



United States of America  
**Federal Trade Commission**

**“Hospital Consolidation: The Good, The Bad, and The Ugly”**

**Keynote Address by Maureen K. Ohlhausen  
Commissioner, Federal Trade Commission**

**Before the**

**2013 National Policy Forum  
America’s Health Insurance Plans  
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Good afternoon. Thanks for the kind introduction and for inviting me to speak with you today.<sup>1</sup> It is a pleasure to be part of your National Policy Forum. I plan to direct my remarks to the role the Federal Trade Commission plays to improve the economics of health care in the United States, and the “Good,” the “Bad,” and the “Ugly” that we have been seeing recently in terms of hospital and provider consolidation.

As this audience is acutely aware, we – and of course in many instances that means you – pay far too much for health care in this country. As Clint Eastwood’s character, Blondie, noted in the movie, “The Good, The Bad, & The Ugly”: “You see, in this world there’s two kinds of people, my friend: Those with loaded guns and those who dig. You dig.” Well, these days it seems as though when it comes to health care we the payers, including businesses and individuals, are always the ones that are being forced to dig . . . deeper and deeper into our wallets. And the numbers bear this out: we spend more today for health care than ever before –

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<sup>1</sup> The views expressed in these remarks are my own and do not necessarily reflect the views of the Commission or any other Commissioner.

expenditures have risen as a percentage of GDP from about 7% in 1970 to roughly 18% in 2010.<sup>2</sup> Think of that. Almost one in five dollars in this country now goes to pay for doctor visits, procedures, hospital facilities fees, medicine, and other costs to keep us healthy. And, unfortunately, this outsized health care system is a uniquely American problem. We outspend our peer nations in the OECD almost two to one on a per capita basis, when adjusted for purchasing power parity.<sup>3</sup> Nor does this translate into comparably better health care. Study after study shows that we are not receiving quality of care that on average is twice as good as those other nations – many studies suggest that by some measures we are in fact falling behind.<sup>4</sup> OK, so what's the problem here?

### **I. The FTC's Role In Policing Provider Consolidations**

There have been many potential causes of this problem discussed and debated over the years, from the structure of the third party payer system<sup>5</sup> to government programs creating costs for providers, to the price of drugs, and many more.<sup>6</sup> At the FTC we are mindful of these many issues, and account for them as appropriate in our approach to enforcement and policymaking in the health care sector. But one of the most immediate drivers of costs that has been top of mind

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<sup>2</sup> Derek Thompson, *The Conventional Wisdom About Government Health Care Spending Is Wrong*, THE ATLANTIC (Jan. 23, 2013), <http://www.theatlantic.com/business/archive/2013/01/the-conventional-wisdom-about-government-health-care-spending-is-wrong/267378/>.

<sup>3</sup> See ORG. FOR ECON. CO-OPERATION AND DEV., OECD HEALTH DATA 2011, <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013-Chart-set.pdf>.

<sup>4</sup> Derek Thompson, *Conventional Wisdom*, *supra* note 2.

<sup>5</sup> Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions* 6 (AEI Paper, June 2012), available at [http://www.aei.org/files/2012/06/12/-concentration-in-health-care-markets-chronic-problems-and-better-solutions\\_171350288300.pdf](http://www.aei.org/files/2012/06/12/-concentration-in-health-care-markets-chronic-problems-and-better-solutions_171350288300.pdf).

<sup>6</sup> See, e.g., Vivian Y. Wu, *Hospital Cost Shifting Revisited: New Evidence From the Balanced Budget Act of 1997*, 10 INT. J. OF HEALTH CARE FINANCE & ECONOMICS 61 (Mar. 2010) (discussing cost shifting phenomenon), available at <http://link.springer.com/article/10.1007%2Fs10754-009-9071-5>; Avik Roy, *How Obamacare's \$716 Billion In Cuts Will Drive Doctors Out of Medicare*, FORBES PHARMA & HEALTH CARE BLOG (Aug. 20, 2012, 1:56AM) (discussing shortage of doctors), <http://www.forbes.com/sites/aroy/2012/08/20/how-obamacares-716-billion-in-cuts-will-drive-doctors-out-of-medicare/>.

for the agency lately is this afternoon's topic of discussion: provider consolidation.<sup>7</sup> First, I'll set the stage with a few facts about what we are seeing in terms of consolidation and then I'll share with you some recent matters that could be fairly characterized as either the Good, the Bad, or the Ugly.

