AHF AIDS HEALTHCARE FOUNDATION

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By email: Verticalmergerguidelines@ftc.gov
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Makan Delrahim
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US Department of Justice
Antitrust Division
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Joseph J. Simons
Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Comments to Draft Vertical Merger Guidelines

Dear Mr. Delrahim and Mr. Simons,

AIDS Healthcare Foundation (AHF) appreciates the opportunity to comment on the Draft 2020 Vertical Merger Guidelines (Draft Guidelines). The Draft Guidelines present a tremendous opportunity for the Agencies to clarify the rules and principles that protect consumers in general and healthcare consumers in particular. In our experience, the increasing vertical integration in the healthcare industry threatens to harm—and actually has harmed—people living with HIV/AIDS and the providers, pharmacies, and health plans that serve them. While the Draft Guidelines are a step forward, we urge the Agencies to issue more robust and nuanced Guidelines that expressly take into account the impacts on the health of vulnerable people living with complex conditions when evaluating a potential vertical merger.

AHF would be interested in speaking at the Agencies' workshops on March 11 or March 18. AHF has not provided funding for research, analysis or commentary on relevant topics, except that it did participate as an amicus in the CVS/Aetna merger proceedings before Judge Leon in the DC District court (Case # 1:18-cv-02340-RJL) where it submitted briefs and presented witness testimony.

Who We Are and Why We Care

Established in 1987 as a non-profit and now the largest HIV/AIDS organization in the United States, AHF has the mission of ending the HIV/AIDS epidemic by providing cutting edge medicine and advocacy, regardless of ability to pay. AHF cares for over 1.3 million patients in 43 countries. In the United States, AHF cares for over 56,000 patients out of AHF's 68

outpatient HIV medical clinics in 16 States, the District of Columbia and Puerto Rico, and 55 HIV specialty pharmacies. AHF also works on behalf of people with HIV/AIDS throughout the country to remove barriers to receiving proper care and treatment for HIV/AIDS through advocacy, including litigation, public policy development, education, and community engagement.

HIV/AIDS is an infectious disease that is difficult to eradicate because of the virus's long latency period and because of continuing stigma that keeps people from seeking or staying in care. Without proper care and treatment, HIV/AIDS is fatal. In order to break the chain of infection and keep people healthy, we must first identify people with the virus through testing, then link them to care, then retain them in medical care. Once in care, people must adhere to a daily medication regimen to reduce the amount of HIV to such a small amount that its presence is virtually undetectable. People who achieve this state are "virally suppressed." For people who are adherent to a medication regimen and virally suppressed, HIV/AIDS can be a chronic but manageable disease, rather than a fatal one. They are able to work, take care of their families, and have an approximately normal life span.

Just as important, people who are virally suppressed are virtually noninfectious – there is so little of the virus in the body, it is extremely difficult to transmit. Medication adherence thus not only keeps people healthy, it prevents new infections from occurring. But lifelong adherence to HIV medications is hard. Unfortunately, today most Americans with HIV/AIDS are not adherent to a medication regimen, are not virally suppressed, and are potentially still infectious. As a result, there are estimated to be 38,000 new HIV infections every year. In the safety net population that AHF serves, many people face what they see are more immediate and critical challenges—like homelessness, loss of job or addiction. But even without these challenges, people can simply become tired of taking pills every day that remind them they have a chronic disease. Getting people living with HIV/AIDS adherent to a medication regimen, and rendering them noninfectious, is the key to stopping new infections and ending this epidemic.

AHF's innovative model of care is based on the wisdom that it takes a multi-discipline, integrated care team to find, link, treat, and retain people in care. That is why AHF employs community outreach workers, testers, linkage staff, providers, case workers, nurses, and pharmacists who work as a team to remove obstacles for people who might otherwise fall through the cracks. Our model works. While just 45% of all Americans who have HIV/AIDS are virally suppressed, nearly 70% of AHF's clients are.

In AHF's model, pharmacists play a lynchpin role in the patient's care, because they regularly dispense the medications that keep patients healthy. In addition, AHF pharmacists perform regular medication assessments and counseling, synchronize patients' medications, and prepare medication in easy-to-use adherence packages. In fact, because the pharmacy staff communicate with patients monthly in person or by phone, it is not unusual for a patient to have a better relationship with the pharmacy team than the patient's healthcare center team, and for the pharmacy to know when a patient is struggling with adherence issues before anyone else. In most cases, the AHF pharmacy is located at our healthcare center, which is convenient for patients and allows the pharmacists to easily communicate with the patients' providers about adherence barriers, potential drug-drug interactions, and other important health matters.

