UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

# PREPARED STATEMENT OF THE FEDERAL TRADE COMMISSION

**Before the**

## COMMITTEE ON THE JUDICIARY
## UNITED STATES HOUSE OF REPRESENTATIVES

## SUBCOMMITTEE ON COURTS AND COMPETITION POLICY

**On**

## Antitrust Enforcement in the Health Care Industry

**December 1, 2010**

## I. Introduction

Chairman Johnson, Ranking Member Coble, and members of the Subcommittee, I am Richard A. Feinstein, Director of the Bureau of Competition at the Federal Trade Commission (FTC). I appreciate the opportunity to testify on behalf of the Commission about the relationship between competition and antitrust enforcement, on the one hand, and lower health care costs and higher health care quality, on the other.[1] The magnitude of health care costs and the importance of health care quality demand our urgent attention. On a daily basis, millions of Americans require health care goods and services to maintain their basic quality of life. We have all seen the stories about the nearly 50 million uninsured,[2] and the fact that the U.S. health care system spends more per person, yet generates lower health care quality, than health care services in many other developed countries.[3] Health care costs burden both employees and employers, large and small, as well as federal, state, and local governments that pay for care under various government programs.

We are at an important point in the history of providing health care in this country. A comprehensive health care reform bill has become law.[4] No one can foresee exactly how all the provisions of the new law will mesh with the current system. But we can be certain that all stakeholders will have a part to play in making the new system run

[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and responses are my own and do not necessarily reflect the views of the Commission or of any Commissioner.
[2] *See* U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, 19-20 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf (noting slight decrease from 2006-07, but a general increase in uninsured from 1987-2007).
[3] *See, e.g.*, The Business Roundtable, The Business Roundtable Health Care Value Comparability Study, Executive Summary at 2 (2009), *available at* http://s73976.grindserver.com/healthcarestudy.pdf (observing 23 percent "value gap" relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France).
[4] The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119-1025 (March 23, 2010), to be codified at scattered sections of 42 U.S.C. ("Affordable Care Act"), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (March 30, 2010).

as efficiently as possible, so that the best health care can be provided to the most consumers at the least cost. Congress has charged the FTC with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] The FTC has played, and will continue to play, an important role in protecting and promoting competition to lower costs and improve quality, and believes that continued effective antitrust enforcement is a necessary component of any plan to improve health care.

Antitrust enforcement can improve health care in two ways. First, by preventing or stopping anticompetitive agreements to raise prices, antitrust enforcement saves money that consumers, employers, and governments otherwise would spend on health care. Second, competition spurs innovation that improves care and expands access.

The Commission tries to leverage its limited resources to yield the greatest benefit for American consumers. For example, the Commission has made stopping pay-for-delay agreements a top priority because of the substantial harm to consumers from these deals: a recent FTC Staff study found that they cost consumers about $3.5 billion a year.[6] On the merger front, the Commission has challenged numerous pharmaceutical acquisitions to prevent price increases and promote innovation. Last year the Commission successfully blocked CSL's attempt to acquire its competitor Talecris, preventing anticipated price increases in the multi-billion dollar blood plasma market.[7] Although pharmaceutical matters demand substantial resources and raise complex issues, the Commission pursues them because of the importance of pharmaceutical competition.

[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] FEDERAL TRADE COMMISSION, PAY-FOR-DELAY: HOW DRUG COMPANY PAY-OFFS COST CONSUMERS BILLIONS (Jan. 2010), *available at* http://www.ftc.gov/os/2010/01/100112payfordelayrpt.pdf.

[7] Fed. Trade Comm'n v. CSL Ltd. and Cerberus-Plasma Holdings LLC, 09-cv-1000-CKK (D. D.C. 2009) (Complaint).