### **A. The National Trend to Provider Consolidation Since the 1990s**

We have seen a trend of consolidation since the 1990s that seems to have picked up pace the last few years with public sources showing more than 300 estimated hospital mergers since 2007.<sup>8</sup> This general trend, among other factors, has led the number of independent physicians to decline from 57% of the total in 2000 to only 39% today.<sup>9</sup> The number of independent specialists has declined even more quickly: In 2000, only one in twenty specialists was a hospital employee. Today, that ratio is one in four.<sup>10</sup> This trend of consolidation and its impact on pricing has led some scholars to conclude that "because antitrust policy has proved ineffective in curbing . . . providers' market power to win higher payments, policy makers need to consider approaches including price caps and all-payer rate setting."<sup>11</sup> I disagree with this conclusion and believe a more flexible, enforcement-based approach is appropriate in this complex field. We

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<sup>7</sup> See, e.g. Patrick S. Roman & David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare* (FTC Bureau of Econ., Working Paper No. 307, Nov. 2010), available at <http://www.ftc.gov/be/workpapers/wp307.pdf>; Robert Berenson, Paul Ginsburg & Nicole Kemper, *Unchecked Provider Clout In California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 699 (April 2010), available at <http://content.healthaffairs.org/content/early/2010/02/25/hlthaff.2009.0715.full.pdf+html>; William B. Vogt & Robert Town, *How Has Provider Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation, Synthesis Project No. 9, Feb. 2006).

<sup>8</sup> Vogt & Town, *supra* note 7, at 11; see also William B. Vogt & Robert Town, *The Impact of Hospital Consolidation - Update* (Robert Wood Johnson Foundation, Synthesis Project, June 2012).

<sup>9</sup> Julie Creswell & Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. TIMES, Nov. 30, 2012, <http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=all& r=0>.

<sup>10</sup> Jameson, Marni, *As Hospitals Take Over Doctors' Practices, Fees Rise*, ORLANDO SENTINEL, Sept. 15, 2012, [http://articles.orlandosentinel.com/2012-09-15/health/os-hospitals-buy-physicians-20120915\\_1\\_hospital-executives-hospital-employee-physician-practices](http://articles.orlandosentinel.com/2012-09-15/health/os-hospitals-buy-physicians-20120915_1_hospital-executives-hospital-employee-physician-practices).

<sup>11</sup> Berenson, Ginsburg & Kemper, *supra* note 7, at 699 (Abstract), available at <http://content.healthaffairs.org/content/early/2010/02/25/hlthaff.2009.0715.full.pdf+html>.

need to try to foster the potential benefits that can come from clinical integration while guarding against the possibility of provider market power, collusion, or other conduct that could harm consumers.

## **B. The FTC As A Health Care Policy Leader**

The Commission plays a valuable role in mitigating the effects of provider consolidation and helping weed out the combinations that are in fact bad for consumers. We do this through informed evidence-based antitrust enforcement that takes into account both the drawbacks and potential gains from various models of physician integration and applies flexible antitrust principles to this rapidly-changing field. We also offer considerable leadership through advocacy efforts, advisory opinions, business review memoranda, industry workshops, reports, and policy statements, like our Joint Statements with the Department of Justice on antitrust enforcement policy in health care<sup>12</sup> that provide specific guidance regarding the various types of provider networks and ventures, or more recently our Joint Statement on antitrust enforcement policy with respect to certain accountable care organizations (ACOs).<sup>13</sup>

While we take a cautious approach to intervening in the markets – we have only challenged a handful of hospital mergers in the last several years – our role in leading best practices will become even more important as the country implements The Patient Protection and Affordable Care Act<sup>14</sup> and its call for increased clinical integration and use of ACOs. The Act’s emphasis on greater clinical integration opens up the possibility of enhanced quality and more

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<sup>12</sup> U.S. DEP’T OF JUSTICE AND FED. TRADE COMM’N, STATEMENTS OF ENFORCEMENT POLICY IN HEALTH CARE (Aug. 1996), available at <http://www.justice.gov/atr/public/guidelines/1791.htm>.

