Walgreens/Rite Aid: FTC’s Aggressive Recent Approach to Provider Mergers Highlights Risk; Provides Roadmap to Potential Challenge

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FTC Update

On December 18, 2015, the FTC, by a unanimous, 4-0 vote, challenged the proposed merger of Chicago-area health systems Advocate Health Care Network and NorthShore University HealthSystem. The Advocate/NorthShore lawsuit represented the Commission’s third full-stop challenge to a proposed health care provider merger in the preceding two months.

Two factors, in particular, have contributed to the FTC’s aggressive litigation approach to these deals. First, there now exists a substantial, yet still-growing, body of empirical evidence that health care provider consolidation (and concentration) typically leads to substantially higher pricing, while providing no corresponding increases in quality. And second, the FTC’s recent streak of federal district (and appellate) court wins in challenges to provider mergers supplies added momentum to an aggressive approach.

The FTC’s posture toward recent hospital mergers may prove a roadmap for a similarly aggressive review of Walgreens’ proposed acquisition of Rite Aid. Retail pharmacies, like hospitals, are health care providers, which set reimbursement rates through negotiations with health plans. As a result, a challenge to Walgreens/Rite Aid would very likely draw upon the theory of harm the FTC has used to challenge recent provider mergers—namely, that the deal would lessen competition for inclusion in PBM networks, thereby increasing Walgreens’ bargaining leverage with PBMs, ultimately driving consumer premiums higher.

FTC Approach to Provider Consolidation; Implications for Walgreens/Rite Aid

FTC has aggressively challenged provider mergers in recent months—litigation winning streak adds momentum to aggressive approach. The FTC’s recent litigation flurry against provider mergers commenced November 6, when the FTC challenged Cabell Huntington Hospital’s proposed acquisition of St. Mary’s Medical Center. Roughly one month later, on December 8, the FTC challenged Penn State Hershey Medical Center’s proposed merger with PinnacleHealth System. And just ten days later, on December 18, the FTC challenged Advocate Health Care Network’s proposed merger with NorthShore University HealthSystem. Notably, each challenge relied upon the same theory of harm—specifically, that the challenged deals were likely to increase the combined provider network’s bargaining power with health plans, thereby driving prices higher, and quality lower.

The FTC’s aggressive recent approach to provider mergers is, aside from the proposed mergers’ underlying merits, the result of two primary factors. The first is the FTC’s track record of success in these challenges—a winning streak now dating back to 2007. The growing streak of court wins not only vindicates the FTC’s modern litigation approach to provider consolidation, but also provides persuasive caselaw to federal district court judges, and ultimately, drives momentum to pursue additional challenges.

The FTC has not always enjoyed such success. In fact, owing to seven straight losses in challenges to provider mergers in the mid to late 1990s, the FTC, in 2002, authorized staff economists and lawyers to undertake a wide-
ranging and comprehensive retrospective of consummated hospital mergers’ competitive effects. Concurrently, the Commission established a new litigation task force to investigate consummated hospital mergers—what is today the Bureau of Competition’s Mergers IV Division.

The FTC’s hospital merger retrospective discovered substantial empirical evidence that consummated hospital mergers had in fact produced anticompetitive effects, including substantially higher prices. This evidence, coupled with input from the new hospital-focused litigation task force, led the FTC to revamp its approach to hospital merger litigation in order to focus primarily on deals’ impacts on providers’ bargaining power with direct payers—namely, managed care organizations.

Owing at least in part to this revised approach, the FTC, beginning with ENG/Highland Park (2007), has enjoyed an uninterrupted streak of litigation victories in challenges to provider mergers in administrative and federal district courts, including ProMedica/St. Luke’s (March 2011), OSF/Rockford (April 2012), and St. Luke’s/Saltzer (January 2014). Notably, the FTC won appellate victories in both ProMedica and St. Luke’s, where district court decisions were upheld by the Sixth Circuit (April 2014) and Ninth Circuit (February 2015) respectively.

These appellate wins appear to have emboldened the FTC—especially given the decisions’ reliance on primarily structural factors. “What [ProMedica] said is high concentration numbers and a little spicy something on the side are enough to show an antitrust violation,” notes a former FTC attorney. “If you look at the Sixth Circuit decision in ProMedica, the Ninth Circuit decision in St Luke’s, you now have cases that go pretty far just on concentration numbers.”

