UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics
Northwest Regional Office

May 18, 2015

Senator Chip Shields
Oregon State Legislature
900 Court St. NE
Salem, Oregon 97301

Re: Request for Comment on Oregon Senate Bill 231A

Dear Senator Shields:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northwest Regional Office[1] are pleased to respond to your request for comment on the potential competitive impact of Oregon Senate Bill 231A ("SB 231A" or "the Bill"), including the purported need for a broad antitrust exemption to enable the creation of alternatives to traditional fee-for-service payment models.[2] The proposed Bill includes language intended to provide federal antitrust immunity for certain conversations, information exchanges, and agreements among participants in Oregon's health care markets, some of whom may be competitors.

FTC staff fully recognizes that collaborations among health care providers, payers, and other industry participants often are procompetitive. However, the broad antitrust exemptions asserted in Section 4 of SB 231A are based on misunderstandings about the antitrust laws.

Antitrust exemptions are unnecessary to enable health care industry participants to engage in procompetitive collaborative activities, such as enhancements to medical care delivery sought through the development of a Primary Care Transformation Initiative ("PCTI"). As a result, because procompetitive health care collaborations already are permissible under the antitrust laws, the main effect of SB 231A would be to immunize joint conduct that likely would restrain competition without generating countervailing efficiencies, and consequently would *not* pass muster under the antitrust laws. Therefore, FTC staff respectfully suggests that the proposed Bill is likely to lead to increased health care costs and decreased access to health care services for Oregon consumers – results that would be contrary to the goals of the PCTI.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting

commerce.[3] Competition is at the core of America's economy,[4] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[5] Pursuant to its statutory mandate, the FTC seeks to identify business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,[6] research,[7] and advocacy.[8] Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations, information exchanges, and other agreements among health care providers, as such exemptions are likely to harm consumers.[9]

II. The Oregon Primary Care Initiative and SB 231A

SB 231A was introduced in the Regular Session of the 78th Oregon Legislature Assembly and passed by the Senate on April 23, 2015.[10] FTC staff commends the underlying goal of the Bill: to study and improve the delivery of primary care services to Oregon health care consumers. The Bill directs the Oregon Health Authority to convene a primary care payment reform collaborative to advise and assist in the development of a PCTI. The collaborative will "develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care."[11] The PCTI will include representatives from throughout the industry.[12] The Bill also provides for data collection regarding the proportion of medical expenses that Oregon insurers, benefit boards, and Coordinated Care Organizations allocate to primary care, and requires information on how the benefit boards and Coordinated Care Organizations pay for primary care.

Section 4(1) of the Bill declares that "collaboration among insurers, purchasers and providers of health care to coordinate service delivery systems and develop innovative reimbursement methods in support of integrated and coordinated health care delivery is in the best interest of the public."[13] This section continues:

> The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, any person participating in the Primary Care Transformation Initiative, described in section 2 of this 2015 Act, that might otherwise be constrained by such laws.[14]

Further, Section 4(3) permits certain groups of industry participants and other stakeholders to meet to facilitate development, implementation, or operation of the PCTI, and Section 4(4) allows certain surveys of the same parties to assist in the evaluation of the PCTI. Section 4(5) purports to grant antitrust immunity for any meeting or survey covered by Section 4(3) or 4(4).

Section 4(2) directs the Director of the Oregon Health Authority to "engage in appropriate state supervision" "as necessary" to promote state action immunity.[15]

III. Concerns Regarding Potential Anticompetitive Effects of Oregon SB 231A

Putting aside the issue of the sufficiency of state oversight, FTC staff is concerned that the purported antitrust immunity provided by SB 231A may facilitate joint negotiations between providers and payers, encourage the exchange of competitively sensitive information among industry participants, and encourage other agreements that may harm competition and consumers. A broad antitrust exemption, such as the one apparently contemplated by SB 231A, is not needed to fulfill the otherwise procompetitive and beneficial goals of the PCTI.

A. The Purported Antitrust Exemption in SB 231A is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The inclusion of the purported antitrust exemption in SB 231A is based on two fundamentally flawed premises: first, that efficient, procompetitive collaborations among otherwise independent health care providers or other competitors are prohibited under the antitrust laws; and second, that blanket antitrust immunity is necessary to encourage such collaborations.