The Commission has also stopped the accumulation of market power among hospitals and other clinics that threatened to increase prices or reduce quality, such as in the proposed merger of Inova Health System and Prince William Hospital in northern Virginia. After the Commission sued to enjoin the merger in federal district court, the parties decided to drop the deal.[8]

The Commission's enforcement efforts in the healthcare arena are also focused on protecting incentives to innovate. For example, Thoratec, the only producer of blood pumps used to support and sustain patients suffering from end-stage heart failure, sought to acquire Heartware, a potential entrant which was seeking approval for a new and innovative product. In 2009, the Commission successfully challenged this transaction to protect the vibrant competition between these two companies to innovate and develop new products that will improve health care.[9]

The FTC has also continued to challenge anticompetitive agreements among health care providers to fix the prices they charge to health insurance plans, conduct likely to raise prices without improving quality of care or expanding access to care.[10] The Commission's enforcement efforts also have helped assure that new and potentially more efficient ways of delivering and financing health care services can develop and compete in the marketplace.[11]

[8] *See infra* note 18 and accompanying text.
[9] *In the Matter of Thoratec Corp. and HeartWare Int'l, Inc.*, FTC Dkt. No. 9339 (July 30, 2009) (Complaint), *available at* http://www ftc.gov/os/adjpro/d9339/090730thoratecadminccmpt.pdf.
[10] *See* Fed. Trade Comm'n, FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *available at* http://www.ftc.gov/bc/healthcare/antitrust.pdf.
[11] *See id.*

Finally, the FTC and its staff have issued studies and reports regarding various aspects of the health care industry[12] and have analyzed competition issues raised by proposed state and federal regulation of health care markets.[13]

Based on the Subcommittee's interest, the Commission's testimony today will describe how our activities in two areas – (1) proposed mergers involving hospitals and outpatient clinics and (2) joint price negotiations by health care providers – further the goals of reducing costs and improving quality in the delivery of health care.[14] The testimony will also discuss Accountable Care Organizations ("ACOs"), and the Commission's efforts to provide guidance to ACOs as they develop in the marketplace. It is important to note, however, that these areas, as important as they are, do not represent the sole or even the bulk of the Commission's broad set of enforcement activities to protect American consumers from anticompetitive activity in health care markets.

## II. Increased Merger Scrutiny

A growing body of literature suggests that providers with significant market power can negotiate higher-than-competitive payment rates.[15] The Commission has

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[12] *See, e.g.*, FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf; FED. TRADE COMM'N, THE STRENGTH OF COMPETITION IN THE SALE OF CONTACT LENSES: AN FTC STUDY (2005), *available at* http://www.ftc.gov/reports/contactlens/050214contactlensrpt.pdf; FED. TRADE COMM'N AND DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[13] *See e.g.*,Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. on the Judiciary, Concerning H.R. 971, "the Community Pharmacy Fairness Act of 2007," 110th Cong. (Oct. 18, 2007), *available at* http://www ftc.gov/os/testimony/P859910pharm.pdf (criticizing proposal to exempt non-publicly traded pharmacies from antitrust scrutiny).

[14] On multiple occasions, the Commission has provided Congress testimony on the dangers of pay-for-delay patent settlements between brand and generic companies and the costs they impose on consumers, employers, and the government. Today, the Commission is providing testimony on other important areas of health care competition.

[15] *See, e.g.*, Ginsburg, Paul B., *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Center for Studying Health System Change, Research Paper No. 16, Nov. 2010,

worked to preserve competition in health care markets, in part, by carefully scrutinizing mergers and acquisitions by providers.

Several recent hospital merger enforcement actions highlight the Commission's ongoing focus on competition among hospitals. If a hospital acquisition deprives patients of choices for health care, it can increase the health care costs to both patients and employers that purchase health insurance. For example, in 2007, the Commission ruled that Evanston Northwestern Healthcare's consummated acquisition of its competitor, Highland Park Hospital, was anticompetitive[16] because the acquisition resulted in substantially higher prices and a substantial lessening of competition for acute care inpatient hospital services in parts of Chicago's northern suburbs.[17] Evanston's acquisition of Highland Park underscores the dangers that the accumulation of market power poses for consumers, the government, and employers, all of whom pay for health care.

A 2008 joint enforcement action by the FTC and the Virginia Attorney General stopped a merger of two health systems in northern Virginia that, according to the complaint, would have resulted in control of 73 percent of the licensed hospital beds in the area.[18] In our most recent merger case, the Commission challenged an acquisition that would have combined the two largest providers of acute inpatient psychiatric

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*available at* www.hschange.org/CONTENT/1162; Berenson, R., Ginsburg, P., & Kemper, N., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,* 29 HEALTH AFFAIRS No. 4 (April 2010).