**Empirical evidence of provider consolidation’s effects likewise drives aggressive approach.** Recent litigation victories are only one piece of the puzzle—eventually, if the facts do not support a case, the FTC’s winning streak will come to a rapid halt. Importantly, however, and in large parts concurrently with the FTC’s litigation winning streak, researchers have developed an extensive body of empirical evidence indicating that provider consolidation (and concentration) typically drives higher prices, with no corresponding quality of care improvements. In fact, perhaps more than any other sector, the empirical evidence indicates that health care provider consolidation is resolutely and comprehensively negative for patients.

At the outset, the FTC’s 2002 review of consummated hospital mergers, which led to four published retrospectives, confirmed that unsuccessfully challenged provider mergers tended to drive anticompetitive effects, including substantially higher prices. This empirical evidence, which indicated that the FTC was right to challenge (and courts wrong to allow) certain hospital mergers, provided significant internal momentum for continued challenges. And the FTC’s findings represented merely the tip of the iceberg—the retrospectives’ conclusion that that hospital consolidation and concentration typically drives anticompetitive effects has found broad support from an extensive body of recent academic research, too voluminous to summarize here (see this comprehensive summary from the RJWF Foundation).

Perhaps the most compelling research regarding provider concentration’s price effects, however, is also the most recent. In a study published December 15, 2015, researchers from Yale, Penn, LSE and Carnegie Mellon examined 92 billion health insurance claims submitted from 2007 to 2011, representing nearly 30% of all claims from the period. The research, unlike prior empirical work, provides evidence of nationwide (rather than state or regional) costs, benefits from access to actual negotiated prices (rather than relying on constructed estimates), and, most importantly, utilizes an incredibly comprehensive set of data.
Like the vast majority of the empirical literature, the study concludes that higher provider concentration, as measured by either HHI or number of competitors, drives substantially higher pricing. Specifically, the researchers’ data shows that prices in monopoly hospital markets were 15.3% higher than in markets with four or more hospitals, while duopoly markets (6.4%) and triopoly (4.8%) markets likewise demonstrated higher prices than markets with four or more hospitals.

Study co-author and Carnegie Mellon economics professor Martin Gaynor, who served as the Director of the FTC’s Bureau of Economics from October 2013 to October 2014, explains that the observed pricing effects in highly concentrated markets are largely a function of providers’ bargaining power. “It’s sort of like competition economics 101—it’s not terribly surprising if the buyer doesn’t have a lot of good alternatives, you’re going to be able to negotiate a higher price” says Gaynor. “So I think what we find conforms with intuition.”

The study’s finding of a relatively linear relationship between provider market concentration and pricing is particularly notable, Gaynor explains. “We do look at whether the market is a monopoly, duopoly or triopoly compared to four or more. And you get these very dramatic and classic type results, exactly as theory would predict,” Gaynor says. Notably, the price-concentration relationship holds constant, whether measured by number of competitors or HHI. “HHI generates the same kind of results, more concentrated markets, higher prices, less concentrated markets, lower prices,” says Gaynor. “We chose to sort of focus on the monopoly, duopoly, triopoly results just because they're sort of very intuitive and very easily interpretable, but if you use market shares and Herfindahl indices, everything works exactly as you would expect.”

Implications for Walgreens/Rite Aid—Walgreens and Rite Aid as health care providers; bargaining leverage. Given the close parallels between retail pharmacy and hospital markets, the FTC’s aggressive recent approach to health care provider consolidation is likely to have implications for the FTC’s review of Walgreens/Rite Aid. At the outset, as retail pharmacies, Walgreens and Rite Aid are health care providers. In fact, 37 states, by either state law or state Medicaid Provider Manual, assign pharmacists (and retail pharmacies) provider status. This designation, for which the pharmacy lobby has fought aggressively, positions pharmacists to receive compensation, and beneficiaries, coverage, for provided care.

That retail pharmacies are statutorily defined as health care providers, however, is not in and of itself particularly important. Much more relevant to the underlying competition issue, however, is the fact that hospitals and retail pharmacies set reimbursement rates in very similar fashions. Pharmacy benefits managers, like managed care organizations, assemble provider networks (retail pharmacies) through which their members acquire care (prescription drugs) at in-network rates. And, like hospitals, retail pharmacies, in negotiations to become in-network providers, bargain with PBMs over reimbursement rates, dispensing fees, and other terms.

As has been the case in recently-challenged provider mergers, the Rite Aid acquisition would position Walgreens with very high shares in a number of markets. including a 35%+ retail pharmacy revenue share in 14 of the top 20 US Core-Based Statistical Areas (CBSAs), and a 40%+ share in 9 of the top 20 CBSAs, including overlap markets Philadelphia (44%), Riverside, California (45%), New York (46%), and San Francisco (48%). Given Walgreens’ significant post-merger presence in the nation’s largest metro areas, PBMs may become less likely to “walk away” from network negotiations with Walgreens post-merger, in response to Walgreens’ demands for higher reimbursement rates, dispensing fees, or other terms.