On the healthcare center side, AHF is staffed with physicians and mid-level practitioners who are HIV specialists, as well as nurses, benefits counselors, case managers, and referral coordinators all working together to provide treatment and a host of other ancillary medical and non-medical services to the patient.

AHF's innovative model—a model that delivers comprehensive lifesaving healthcare services to people living with HIV—is threatened in a number of ways by the rapid consolidations in the healthcare industry, which would break up or take away important services that are valued by patients. Representing a special needs population that depends upon a competitive marketplace for access to drugs, insureds, and payors, AHF is especially troubled by the recent vertical integrations that consolidate the payor, pharmacy benefits manager ("PBM"), and provider under the same roof. In AHF's experience, this kind of integration leads to higher prices, reduced access, and less choice for consumers and patients.

I. Vertical Integration in the Healthcare Industry Raises Wide-Ranging Competitive Concerns that the Agencies Must Address

As the Agencies know, while vertical mergers do not eliminate direct competition between the merging firms, they can restrain competition by raising barriers to entry, foreclosing or threatening to foreclose competitors' access to an important input, or otherwise raising rivals' costs by limiting their access to customers. The increasing vertical integration in the healthcare industry threatens to make the healthcare marketplace substantially less competitive in each of these ways. With alarming speed and little federal restraint, the nation's largest retail pharmacy chains and specialty pharmacies are combining with the largest PBMs, and with the country's largest health insurers.

Specifically, over the last few years, the three largest PBMs have taken control of 80 to 85 percent of the market. PBMs are middlemen that operate at the intersection of drug manufacturers, payors and pharmacies. PBMs negotiate prices with drug companies, receive rebates from drug companies to place specific drugs on formularies, provide drug benefit administration services, and establish pharmacy networks for the insurer's members to utilize. However, the PBM market suffers from a lack of transparency and an absence of meaningful regulation. This is so despite the substantial impact that PBMs have on health care costs in the United States.

As the PBM market has become more highly concentrated, the power of PBMs in the marketplace has only increased. PBMs have the ability to reap significant rebate dollars from drug manufacturers, who must provide these concessions if they are to be assured a place on the PBM's formularies. Without placement on a PBMs' formularies, drug manufacturers have no access to plan members, and, accordingly, plan members have no access to drugs unless they pay full price out of their own pockets. In addition, PBMs dictate which pharmacies patients can utilize, because PBMs create the pharmacy network available to plan members. Pharmacies must be part of these networks, or they have no access to their patients who are plan members. This gives PBMs enormous leverage power over community and specialty pharmacies—a power made more oppressive and abusive by recent consolidations.

In the last few years, each of the three largest PBMs has combined with other, equally powerful healthcare companies. Recently, Aetna, the third-largest health insurance company, acquired CVS Caremark, which was already both the largest pharmacy chain and the second largest PBM. Cigna, one of the "big-five" health insurers, acquired Express Scripts (the largest PBM). The third major PBM (OptumRx) is already affiliated with the largest health insurer in the country, UnitedHealthcare.

These gargantuan companies—or Mega Firms—operate as vertically integrated firms in markets where only a few meaningful rivals compete and barriers to entry are high. The Mega Firms have the incentive and ability to favor their own medical and pharmacy providers and threaten to foreclose rival providers from having access to the Mega Firms' plan members (customer foreclosure). The firms also have the incentive and ability to cut off or raise costs of critical inputs owned by the Mega Firm and needed by competitors (input foreclosure). Such foreclosures not only hurt competing providers, pharmacies, and insurers, but they hurt patients, who face less choice, more fragmented care, and higher costs.

Having participated in the CVS/Aetna merger proceedings, AHF is aware that the Agencies consider vertical integration concerns before approving any mega merger. However, in the CVS/Aetna proceedings, when challenged to respond to the hundreds of thoughtful public comments expressing concerns over the vertical aspects of the proposed merger, the DOJ offered little more than a "trust me" response that deeply troubled the court, not to mention the public. AHF urges the Agencies' to make their harms analyses and decisions more transparent. And we urge the Agencies to periodically review the actual, materialized effects of these mergers, with an eye to learning whether harms considered unlikely by the Agencies prospectively have, in fact, occurred, and to commit to taking enforcement actions if so. In AHF's experience, these harms have materialized and are ongoing.