<sup>13</sup> U.S. DEP’T OF JUSTICE AND FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM (Aug. 1996), available at <http://www.ftc.gov/opp/aco/>.

<sup>14</sup> Patient Protection and Affordable Care Act, Pub. L. No. 11-48, 124 Stat. 119 (2010). This law was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

efficient care – the potential “good” that can come out of providers working together more closely and rationally. Hopefully, this will not be taken as express support for further financial consolidation by providers. Enforcement agencies like the FTC will have to evaluate any such arrangements carefully, so as to mitigate the possible adverse effects of potential increases in provider market power, to prevent tacit pricing coordination, and to minimize the risk of outright collusion. The Commission has spent decades evaluating these types of issues and can continue to offer steady leadership in the years to come. With that, let me tell you some of the Good, the Bad, and the Ugly we’ve been seeing lately.

## **II. The FTC’s Recent Experiences with the Good, the Bad and The Ugly**

### **A. The “Good”**

One of the best kinds of “good” activity we have been seeing lately is a grassroots push in many states for expanded licensure of basic medical practices to include more registered nurses. This of course could have a strong effect in mitigating provider market power and in increasing affordable access to quality care in rural and less well-off areas of the country. The FTC’s Office of Policy Planning has been actively advocating to state legislatures in reports and testimony to loosen the restrictions on advanced practice registered nurses (APRNs) to allow them to prescribe certain medications, subject to responsible measures to control for quality and safety. Most recently, in September, Staff submitted testimony encouraging the West Virginia legislature to review the safety record of APRNs and consider whether it would make sense to remove the requirement that they must have a collaborative agreement with a physician before being able to prescribe medicine.<sup>15</sup> Currently, some evidence suggested some physicians in West Virginia were using this collaborative agreement requirement to charge APRNs to account

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<sup>15</sup> Prepared Statement of the Federal Trade Commission Staff before Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature, at 5 (Sept. 10-12, 2012), *available at* <http://www.ftc.gov/os/2012/09/120907wvatestimony.pdf>.

for the perceived loss of physician business or were simply refusing to enter into the agreements at all. While West Virginia is still considering this issue, 16 states and the District of Columbia already allow full practice by APRNs,<sup>16</sup> while nearly twenty other states are considering some type of measure to increase scope of practice. The FTC will continue to provide leadership in this important effort.

Another example of a “good” development is the continued use of the FTC/DOJ health care guidelines and advisory opinion program by providers looking to realize the efficiencies of clinical integration and cost-sharing while staying within the bounds of the antitrust laws. The FTC Staff recently gave an advisory opinion to a physician hospital organization in Oklahoma. There, the Norman Physician Hospital Organization was looking to create a “clinically integrated” network and to engage in joint contracting with third-party payers on behalf of its participating physicians and hospitals.

Norman’s proposal, which had been developed “slowly and deliberately” to get community buy-in, involved, among other things, creating a new organizational structure with specialty advisory groups that would be responsible for developing and updating clinical practice guidelines, a mentor’s committee to oversee global quality improvement planning, and a quality assurance committee to establish performance benchmarking, monitor compliance and administer corrective actions.<sup>17</sup> The Norman PHO also represented that there were no “vertical” arrangements between the hospitals and physicians that could allow for the exercise of market power and the PHO would operate as a non-exclusive network, meaning that if any health plan,

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<sup>16</sup> *Id.* at 6.