The antitrust laws already recognize and, indeed, have long stood for the proposition that procompetitive collaborations among competitors do not violate the antitrust laws. As explained in numerous sources of guidance issued by the federal antitrust agencies,[16] this position extends to collaborations among competing health care providers. FTC officials recently have emphasized that "[t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve."[17] The federal antitrust agencies have challenged very few of the thousands of mergers, joint ventures, and other types of collaborations among health care providers that have occurred in recent years. When the federal antitrust agencies have done so, they have "brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition."[18]

These same principles extend to meetings, surveys, and other forms of information exchange among competitors – many of which yield efficiencies and satisfy procompetitive goals, and therefore do not run afoul of the antitrust laws. For example, providers can use information derived from exchanges to price services more competitively or to offer compensation that attracts quality employees.[19] In fact, in their joint Statements of Antitrust Enforcement Policy in Health Care, the antitrust agencies have articulated an "Antitrust Safety Zone" for exchanges of price and cost information among providers that will not be challenged, absent extraordinary circumstances.[20] Similarly, procompetitive information exchanges by

purchasers can allow for more informed purchasing decisions.[21] At the same time, without appropriate safeguards, information exchanges among competitors can facilitate collusion.

Moreover, the goals of antitrust are consistent with the goals of the Patient Protection and Affordable Care Act ("ACA")[22] and Oregon's new PCTI. Antitrust is not a barrier to health care providers and other industry participants who seek to form procompetitive collaborative arrangements and transform health care delivery in ways that are likely to reduce costs and benefit health care consumers through increased efficiency, improved coordination of care, and greater innovation.

B. Antitrust Exemptions That Immunize Otherwise Anticompetitive Conduct Pose a Substantial Risk of Consumer Harm and Are Disfavored

Because antitrust law permits procompetitive collaborations and information exchanges among health care providers, no special "exemption" or "immunity" from existing antitrust laws is necessary to ensure that such procompetitive collaborations or information exchanges occur. The U.S. Supreme Court recently reiterated its long-standing position that "the antitrust laws' values of free enterprise and economic competition" make such special exemptions or immunities "disfavored."[23] There is no reason to treat the health care industry differently with regard to application of the antitrust laws. In the health care industry, just like in other industries, consumers benefit from vigorous competition and are harmed by anticompetitive conduct.[24]

Health care providers have repeatedly sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payers, asserting that immunity for joint bargaining is necessary to level the playing field so that providers can create and exercise countervailing market power.[25] In a 2004 report on health care competition, the federal antitrust agencies jointly responded to and countered this argument, explaining that antitrust exemptions "are likely to harm consumers by increasing costs without improving quality of care."[26] In its 2007 report, the bipartisan Antitrust Modernization Commission succinctly stated a widely recognized proposition: "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[27] In other words, antitrust exemptions threaten broad consumer harm while usually benefitting only a relatively few market participants.

Furthermore, FTC officials have noted that state legislation aimed at exempting health care providers engaging in collaborative activities from antitrust scrutiny may "encourage providers to negotiate collectively with health plans in order to extract higher rates, in effect allowing providers to fix their prices. By permitting conduct that would ordinarily violate antitrust laws, the bills would lead to higher prices and lower-quality care – undercutting the very objectives they aim to achieve."[28] While FTC officials have acknowledged that "[c]ollaboration designed to promote beneficial integrated care can benefit consumers," they also have warned that "collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payers raises significant antitrust concerns. Antitrust

concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty[.]"[29] SB 231A appears so broad as to invite competitors and other interested persons in any area of the state to exchange all manner of competitively sensitive information – perhaps even including current and future pricing information – which could facilitate or enable providers to increase the price and reduce the supply of health care services and goods. Indeed, SB 231A may even insulate unintegrated health care providers from liability for engaging in concerted negotiations with payers.

Given that efficient collaborations and information exchanges among health care providers (or other competitors) that are likely to benefit consumers already are consistent with the antitrust laws, FTC staff is concerned that SB 231A will encourage precisely the types of agreements among competitors that likely would *not* pass muster under the antitrust laws – agreements that would reduce competition, raise prices, and provide few or no benefits to consumers. Any effort to shield such harmful agreements from antitrust enforcement, including attempts to confer state action immunity, is likely to harm Oregon health care consumers.