A. Vertical Mergers Inflict Customer Foreclosure Harms on Providers and their Patients

When a healthcare provider, PBM and insurer merges—as CVS and Aetna recently did—the Mega Firm has the increased incentive and ability to steer insureds to the insurer's own health care providers (i.e., CVS Minute Clinics and health hubs). This is not a theoretical concern. CVS announced its intention to significantly integrate Aetna insureds into Minute Clinics, including patients with chronic diseases.[1] Already, this has forced health care providers to close their doors.[2] Indeed, at the hearings on the Aetna/CVS merger, Dr. Alan Lotvin, CVS's Executive

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[1] See Allison Inserro, CVS Health CEO Outlines How Aetna Deal Will Benefit Customers, The Am. J. of Managed Care (Jan. 8, 2019), available at https://www.ajmc.com/newsroom/cvs-health-ceo-outlines-how-aetna-deal-will-benefitcustomers (describing plans for Aetna care managers to schedule Minute Clinic visits after patient hospital discharge).

[2] *See* Christian Flanagan, Hospitals Shut at 30-a-year Pace in U.S., With No End In Sight, Bloomberg (August 21, 2018), available at https://www.bloomberg.com/news/articles/2018-08-21/hospitals-are-getting-eaten-away-bymarket-trends-analysts-say ("Hospitals have been closing at a rate of about 30 a

Vice President and Chief Transformation Officer, testified that post-merger Aetna will provide more data to CVS, which can be used to provide Aetna's insureds with healthcare advice. He further testified that CVS is already using Aetna's data to contact patients about its HealthHUBs and Minute Clinics and grow these services.

While the Draft Guidelines provide that access to competitively sensitive information is a consideration in a proposed merger, it is not clear that this factor was considered or weighed appropriately in the CVS/Aetna proceedings. The final Guidelines should emphasize this consideration more strongly, with more illustrations and more clarity on the degree of access that will trigger withholding of Agency approval of a proposed merger.

Beyond the anti-competitive foreclosure effects of mega mergers on health care providers, AHF has real quality of care concerns when a mega merger breaks up successful care models for people with chronic diseases and at-risk populations. For example, minute clinics replace fundamental elements of the patient-physician relationship with "cookie cutter" treatment administrated by non-physicians. This may be cost-effective for the general population, but can be dangerous for people with special conditions. Because AHF runs numerous clinics focused on the treatment of individuals living with HIV, we understand that the treatment must be comprehensive and under the watchful eye of the patient's primary care physician/HIV specialist. Even the most "routine" services are not routine for a person with HIV. For example, a CVS Minute Clinic delivering a flu shot to a person with HIV is risking the health of a person whose immune system might be vulnerable to a partial live virus vaccine.

In recognition of these anticompetitive and quality of care concerns, at least one state, Georgia, approved CVS's acquisition of Aetna on the condition, among others, that the merged entity must invite non-CVS health care providers to join its networks, and must set the same criteria for each of its providers. The merged entity is also required to allow Georgia residents to use any health care provider, in or out of network, if that provider accepts the same conditions as those within the network. We urge the Agencies to expressly include in their final Guidelines the Agencies' power and discretion to impose behavioral conditions such as Georgia's as a way to limit the impact of the likely competitive harms of mega mergers on competition, quality of care, and patient choice.

B. Vertical Mergers Inflict Customer Foreclosure Harms on Pharmacies and their Patients

Mega Firms engage in "customer foreclosure" in the pharmacy market by denying rival pharmacies access to healthcare plan members of the Mega Firms. For example in 2011, United HealthGroup, the largest health insurer in the United States, formed its PBM, OptumRX. Shortly afterward, the combined firm engaged in exclusionary conduct as Optum RX took active steps to steer AHF pharmacy patients to Optum's mail order service. Mandatory mail order is particularly troubling because of the critical role played by in-person, trusted HIV pharmacists who communicate monthly with their patients and the patients' care team. As discussed earlier,