<sup>17</sup> Letter from Markus Meier, Ass’t Dir., Bureau of Competition, to Michael Joseph, Esq., regarding FTC Staff Norman PHO Advisory Opinion, at 4-6 (Feb. 13, 2013), *available at* [http://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr\\_0.pdf](http://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf).

employer, or third party payer did not wish to deal with the entire network, it could negotiate with individual participants or other networks with the same participating physicians without any interference from Norman.<sup>18</sup> These measures, and others, appeared to our Staff to offer the potential for a high degree of cooperation among the participating physicians and to generate significant efficiencies. In addition, Staff observed that the joint contracting activities were subordinate to the network's integrative activities and reasonably necessary to implement the program and achieve the efficiencies, leading Staff to indicate no present intention to recommend an enforcement action against the PHO. Hopefully we will see some efficiencies realized from this PHO.

In a similar vein, as many of you know the FTC provided considerable guidance in the new program for Accountable Care Organizations being administered by the Centers for Medicare and Medicaid Services (CMS). While it is still too early to tell whether this program can achieve its goals, thus far more than 250 ACOs have been established insuring in excess of 4 million people, many in areas in greatest need of quality care.<sup>19</sup> We are keeping our eye on this program and of course hope that it does in fact realize some of its goals without further exacerbating the problems we have seen with provider consolidation these last several years.

## **B. The “Bad”**

Let me now turn to some of the “bad” things we’ve seen in the last couple of years – although from our perspective many of these could be considered “good” because of their ultimate outcomes. As many of you know, some of our earlier efforts in challenging potentially

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<sup>18</sup> *Id.* at 1, 19.

<sup>19</sup> Press Release, U.S. Dep’t of Health & Human Servs., More Doctors, Hospitals Partner to Coordinate Care for People with Medicare (Jan. 10, 2013), available at <http://www.hhs.gov/news/press/2013pres/01/20130110a.html>.

anticompetitive provider consolidations met with mixed success, including a stinging series of losses in federal court during the 1990s.

While we lost those initial battles, we did not concede defeat. Instead, in 2002 then-chairman Tim Muris announced a study of consummated hospital mergers by Commission economists.<sup>20</sup> This study, and other subsequent work, helped show empirically that provider consolidation could indeed lead to higher prices and lower quality care. Following on the heels of these studies, the Agency stepped up its enforcement program.

This enhanced program has borne a lot of fruit recently. Most recently, just yesterday in fact, the Commission unanimously authorized Staff to file a lawsuit, together with the Idaho Attorney General, to block St. Luke's Health System's acquisition of Idaho's largest independent, multi-specialty physician practice group, Saltzer Medical Group.<sup>21</sup> St. Luke's is the largest health care system in Idaho and also the state's largest employer. This acquisition of the Saltzer Group, with its 44 physicians, gives St. Luke's nearly a 60 percent share of adult primary care physicians in the Boise suburb of Nampa, Idaho. St. Luke's now owns Saltzer's property and equipment and has the power to negotiate health plan contracts and set rates and service charges on Saltzer's behalf. Saltzer has entered five-year professional services agreements with St. Luke's on behalf of its doctors. We allege that the transaction makes St. Luke's dominant in this market and renders an alternative health care network without St. Luke's/Saltzer's primary care physicians much less attractive for employers with employees living in Nampa. Until now, health plans serving Nampa have been able to resist some of St.

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<sup>20</sup> Timothy J. Muris, Everything Old Is New Again, Remarks Before the 7th Annual Competition in Health Care Forum, at 19 (Nov. 7, 2002), available at <http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf>; William M. Sage, *Protecting Competition and Consumers: A Conversation With Timothy J. Muris*, 22 HEALTH AFFAIRS 101 (Nov. 2003), <http://content.healthaffairs.org/content/22/6/101.full> (last visited Mar. 12, 2013).

<sup>21</sup> Press Release, Fed. Trade Comm'n, FTC and Idaho Attorney General Challenge St. Luke's Health System's Acquisition of Saltzer Medical Group As Anticompetitive, (Mar. 12, 2013), available at <http://www.ftc.gov/opa/2013/03/stluke.shtm>.

Luke's demands for higher rates by turning to a network including a competing hospital, St. Alphonsus, and Saltzer Group. This deal has eliminated the ability of health plans to create that alternative network of adult primary care physicians.

