcement. For example, the FTC's retrospective analysis of several consummated hospital mergers, which revealed evidence of significant anticompetitive harm, led the agency to revamp its approach to horizontal mergers among hospitals and healthcare providers, with great success.[15] And the DOJ's recent successful challenges to two proposed health insurance mergers demonstrated that agency's evolving approach to healthcare competition by, for example, recognizing that competitive harm can result from the amalgamation of *buyer* power just as it does for combinations of competing sellers.[16] The unchecked wave of vertical consolidation in healthcare demands a similar policy overhaul, including retrospective review of these recent healthcare mega-mergers.

Vertical merger enforcement policy in the healthcare sector must account for anticompetitive harm to healthcare access, quality, and service

Like the 2010 Horizontal Merger Guidelines, these draft guidelines recognize that anticompetitive harm can take multiple forms – by, for example, leading to higher prices *or* diminished quality or service.[17] In the healthcare field, these "non-price" factors – which may not be as easy to quantify or fit within conventional economic models – are of paramount importance. Indeed, pharmacists and other healthcare providers are entrusted to provide and coordinate life-saving treatment to patients. Because the public health benefits of ensuring access to high-quality care may be difficult to quantify, at least in a way that fit neatly into conventional economic models often employed in merger analysis, healthcare antitrust enforcement must deliberately account for ways that a transaction may harm competition in ways other than higher prices (although the evidence summarized above indicates vertical consolidation in healthcare has also led to increased prices and costs for consumers).

Notably, in the context of horizontal mergers among healthcare insurers, the Department of Justice has recognized that the case law condemns mergers that substantially lessen competition, including by enhancing "monopsony" or buyer power over healthcare providers, even where the government cannot show precisely *how* the reduction in competition will "restrict access to medical care, reduce the quality of medical care, or otherwise harm patients."[18] Rather, in the

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[15] *See, e.g.*, "Prepared Opening Remarks of Chairman Joseph J. Simons1 Hearings on Competition and Consumer Protection in the 21st Century: Merger Retrospectives", April 12, 2019, available at https://www.ftc.gov/system/files/documents/public_statements/1513555/merger_retrospectives_hearing_opening_remarks_chairman.pdf "Remarks of Commissioner Rebecca Kelly Slaughter, as Prepared for Delivery, Antitrust Health Care Providers, Policies to Promote Competition and Protect Patients, Center for American Progress, May 14, 2019, available at: https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf;.

[16] Plaintiff's Pretrial Brief, *United States v. Anthem, Inc. and Cigna Corp.*, No. 16-cv-1493-ABJ, Doc. No. 325, at 6 (D.D.C. Nov. 10, 2016) [hereinafter "Anthem/Cigna Pre-Trial Brief"] (The antitrust laws 'also apply to abuse of market power on the buyer side.' (quoting *Todd v. Exxon Corp.*, 275 F.3d 191, 201 (2d Cir. 2001)); *id.* at 7 (arguing a presumption of legality applies to 'buy-side' mergers that are likely to substantially reduce competition); *id.* at 10 (arguing that reductions in prices due to increased market power "are not procompetitive purchasing efficiencies.").

[17] *See* Draft Guidelines § 5; *see also* Fed. Trade Comm'n and United States Dep't of Justice, Horizontal Merger Guidelines § 1 (2010) ("Enhanced market power can also be manifested in non-price terms and conditions that adversely affect customers, including reduced product quality, reduced product variety, reduced service, or diminished innovation.").

[18] *See* Anthem/Cigna Pre-Trial Brief at 8.

horizontal context, these anticompetitive effects are *presumed* to flow from a substantial reduction in competition.[19]

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 a myriad of ways, including the mechanisms identified in the draft guidelines:

- *Network foreclosure and exclusionary steering.* For example, a health insurer or PBM that merges with a large retail pharmacy chain may have the incentive to exclude competing pharmacies from preferred networks or to provide financial incentives to utilize the acquired pharmacies over the patients' pharmacy of choice. Having the opportunity to be part of a plan's preferred network can be critical, as nearly all Part D plans include preferred networks that offer lower co-pays to beneficiaries. It is important to note, however, that in Medicare Part D plan sponsors/PBMs are not required to offer small business pharmacies terms and conditions to participate in preferred networks. This risk is particularly acute for pharmacies and other healthcare providers that care for underserved patient populations.

- *Enhanced bargaining leverage and raising rivals' costs.* To use the same example, even if the merged company does not technically exclude competing pharmacies, it may have the incentive and ability to demand untenable reimbursement rates from competing pharmacies in exchange for continued participation in pharmacy networks. Independent pharmacies have very little negotiating power when contracting with PBMs like CVS Caremark, and routinely must agree to take-it-or-leave-it contracts to be part of a PBM's pharmacy network.