[16] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Dkt. No. 9315 (Aug. 6, 2007) (Opinion of the Commission), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf (upholding with some modifications an October 2005 Initial Decision by an FTC Administrative Law Judge).

[17] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Dkt. No. 9315 (Oct. 20, 2005) (initial decision), *available at* http://www ftc.gov/os/adjpro/d9315/051021idtextversion.pdf.

[18] *See In the Matter of Inova Health System Foundation and Prince William Health Systems, Inc.*, FTC Dkt. No. 9326 (Jun. 17, 2008) (Order dismissing complaint), a*vailable at* http://www.ftc.gov/os/adjpro/d9326/080617orderdismisscmpt.pdf.

services in each of three markets – Delaware, Puerto Rico, and metropolitan Las Vegas.[19] The settlement preserves competition in the relevant areas by requiring the sale of 15 facilities to FTC-approved buyers. In all of these instances, the Commission acted to protect consumers and competition.

## III. Physician Services: Price Fixing vs. Clinical Integration

Some have suggested that the antitrust laws act as barriers to health care provider collaborations that could lower costs and improve quality.[20] That is simply wrong. Antitrust standards distinguish between price fixing by health care providers, which is likely to increase health care costs, and effective clinical integration among health care providers that has the potential to achieve cost savings and improve health outcomes. In order to assist in making that distinction clear, the Commission has provided extensive guidance on how health care providers can collaborate in ways consistent with the antitrust laws, precisely because such collaborations have the potential to reduce costs and improve quality.

### A. Price Fixing and Group Boycotts Are Likely to Raise Prices and Harm Consumers.

For more than 25 years, the Commission has challenged price fixing and boycott agreements through which health care providers jointly seek to increase the fees that they

[19] *In the Matter of Universal Health Services, Inc.*, FTC Dkt. No. C-4308 (consent order) (Nov. 15, 2010), *available at* http://www.ftc.gov/os/caselist/1010142/101115uhspsido.pdf.

[20] *See, e.g.*, Letter from Michael D. Maves, MD, Exec. Vice President, CEO, American Medical Ass'n, to the Hon. William E. Kovacic, Chairman, Federal Trade Commission, regarding Physician Network Integration and Joint Contracting (June 20, 2008), *available at* http://www.ftc.gov/bc/healthcare/checkup/pdf/AMAComments.pdf ("We are extremely concerned with what we see as the significant regulatory barriers that restrict physicians' ability to collaborate in ways crucial to improving quality and containing costs"); *cf.* Timothy Stolzfus Jost and Ezekiel J. Emmanuel, *Commentary: Legal Reforms Necessary to Promote Delivery System Innovation*, 299 JAMA 2561, 2562 (2008) (suggesting that uncertainty about forms of clinical integration permitted under the antitrust laws "could deter attempts to create accountable health systems.")

receive from health care plans.[21] Such arrangements typically involve competing health care providers agreeing to charge the same high prices and collectively refusing to serve a health plan's patients unless the health plan meets their fee demands. Since its 1982 *Maricopa* decision,[22] the U.S. Supreme Court has held that such conduct is considered to be *per se* unlawful because it is so likely to harm competition and consumers by raising prices for health care services and health care insurance coverage. This remains good law, and is also good competition policy. As part of its mission, the Commission continues to investigate such conduct.

The Commission's cases have challenged groups of providers that simply seek to jointly negotiate the fees they receive without improving quality, coordinating the care they provide, or reducing health care costs. The U.S. Court of Appeals for the Fifth Circuit recently affirmed a Commission opinion finding that an association of independent physicians in the Fort Worth area engaged in horizontal price fixing that was not related to any procompetitive efficiencies.[23] This type of conduct is likely to increase health care costs.