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year, according to the American Hospital Association,...as insurers push [patients] toward...clinics such as CVS Health Corp's MinuteClinic.").

controlling the virus depends upon rigid adherence to a drug treatment plan, and the pharmacy team is often closest to the patient's adherence challenges. Mail order delivery distances the patient from their sentinel caregivers and jeopardize patient health. [3]

After a mega merger like the Aetna/CVS merger, the insured—in this case Aetna and its 22 million lives—has the leverage and incentive to use increasingly aggressive tactics to narrow its networks to exclude small and specialty pharmacies. CVS is already the PBM and sole-source pharmacy network for state AIDS Drug Assistance Programs (ADAPs) in Florida, Illinois and Ohio, affecting thousands of uninsured individuals living with HIV/AIDS. With Aetna, there is every reason to believe it will move toward the same kind of exclusive network arrangements for Aetna insureds.

Even when a Mega Firm does not expressly exclude rival pharmacies, it can disadvantage them by placing them on non-preferred networks, which means higher co-pays for members. The Mega Firm can also use its control over member communications to steer plan members to its own pharmacies. For example, after CVS and Caremark merged in 2007, there were allegations that CVS Caremark, the PBM arm, used its PBM business to steer patients to CVS retail pharmacies. Through that merger, CVS obtained competitively sensitive information of non-CVS pharmacies including the identity of their customers and prescribers, the drugs prescribed, the cost of the drugs, the amount of the drugs acquired, the drug acquisition cost, and the reimbursement amount. Non-CVS pharmacists believe that Caremark shared its patient data with CVS's pharmacy arm and used the information to steer customers toward CVS's pharmacies by directly informing patients who use non-CVS pharmacies of the risks of using multiple pharmacies, and by urging them to consolidate all of their prescription drug purchases through CVS or pay an increased copay. [4] As recently as April 2018, non-CVS pharmacies were still expressing these concerns.[5]

Mega Firms use their enormous power to drive up competing pharmacies' costs through oppressive requirements, such as unnecessary, multiple accreditations. They also use their power to drive down competing pharmacies' reimbursement rates and dispensing fees to uncompetitive levels. As explained earlier in this letter, HIV specialty pharmacists are not pill dispensers. They provide adherence counseling, medication management, provider consults and other critical

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[3] See Steven Pearlstein, CVS Bought Your Local Drugstore, Mail-Order Pharmacy and Health Insurer. What's Next, Your Hospital?, The Washington Post (Jan. 31, 2019) ("CVS often requires consumers to buy drugs for chronic conditions from its mail-order pharmacy, or makes it more expensive not to do so.")

[4] Letter from Holly Henry, president, National Community Pharmacists Association to FTC Chairman Jon Leibowitz; May 12, 2009, available at http://www.ncpanet.org/pdf/needftcinvestigation.pdf. (citing potential violations of the Clayton and the FTC Act).

[5] See Catherine Candisky, Darrel Rowland, and Marty Schladen,Three CVS Actions Raise Concerns for Some Pharmacy Consumers, the Columbus Dispatch (April 15, 2018) at https://www.dispatch.com/news/20180415/three-cvs-actions-raise-concerns-for-some-pharmacies-consumers

services that are reimbursed solely through dispensing fees. When their fees are reduced to nothing or nearly nothing, the quality of care that pharmacies provide to their patients can suffer. A few states have identified these abusive reimbursement tactics and are taking action.

- In 2018, Arkansas Attorney General Leslie Rutledge announced her office's investigation into a scheme in which CVS is alleged to be providing unprofitable reimbursement arrangements to independent pharmacies, rendering the pharmacies unable to remain in operation, and then offering to buy out these pharmacies for pennies on the dollar.

- In Ohio, Medicaid leaders saw how poor Ohioans' access to needed medication was threatened because of CVS's aggressive tactics of slashing pharmacy reimbursements to local pharmacies and then offering buyouts. Their pressure caused CVS to raise reimbursements for one drug—suboxone, a treatment of addiction used widely in Ohio's opioid crisis.[6]

- The Pennsylvania Auditor General, Eugene DePasquale, opened an investigation into PBMs' "spread pricing"—the difference between what PBMs charge state the Medicaid program and what they pay pharmacies for services to Medicaid beneficiaries. A focus of the investigation is depressed pharmacy reimbursements by CVS.