- *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 three largest PBMs own mail order pharmacies and specialty pharmacies. These three PBMs also contract with all other retail pharmacies to form pharmacy networks that are direct competitors to the PBM-owned pharmacies. PBMs regularly design plans, including plans with preferred networks, that require or incentivize patients to use the PBM-owned pharmacy option over another retail pharmacy competitor. 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, 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 have information on the reimbursement rates paid to the pharmacies they own *and* competing pharmacies and other providers included in their networks, the vertical integration of competing providers creates the opportunity for this

[19] *See id.* at 7-8 (arguing that, upon a showing of increased buy-side market power, the merger can be presumed unlawful "even when the anti-competitive activity does not harm end-users." (quoting *Telecor Commc'ns, Inc. v. Sw. Bell Tel. Co.*, 305 F.3d 1124, 1134 (10th Cir. 2002)).

confidential information to be exploited to gain an unfair competitive advantage, which cannot be fully addressed through firewalls or other purported safeguards.

According to a recent report commissioned by the Florida Pharmacy Association and American Pharmacy Cooperative, Inc., patients are being steered to pharmacies owned by or affiliated with the PBMs.[20] There is a self-serving incentive driving this behavior that has nothing to do with patient healthcare or lowering cost. 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. Prescriptions allowed by PBMs to be dispensed by non-affiliated retail pharmacies are being reimbursed between only $2-4 per medication. Meanwhile, "specialty" medications being routed by PBMs to their affiliated or specialty pharmacies are being reimbursed up to $200 per medication.
- Five specialty pharmacies, all affiliated with an MCO or PBM, collected 28 percent of the available "profit" paid to all providers, despite only dispensing 0.4 percent of all managed care claims.

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 independent pharmacies in their preferred networks. Instead, these networks are often limited to a smaller number of select pharmacies and regularly exclude independent 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.

We commend the agencies for recognizing these and other potential sources of competitive harm from vertical transactions. Where we believe the draft guidelines fall short, however, is in more concrete policy guidance to translate these *theoretical* concepts into actionable and effective vertical merger *enforcement*. The agencies have considered these theories, at least on occasion, in several recent merger investigations.[21] But in practice, the agencies have only rarely pursued

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[20] 3ΔXIS Advisors, "Sunshine in the Black Box of Pharmacy benefits Management: Florida Medicaid Pharmacy Claims Analysis, (January 30, 2020) available at https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/5e3841266fc490b221da7ced/1580748598035/FL+-Master+Final+-Download.pdf.

[21] *See, e.g.,* Statement of Chairman Joseph J. Simons, Commissioner Noah Joshua Phillips, and Commissioner Christine S. Wilson Concerning the Proposed Acquisition of Essendant, Inc. by Staples, Inc. FTC File No. 181-0180 at 2 (Jan. 28, 2019), available at:

these vertical merger principles to meaningfully investigate and, where appropriate, challenge transactions that are likely to cause significant anticompetitive harm. Given the anticompetitive harm that has been caused from unchecked consolidation in the healthcare industry, we respectfully submit that a more forceful overhaul of vertical merger enforcement policy is needed.

The agencies should rigorously scrutinize claimed efficiencies from vertical mergers, including whether any efficiencies will be passed on to consumers

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.[22] Although the draft guidelines state that the agencies will evaluate efficiency claims using the approach outlined in the Horizontal Merger Guidelines (§ 8), the draft guidelines devote an entire section to the theoretical benefit presumed to inure from vertical integration, elimination of so-called double margination (§ 6). 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, 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.

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https://www.ftc.gov/system/files/documents/public_statements/1448328/181_0180_staples_essendant_majority_statement_1-28-19.pdf (considering vertical theories based on raising rivals cost and vertical foreclosure and imposing a firewall to limit anticompetitive exploitation of competitively sensitive information); Statement of Commissioner Rohit Chopra regarding same, available at 3-4:
https://www.ftc.gov/system/files/documents/public_statements/1448328/181_0180_staples_essendant_majority_statement_1-28-19.pdf (questioning whether economic models sufficiently capture possible vertical harms); Trial Brief of the United States, *United States v. AT&T, Inc., DirecTV Group Holdings LLC, and Time Warner, Inc.*, Doc. No. 17-cv-2511, at 3 (D.D.C. March 12, 2018) (arguing that the combined entity would allow AT&T to increase its rivals' costs, and that those higher costs would be passed on to consumers).(

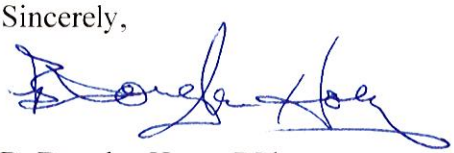
[22] Greaney, Supra note 10, at 919-920 ("Questioning the 'vertical, good' assumption") (citation omitted); Steven C. Salop, "Invigorating Vertical Merger Enforcement," 127 Yale L.J. 1962, 1962 (2018) (criticizing Chicago School and laissez-faire economic assumptions that have lead to insufficient scrutiny 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.").

Conclusion

NCPA appreciate the opportunity to provide comments on the proposed guidelines concerning vertical mergers. As an organization focused on community pharmacy, healthcare, and responsible regulation, we believe it is critically important that the right regulatory framework be developed as a result of this formal rule making process.

NCPA further welcomes the opportunity to share our thoughts, experiences, and insights that our members and staff have cultivated on this topic at either the March 11, 2020 workshop or the March 18, 2020 workshop led by the U.S. DOJ and FTC.

Sincerely,



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National Community Pharmacists Association