This acquisition also is the subject of a long-running private dispute between St. Luke's, St. Alphonsus, and another Idaho hospital, Treasure Valley.<sup>22</sup> The deal and the private litigation have garnered national attention with the press focusing on the ability of hospital systems to buy up primary care groups, change the sign over the door, and then raise prices for the same procedures as before and impose new facilities fees because the doctors are now ostensibly in a hospital facility.<sup>23</sup> Some studies estimate that these types of price increases cost Medicare over \$1 billion per year and may cost private insurers as much or even more.<sup>24</sup> This is a matter of significant national importance, with the Commission laying down a marker to show we will turn a critical eye and carefully examine transactions that increase market power and may permit price increases not tied to improved quality of care.

In another recent matter, the Commission voted to file an administrative complaint against the Reading Health System in Pennsylvania to stop the purchase of a local specialty hospital, the Surgical Institute of Reading. As alleged in the administrative complaint, the Reading Health System was a dominant, vertically-integrated system in a small Pennsylvania town with several profitable facilities and over \$1 billion in cash and liquid assets. Despite being small, the Surgical Institute had entered the area in 2007 and successfully challenged Reading Hospital in several surgical specialties. Its presence had pushed down rates for these procedures

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<sup>22</sup> *Id.*

<sup>23</sup> Julie Creswell & Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. TIMES, Nov. 30, 2012, <http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=all&r=0>.

<sup>24</sup> *Id.*

and increased quality of care, allowing it to draw significant volumes of commercially-insured surgical patients away from the Reading Health System.<sup>25</sup>

According to the complaint, Reading pulled out all the stops to defeat the Surgical Institute and protect its turf, including allegedly using its vertically-owned businesses to attempt to foreclose the Surgical Institute. It offered health plans discounts to exclude the Surgical Institute from their networks, attempted to steer people covered by its partially-owned health plan away from the Surgical Institute (a meaningful issue considering it was the largest employer in the area), and its primary care doctors refused to refer patients to Surgical Institute specialists, unless the surgeries took place at one of Reading's facilities.<sup>26</sup> When these measures failed, Reading decided to buy its way out of the problem.<sup>27</sup> We filed suit on November 16, 2012, and the parties announced their abandonment of the deal the next business day. While counsel for one of the parties recently criticized this decision,<sup>28</sup> I think this was the right decision based on the facts before us. Had we not been vigilant and kept an eye on this deal it could have been a major blow to consumers in a hardscrabble part of central Pennsylvania.

One final example of the "bad," so to speak, comes out of a deal in Ohio. In early 2011, we challenged Promedica Health System's purchase of St. Luke's Hospital near Toledo. The complaint alleged that the acquisition gives Promedica the ability to demand higher rates for services at its three hospitals in that area of Ohio, because the addition of St. Luke's would make

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<sup>25</sup> Complaint ¶¶ 2-3, Reading Health System, File No. 121-0155 (F.T.C. Nov. 16, 2012), *available at* <http://www.ftc.gov/sites/default/files/documents/cases/2012/11/121116readingsurgicalcmpt.pdf> .

<sup>26</sup> *Id.* at ¶¶ 27-29.

<sup>27</sup> *Id.* at ¶ 29.

<sup>28</sup> Nicole Castle, *Recent Hospital Merger Antitrust Enforcement Action Highlights Conflicts and Uncertainties in Policies*, ANTITRUST HEALTH CARE CHRONICLE, at 9 (March 2013).

the Promedica system a “must-have” for health plans in the area.<sup>29</sup> I am sure this is an issue all of you are familiar with. In addition, this deal puts at risk the beneficial competition between Promedica and St. Luke’s, who had pushed each other to increase quality of care, add services, and provide non-financial benefits to local residents. After obtaining a preliminary injunction in federal court, the matter was litigated before an administrative law judge, who ordered Promedica to divest. The Commission affirmed this decision and the matter is currently on appeal to the Sixth Circuit. I know many of you are aware of this important case, as AHIP submitted an amicus brief making the court aware of the trend in provider consolidation and the impact that trend has had on health care prices.