Last month, the Florida Pharmacy Association and American Pharmacy Cooperative Inc. issued a report analyzing PBM conduct in Florida Medicaid and, among other things, found that "pharmacies were paid a weighted average of just $2.72 per claim in 2018 – enough to cover just 27 cents on the dollar spent to maintain pharmacy operations. This was down from $7.70 per claim in 2014."[7] While PBMs squeeze competing pharmacies to the point of bankruptcy, there is mounting evidence that the same PBMs overprice high-utilization and expensive specialty drugs when they are dispensed at their own pharmacies, costing state Medicaid programs millions of dollars.[8]

One of the more egregious PBM reimbursement practices is the imposition of Direct and Indirect Renumeration (DIR) or "performance" fees. PBMs impose such fees on pharmacies, requiring them to meet sometimes vague performance metrics, whose thresholds are often set at unattainable levels. When the pharmacies do not meet these metrics, the PBMs retroactively claw back these fees often months or even a year after the medication was dispensed. If the pharmacies do meet certain metrics, less fees are clawed back, but the pharmacies are still not made whole. For pharmacies such as those run by AHF that concentrate on the treatment of

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[6] See Three CVS Actions Raise Concerns for Some Pharmacy Consumers, the Columbus Dispatch (April 15, 2015) at https://www.dispatch.com/news/20180415/three-cvs-actions-raise-concerns-for-some-pharmacies-consumers

[7] See Sunshine in the Black Box of Pharmacy Benefits Management, Florida Medicaid Pharmacy Claims Analysis, January 27, 2020, at http://www.ncpa.co/pdf/florida-3aa-medicaid-pharmacy-analysis.pdf

[8] *Ibid.*

HIV/AIDS, performance metrics aimed at general populations often simply do not apply, but the PBMs impose the fees anyway. Furthermore, when the fees and penalties are based on a percent of the drug cost (as they often are), specialty pharmacies like AHF bear a disproportionate hit, because HIV and AIDS drugs can cost thousands of dollars for a single prescription.

Furthermore, DIR fees, like rebates, are not considered when calculating the patient's coinsurance at the point of sale. Rather, this out-of-pocket expense is based on the drug's list price. Thus, DIR and rebates do nothing to lower patients' out of pocket costs; they serve solely to reduce pharmacy competition and further drive patients to the PBMs' own pharmacy businesses.[9]

As mentioned above, Georgia approved CVS's acquisition of Aetna on the condition, among others, that the merged entity must invite non-CVS health care providers—including pharmacies—to join its networks, and must set the same criteria for each of its providers, so that PBMs cannot discriminate between the reimbursement they pay their own pharmacy business lines and competing pharmacies. The merged entity is also required to allow Georgia residents to use any provider, in or out of network, if that provider accepts the same conditions as those within the network. Additionally, CVS/Aetna cannot require patients to use CVS-owned pharmacies, period—not for regular prescriptions, refills or specialty drugs. These concessions reduce the chance that a combined CVS/Aetna can limit patients' choice of healthcare providers. New York approved the CVS/Aetna merger on a number of similar conditions around pharmacy network access, and also requires annual reporting of the percentage of independent New York pharmacies in the CVS/Aetna networks. Additionally, CVS/Aetna must adhere to a firewall policy that will keep Aetna employees from learning information concerning individual pricing and rates paid by other health plans and clients to CVS Caremark for PBM and retail pharmacy services.

We urge the Agencies to underscore in its final Guidelines that, especially in the healthcare arena, they will aggressively investigate all possible foreclosure harms before a merger is consummated and challenge mergers where those harms are likely to materialize. If the Agencies are inclined to approve a merger despite some likelihood of some harm, we again urge the Agencies to expressly state in the final Guidelines that the Agencies should impose behavioral conditions as a way to limit the impact of mega mergers on competition and patient choice, and to limit access to competitively sensitive information.

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[9] See *Payers and PBMs Profit From Obscure Pharmacy Fees, While Seniors See No Relief in Prescription Costs,* XIL Consulting (February 2020) (describing how PBMs manipulate the Medicare Part D system with DIR fees and hurt pharmacies and patients; specifically, PBMs are profiting from obscure pharmacy fees at a rate in excess of 500% per prescription as compared to the average PBM administration fee by exploiting a loophole in the Medicare Part D program that allows health plans and PBMs to pocket an excessive amount of pharmacy DIR fees rather than offset prescription costs for seniors) at https://www.xilangconsulting.com/post/policy-alert.