### B. The Antitrust Laws Promote Health Care Collaborations that Can Reduce Costs and Improve Quality.

The antitrust laws treat collaborations among health care providers that are *bona fide* efforts to create legitimate, efficiency-enhancing joint ventures differently from the way they treat price fixing schemes. The Commission asks two basic questions with respect to such collaborations. First, does the proposed collaboration offer the potential

[21] *See* FTC Bureau of Competition, Overview of FTC Antitrust Actions in Health Care Services and Products, *available at* http://www.ftc.gov/bc/0608hcupdate.pdf.
[22] *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 356-57 (1982) (agreements among competing physicians regarding fees they would charge health insurers for their services constituted *per se* unlawful horizontal price fixing).
[23] *North Texas Specialty Physicians v. Fed. Trade Comm'n*,528 F.3d 352 (5th Cir. 2008).

for pro-consumer cost savings or quality improvements in the provision of health care services? Second, are any price or other agreements among participants regarding the terms on which they will deal with health care insurers reasonably necessary to achieve those benefits? If the answer to both of those questions is "yes," then the collaboration is not considered a *per se* illegal agreement, but rather is evaluated under a rule of reason standard, which takes into account any likely procompetitive or anticompetitive effects from the collaboration.[24]

The FTC and the U.S. Department of Justice Antitrust Division issued Health Care Statements in 1993, and supplemented them in 1994 and 1996,[25] to provide guidance about what type of antitrust analysis the agencies will apply to various types of health care arrangements. Statement 8 explains how *bona fide* clinical integration by health care providers with the potential for significant cost savings and quality improvements may be demonstrated,[26] and in recent years, FTC staff have issued detailed advisory opinions responding to providers' proposed programs to help inform the industry about how the antitrust laws evaluate such agreements.[27] Proposed collaborations have often used programs such as electronic health records[28] and clinical

[24] *See Maricopa County Medical Soc.*, *supra* note 14, at 343 ("since Standard Oil Co. of New Jersey v. United States, 221 U.S. 1 (1911), we have analyzed most restraints under the so-called 'rule of reason.' As its name suggests, the rule of reason requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition.")

[25] U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), *available at* http://www ftc.gov/bc/healthcare/industryguide/policy/index.htm [hereinafter *Health Care Statements*].

[26] *Health Care Statements* at Statement 8, § B.1.

[27] *See, e.g.*, Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun, Ober, Kaler, Grimes & Shriver 8 (April 13, 2009) [hereinafter TriState Letter], *available at* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf; Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun & John J. Miles, Ober, Kaler, Grimes & Shriver 7 (Sept. 17, 2007) [hereinafter GRIPA letter], *available at* http://www.ftc.gov/bc/adops/gripa.pdf.

[28] Clinical integration programs frequently use sophisticated health information technology ("HIT") systems to help them implement their programs. However, the use of HIT systems or electronic health records alone is not sufficient to establish that a group has clinically integrated. It is how the collaboration uses those tools that counts for the antitrust analysis.

support for care management and quality improvement as means to achieve efficiencies and improved quality. These arrangements often involve collaboration among clinicians to create guidelines, measure their performance in relation to those guidelines, and agree on remedial approaches and consequences for failures to achieve certain performance goals. These are the same types of measures proposed by advocates of health care reform as ways to reduce costs and improve quality.[29]

## IV. Accountable Care Organizations

The new health care law encourages providers to create integrated health care delivery systems that can improve the quality of health care services and lower health care costs. In particular, Section 3022 of the Affordable Care Act establishes a Shared Savings Program to promote the formation of Accountable Care Organizations (ACOs).[30] An ACO can share in savings it creates for Medicare if the ACO meets certain quality performance standards, which are to be established by the HHS Secretary. Although there are several definitions of ACOs, the Congressional Research Service has explained the essential elements as:

> ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others around the ability to receive shared-savings bonuses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.[31]

The basic goal is for ACOs to improve the quality, and lower the costs, of health care by providing coordinated – rather than fragmented – care to patients. For example, an ACO

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[29] Elliot S. Fisher et al., *Achieving Health Care Reform – How Physicians Can Help*, 360 NEW ENG. J. MED. 2495, 2496 (2009); *see also, e.g.*, TriState Letter, *supra* note 18 (discussing web-based HIT system, software, and clinical guidelines and review proposal); GRIPA Letter *supra* note 18 (regarding GRIPA's tablet computer, HIT system, and data sharing proposal).