### **C. The “Ugly”**

And now, let me turn to an example of the “ugly.” And I call this matter “ugly” not to be pejorative, but because while most of the cases I have described so far have involved a nuanced and careful balancing of the “good” and the “bad” competitive effects of joint ventures or acquisitions, this one is a situation of blatantly anticompetitive conduct among a group of providers in the guise of joint negotiation. This matter, which we settled a few weeks ago, involves a group of eight independent providers of nephrology services in southwestern Puerto Rico. Together, they represent about 90% of the available nephrologists in the region. The complaint alleges that these nephrologists became incensed when Humana began reducing reimbursements to reflect a change made by the Puerto Rican agency relating to certain dual eligible patients in Puerto Rican Medicaid, Mi Salud, and Medicare.<sup>30</sup>

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<sup>29</sup> Complaint ¶¶ 26-28, Promedica Health System, File No. 101-0167 (F.T.C. Jan. 6, 2011), *available at* <http://www.ftc.gov/os/adjpro/d9346/110106promedicacmpt.pdf>.

<sup>30</sup> Complaint ¶¶ 12-13, Práxedes E. Alvarez Santiago, M.D., File No. 121-0098 (F.T.C. Feb. 28, 2013), *available at* <http://www.ftc.gov/os/caselist/1210098/130228nephrologistscmpt.pdf>.

Now, there are many ways that these nephrologists could have expressed their frustration with this change, including some that were not naked violations of the antitrust laws. Instead, they chose to negotiate prices collectively for higher reimbursement rates with Humana via multiple emails in which many of them copied one another.<sup>31</sup> In case you aren't familiar with our antitrust laws, this is called price fixing. And it's a problem, particularly because these physicians' practices were all completely independent. But they did not stop there. When Humana declined to meet their demands, the complaint alleges the doctors collectively terminated their contracts with Humana and refused to treat their Mi Salud patients, including at least two people that had emergency situations requiring immediate transport to hospitals sixty and seventy miles away.<sup>32</sup> Thankfully, there were no fatalities. This latter negotiating tactic by the doctors is called, in antitrust parlance, a collective refusal to deal. Also not good. After negotiations with Staff, and perhaps upon seeing the error of their ways, the doctors settled with the Commission and are now subject to an order to cease and desist their conduct and to refrain from jointly refusing care in the future. The Commission did, however, leave the door open to them to enter a lawful, procompetitive joint venture, provided they notify us first. Hopefully, our strong action here will serve as a cautionary tale for providers thinking about joint negotiations in the future.

### **III. Conclusion**

The success of our health care system and of your work as insurers is critically important to the future of this country – particularly given our growing longevity and the record number of baby boomers now entering the years of greatest reliance on the health care system. While the

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<sup>31</sup> *Id.* at ¶ 13.

<sup>32</sup> *Id.* at ¶¶ 22-23. One patient's family objected to the transfer. *Id.* at ¶23. *See also* Press Release, Fed. Trade Comm'n, Eight Puerto Rican Doctors Settle FTC Price-Fixing Charges (Feb.28, 2013), *available at* <http://www.ftc.gov/opa/2013/02/prnephrologists.shtm>.

Affordable Care Act is controversial, I am hopeful that we are at the forefront of a new era in which we are better able to extract the efficiency and quality of care gains that come from reasonable clinical integration while adopting sound policies that can slow the unreasonable inflation we have seen these last several decades. You have a valuable voice in shaping the future of health care, one that could be put to good use in further educating consumers about the cost of care or informing some of the new programs being contemplated, like health insurance exchanges, which of course have been the subject of much vigorous debate these last few years. I want you to know that the FTC is a partner in this future and is actively and aggressively monitoring and enforcing the antitrust and competition laws when it comes to provider consolidation. I see a potentially significant benefit in laying down a marker in defense of competition as the key ordering principle in health care. While antitrust intervention should be pursued with great care, in the health care space antitrust actually may help to prevent or forestall much more onerous forms of regulation that may be called for in the future if too much consolidation takes place. I hope you've enjoyed my round-up of some of "the Good, the Bad, and the Ugly" that we are seeing at the FTC today and I look forward to the panelists' discussion. Thanks very much.