C. Vertical Mergers Inflict Foreclosure Harms on Insurers and their Members

Both the insurance and the PBM markets have high barriers to enter. When an insurer and PBM consolidate, the playing field narrows because new entrants are unlikely to take each single entity's place. Worse, when an insurer, PBM *and* national pharmacy chain combine, the Mega Firm is positioned to engage in "input foreclosure" in the insurance market by denying competing health insurers a "must have" input, namely access to the national pharmacy chain. For example, CVS has a network of 7,900 retail pharmacy stores, and is in three miles of 70 percent of the US population. Because insurance regulations have "time and distance" standards, CVS is a "must have" pharmacy in a number of regional markets around the country. Post merger, Aetna/CVS has the increased incentive and ability to raise the costs to rival insurers that need its retail chain footprint (i.e., CVS pharmacies). This concern is not simply about the combined firm flat-out denying insurer rivals from using CVS retail pharmacies; rather, it is about disadvantaging insurer rivals through increased pricing, or non-price factors that may be designed to frustrate access.

Indeed, in 2019, the FTC took action to mitigate similar harms when it announced a settlement with UnitedHealth Group and DaVita Medical Group, which resulted in United's divestiture of DaVita's Las Vegas operations. The settlement resolved the FTC's complaint that United's acquisition of DaVita would reduce competition in the Las Vegas area in markets for managed care provider organization services sold to Medicare Advantage insurers, as well as Medicare Advantage plans sold to individual Medicare Advantage members. The FTC alleged that United's acquisition of DaVita, a large combined managed care provider organization ("MCPO"), would allow United to raise the costs of its MCPO services to rival Medicare Advantage insurers.

We urge the Agencies to include examples like this in its final Guidelines. The Draft Guidelines discuss input foreclosure, but the discussion is short and the generic illustrations do not speak to the heightened considerations needed to prevent harms to vulnerable populations like the elderly, or those with chronic conditions. For example, AHF, a nonprofit, operates both a Medicare and Medicaid plans for people living with HIV/AIDS. If such special needs plans were forced out of the market by input foreclosure, their plan members would likely be forced into healthcare plans for the general population. Most health insurers—operating for profit—simply do not want HIV/AIDS patients. At a minimum, these individuals would likely face higher copays for their expensive medications (AHF puts these drugs on the lowest copay tier), and worse, they would experience the degradation in care described in previous sections of this letter.

II. Besides Foreclosure, Vertical Integration in the Healthcare Industry Raises Other Serious Concerns Around Costs and Consumer Protection

When we are talking about people's health, and especially the health of vulnerable populations, it is critical that the Agencies take into account other, non-price considerations when evaluating a proposed vertical merger. In the previous sections, we emphasized some of the access and quality of care concerns that the Agencies should expressly consider before approving a vertical merger in the healthcare arena. The Agencies should also consider whether the separate entities have acted according to the highest health, safety, and integrity standards before allowing the

entities to combine and potentially do greater mischief. For example, CVS's relentless drive for more market share and emphasis on its financial bottom line has led to unsafe practices like automatic 90-day refills that jeopardize the health of mental health patients. The incessant pressure to fill has caused pharmacists to admittedly engage in unsafe filling practices.[10]

Also, until recently, PBMs used their market power to implement "gag" clauses in pharmacy contracts that prohibited pharmacists from informing consumers of lower-priced prescription drug alternatives. These gag clauses served no procompetitive purpose, but rather were designed to conceal the costs of prescription drugs from consumers at the pharmacy, causing consumers to pay more, with the only clear benefit going to the PBM's bottom line. Fortunately, Congress stepped in and outlawed the practice in the fall of 2018. Nonetheless, the fact that PBMs were able to force pharmacies not to disclose this information to their patients demonstrates that the big three PBMs' troubling propensity to act in their own financial self-interest rather than their members' best interests.