[30] Affordable Care Act, 42 U.S.C. § 3022.

[31] Congressional Research Service, "Accountable Care Organizations and the Medicare Shared Savings Program," (Nov. 4, 2010), at 1, *available at* http://op.bna.com/hl nsf/id/bbrk-8b2tvz/$File/CRSACO2010november.pdf.

can ensure that a particular patient with multiple chronic conditions is treated by ACO doctors that all have access to the same patient medical records, work together to plan the appropriate courses of treatment, and manage the patient's care to avoid harmful pharmaceutical interactions.

Experience has shown that integrating health care delivery among independent providers is a complex process that requires a substantial commitment of health care providers' resources and time.[32] Recent commentary suggests that, because of the resources and time required to integrate independent provider practices, health care providers are more likely to integrate their care delivery for Medicare beneficiaries if they also can use the same delivery system for patients covered by health care insurance in the private market. Thus, antitrust guidance may be appropriate for ACOs operating both under the Shared Savings Program and in the private market.

The FTC is using its experience and expertise in enforcing the antitrust laws in health care markets to work with other agencies, including the Department of Justice ("DOJ"), the Centers for Medicare & Medicaid Services ("CMS"), and the Office of the Inspector General ("OIG") of the Department of Health and Human Services, to develop workable rules and guidance for such ACOs.

To learn as much as possible about how well integrated health care delivery systems are currently operating, and to understand better how providers plan to integrate and participate in the Shared Savings Program, the FTC, CMS, and OIG hosted a workshop on October 5, 2010. The workshop was designed to obtain information from industry stakeholders who have an interest in, or experience with, the development and

[32] *See* Stephen M. Shortell, Lawrence P. Casalino, Elliott Fisher, "Implementing Accountable Care Organizations," Policy Brief (May 2010), *available at* http://www.law.berkeley.edu/files/chefs/Implementing_ACOs_May_2010.pdf.

operation of clinically or financially integrated health care groups. Participants included health care providers with integration efforts planned and underway, payers (insurers, employers, and consumers), and experts in health care policy. We learned a great deal from the workshop participants and from those who submitted comments in connection with the workshop, and that learning informs our consideration of possible policy approaches to ACOs.

As Chairman Leibowitz explained in opening the workshop, we want to explore whether we can develop safe harbors for ACOs, and whether it may be possible to have an expedited review process for those ACOs that fall outside of the safe harbors.[33] Commission staff is discussing those issues in depth with our colleagues at the Antitrust Division. Staff has received comments suggesting other approaches as well.[34] We believe antitrust policy can support the improved health care services and lower health care costs that Congress sought through the Shared Savings Program; after all, the antitrust laws do not stand in the way of collaborations among providers that improve health care quality and lower costs.

At the same time, it would be a mistake to ignore the lessons of the last quarter century. Simply allowing providers to fix prices or to accumulate market power will increase health care costs and frustrate the national imperative to control health costs, a goal that we all share. As Chairman Leibowitz noted at the workshop:

> So, the question before us today is: How can we design rules for ACOs that are flexible enough to allow the health care community to collaborate

[33] Jon Leibowitz, Chairman, Federal Trade Commission, Remarks Before the Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty Laws at 1 (Oct. 5, 2010) *available at* www ftc.gov/opp/workshops/aco/docs/leibowitz-remarks.pdf (hereinafter, "Leibowitz Remarks").

[34] *E.g.*, Comments of Blue Shield of California, *available at* www ftc.gov/0s/comments/aco/101104bsc.pdf (suggesting ACOs should not be permitted to engage in certain practices with alleged anticompetitive effects).

> to improve quality and decrease costs – but not to fix prices or create market concentration?[35]

The Commission will continue to work with DOJ, CMS and OIG, and will continue to solicit ideas from those who have a stake in the establishment of an optimum enforcement regime. Of course, that includes all of us – providers, enforcers, and most of all, consumers.

## V. Conclusion

Thank you for this opportunity to share the Commission's views on these vitally important issues. The Commission looks forward to working with the Committee to ensure that competitive health care markets deliver on the promise of competitively priced health care goods and services and increased innovation and quality.

[35] Leibowitz Remarks at 3.