In fact, this potential theory of harm appears to have basis in market reality, as interviewed PBM executives and consultants predict that the Rite Aid acquisition will indeed increase Walgreens’ bargaining leverage in negotiations.
with PBMs, thereby driving consumer premiums ultimately higher. These predictions, coupled with the significant parallels between retail pharmacy and hospital markets, provides further ammunition to the view that Walgreens will face a long, treacherous, and potentially uphill climb to FTC (and state AG) clearance of its Rite Aid acquisition.

**Issue Snapshot**

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<td>By acquiring Rite Aid, Walgreens would both extend its position as the nation’s largest retail pharmacy chain, and more importantly, obtain a quasi-dominant presence in many of the nation’s top metropolitan areas. By virtue of its expanded scale and penetration, Walgreens would be positioned to demand higher reimbursement rates and dispensing fees from PBMs. Given pass-through pricing, these higher costs would flow directly to consumers in the form of higher health insurance premiums or out-of-pocket costs. Combined with issues in the market for cash-paying customers, this analysis may drive federal and state regulators to pursue divestitures above and beyond Walgreens’ 1,000 store divestiture cap—or even pursue a full-stop injunction.</td>
<td>Potential harm in the market for cash-paying customers is addressable through targeted divestitures. On bargaining leverage, large PBMs are sophisticated, powerful buyers, and the Rite Aid acquisition will do very little to increase Walgreens’ leverage to demand higher reimbursement rates or dispensing fees. PBMs and employers have a number of levers to pull, including narrow/tiered networks, substitution to mail order pharmacy, or simply excluding Walgreens in favor of a network composed of CVS, independent pharmacies, mass merchants, and supermarkets. Furthermore, by solidifying and extending its national footprint, the Rite Aid deal may position Walgreens to offer more attractive preferred pharmacy networks—a move that could ultimately benefit consumers.</td>
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**Competitive Analysis**

- Walgreens/Rite Aid have significant geographic overlap, and the combination is likely to drive prices higher in the market for cash-paying customers. Effects in this market, alone, are likely to drive significant divestitures, perhaps 500 or more.
- In addition, the increased penetration, according to interviewed consultants and PBM executives, will position Walgreens to demand higher reimbursement rates or dispensing fees from PBMs. Divestitures to address the cash-paying market are unlikely to sufficiently address the bargaining leverage issue.
- Given pass-through PBM pricing, higher retail reimbursement rates or dispensing fees are likely to

**Competitive Analysis**

- The retail pharmacy industry is highly competitive, and cash-paying customers will typically have numerous, convenient options aside from Walgreens or Rite Aid.
- A combined Walgreens/Rite Aid would operate just 20% of pharmacy counters nationwide—a share significantly below what would be expected to drive unilateral market power. Even in overlap areas, PBMs (and cash-paying customers) will continue to have a number of proximate non-Walgreens pharmacy options.
- Although the combined Walgreens/Rite Aid would have relatively higher shares in top metro areas, PBMs are unlikely to pay higher rates or fees to retain Walgreens in-network, given the trend toward narrow/tiered networks, substitution to mail order, and abundant retail pharmacy competition.
pass through to consumers in the form of higher health insurance premiums or out-of-pocket costs.

- In Rite Aid/Revco (1996), the FTC pursued a full-stop injunction on a bargaining leverage theory of harm—leading the parties to ultimately abandon their deal.

- The FTC’s most recent large-scale retail pharmacy merger enforcement action, Rite Aid/PJC (2007), focused solely on the transaction’s effects on cash-paying customers, potentially indicating that the bargaining leverage theory is no longer relevant, given PBMs’ growth into national players with substantial countervailing buyer power.

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<td>- Deals with potential impact on health care costs are highly politically sensitive—especially in a post-ACA environment.</td>
<td>- To the extent Walgreens can demonstrate that, price effects notwithstanding, the Rite Aid acquisition would promote wellness or quality of care goals, enforcers could ultimately view the transaction as positive for ACA implementation.</td>
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<td>- In a close call, the Democratic-majority FTC is likely to err on the side of enforcement, to the extent staff paints a compelling picture of likely effects on health insurance premiums or out-of-pocket costs.</td>
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<td>- The FTC’s aggressive recent approach to health care provider consolidation, including three full-stop challenges in a two-month period, may provide a roadmap to a Walgreens/Rite Aid court challenge.</td>
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<td>- October 28, 2015 deal announcement; December 11 FTC second requests; - Parties project 2H 2016 close.</td>
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