Also, mega mergers substantially increase concerns about preserving patients' and insureds' privacy and confidentiality. CVS is currently defending a lawsuit over its revealing the HIV positive status of up to 6,000 Ohioans through a botched mailing. This follows a 2017 breach by Aetna that revealed the HIV status of patients across several states. Several state attorneys general, including but not limited to those in Connecticut, New Jersey, New York, and Washington, recovered money from Aetna in the form of civil penalties for this breach. Additionally, Aetna settled a private lawsuit stemming from the same conduct for $17 million.

In CVS's case, in the five years prior to the merger, it had paid tens of millions of dollars in settlement of DOJ claims for antikickback, controlled Substances Act violations, and Medicaid fraud.[11]

We urge the Agencies to expressly include consideration of these kinds of non-price considerations in the final Guidelines.

IV. The Draft Guidelines Should Go Farther to Protect Competition and Consumer Health

Despite the increasing number of vertical mergers in the healthcare industry and the risks they pose to millions of people's health, the Guidelines are silent on the topic of healthcare and do not provide healthcare-related examples. The final Guidelines should speak to this.

History shows that when PBMs, insurers, and pharmacy chains merge, the combined Mega Firms are rife with conflicts of interest and opportunities for self-dealing. In part because of lack of regulation and transparency in the PBM industry, these Firms can operate secretly, which allows them to take outsized profits from rebates, spread-pricing and oppressive reimbursement

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[10] See E. Gabler, How Chaos at Chain Pharmacies Is Putting Patients at Risk, New York Times (Jan. 31, 2020).

[11] For a comprehensive listing of CVS violations, see https://violationtracker.goodjobsfirst.org and search "CVS Health"

practices. Because they control sensitive competitive information, customers' access to providers, and critical inputs, PBMs can foreclose markets from competing providers, pharmacies, and insurers. As we hope this letter has shown, all this is deadly for competition and dangerous for consumer health.

We urge the FTC and DOJ, as the public's antitrust guardians, to publish stronger Guidelines that provide for heightened scrutiny of proposed mergers in the healthcare industry—especially in concentrated markets like the PBM and health insurance markets—and not apply any presumption that a proposed merger is procompetitive, regardless of the entities' market share. If anything, given the stakes (human health), there should be a presumption of harm if the percent of market share is over a certain amount, such as 20%.

The Guidelines should provide illustrations of the kinds of concrete harms that can materialize in vertical healthcare mergers:

- Customer foreclosure and exclusionary steering
- Input foreclosure
- Enhanced bargaining leverage and raising rivals' costs
- Unfair and anticompetitive conflicts of interest
- Anticompetitive exploitation of competitively sensitive information
- Conduct raising integrity and safety concerns

The Guidelines should emphasize that the Agencies must thoroughly investigate all potential theories of harm, because if a harm is not identified and mitigated early, it may be difficult or (in the case of patient health) impossible to undo. The Guidelines should emphasize that the Agencies should take time to thoroughly analyze the deal rationale and inquire into all incentives and opportunities that can lead to price and non-price-related harms. The bar for certainty should not be set so high as to prevent the Agencies from investigating and acting when harm is possible–even if not certain to occur.

When investigating a proposed merger, we urge the Agencies to make more of their analyses and findings open to the public. And after they greenlight a merger, the Agencies should periodically assess completed mergers for the kinds of concerns and actual abuses—both price and non-price related—that we describe in this letter. The Agencies should abolish an all-or-nothing approach when reviewing mergers and consider using their powers to impose behavioral remedies on parties to mitigate likely harms.

As AHF's 33-year history shows, hundreds of thousands of people living with HIV will choose an integrated care model like AHF's, if they are just given free choice on a fair playing field. Vertical integration distorts the field and even threatens to wall it off, preventing innovative healthcare service providers like AHF from competing. The Agencies should make sure the playing field is fairly leveled so that a wide variety of healthcare models from a variety of healthcare players can play. Health is not a one-size-fits-all business, and focusing solely on financial efficiencies misses the fact that different people with different health conditions need different models of care. With mega mergers, healthcare is rapidly becoming homogenized

(minute clinics), fractured (narrow networks), and automated (mail order), and some consumers—especially the most vulnerable—are at risk. These consumers are essentially trapped—captured in a firm that limits their health benefits, their provider and pharmacy choices to those of the firm's own brand.

We urge the Agencies to protect patient health and access and decrease healthcare costs by strengthening the Draft Guidelines.

Sincerely,

Laura Boudreau
Chief of Operations/Risk Management and Quality Improvement