IV. Conclusion

In summary, FTC staff not only believes that the antitrust exemptions contemplated in SB 231A are unnecessary to promote the goals of health care reform, but also is concerned that the purported exemptions are likely to foster anticompetitive conduct to the detriment of Oregon health care consumers. Therefore, we urge the Oregon legislature to reconsider whether SB 231A is in the public interest.

The FTC will continue to investigate and challenge transactions that are anticompetitive. In addition, we will continue to challenge defenses based on asserted state action immunity where the state fails to provide adequate active supervision.

Respectfully submitted,

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[1] This letter expresses the views of the FTC's Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northwest Regional Office. The letter does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Letter from Chip Shields, Senator, Or. State Legislature, to Marina Lao, Dir., Office of Policy Planning, Fed. Trade Comm'n (Apr. 30, 2015).

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

[4] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[5] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[6] *See generally* FED. TRADE COMM'N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Mar. 2013), https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/hcupdate.pdf. *See also Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care ("Cases").

[7] *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC sponsored workshop, independent research, and the Agencies' enforcement experience. *See also* FTC-DOJ workshop series, *Examining Health Care Competition*, Mar. 20-21, 2014 and Feb. 24-25, 2015, https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

[8] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports.

[9] *See, e.g.*, FTC Staff Comment to the Center for Health Care Policy and Resource Development on Certificate of Public Advantage Applications under the Delivery System Reform Incentive Program (Apr. 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf; FTC Staff Comment to Sen. Catherine Osten and Rep. Peter Tercyak, Conn. Gen. Assembly, Concerning H.B. 6431, Intended to Exempt Health Care Collaboratives from the Antitrust Laws (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to Sen. John J. Bonacic, N.Y. State Senate, Concerning N.Y. Senate Bill S.3186-A, Intended to Permit Collective

Negotiations by Health Care Providers (Oct. 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf; FTC Staff Comment to Sens. Coleman and Kissel and Reps. Fox and Hetherington, Conn. Gen. Assembly, Concerning Connecticut H.B. 6343, Intended to Exempt Members of Certified Cooperative Arrangements from the Antitrust Laws (June 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-senatorscoleman-andkissel-and-representativesfox-and-hetherington-concerning.b.6343intended-toexempt-members-certified-cooperative-arrangements-antitrust-laws/110608chc.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Tex. S.B. 8 to Exempt Certified Health Care Collaboratives from the Antitrust Laws (May 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.elliot-naishtat-concerning-texas-s.b.8-exempt-certified-health-care-collaboratives-antitrust-laws/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minn. House of Reps. Concerning Minn. H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-representative-tom-emmer-minnesota-house-representatives-concerning-minnesota-ok-h.f.no.120-and-senate-bill-s.f.no.203-health-care-cooperatives/v090003.pdf; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.william-j.seitz-concerning-ohio-executive-order-2007-23s-establish-collective-bargaining-home-health-care/v080001homecare.pdf; FTC Staff Comment before the P.R. House of Reps. Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-puerto-rico-house-representatives-concerning-s.b.2190-permit-collective-bargaining-health-care-providers/v080003puerto.pdf. All advocacies are available at https://www.ftc.gov/policy/advocacy/advocacy-filings.

[10] For more information on SB 231A and the Primary Care Transformation Initiative, *see* Oregon Health Authority Measure Summary, http://www.oregon.gov/oha/legactivity/SB%20231%20%28PC%20transformation%29%20one-pager%201.21.15.pdf.

[11] S.B. 231A, Section 2(2), 78th Leg. Assemb. (Or. 2015).

[12] *Id.* at Section 2(3).

[13] *Id.* at Section 4(1).

[14] *Id.*

[15] States may provide private actors or state agencies controlled by regulated persons with antitrust immunity for certain activities when there is a clearly articulated state policy to displace competition and there is active state supervision of the policy or activity. *See* Parker v. Brown, 317 U.S. 341 (1943), FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003 (2013), and North Carolina State Bd. Of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015). FTC staff takes no position at this time on whether SB 231A or the PCTI, as implemented, would satisfy the active supervision prong of the state action doctrine.

[16] To assist the business community in distinguishing between lawful and potentially harmful forms of competitor collaboration, the FTC and its sister federal antitrust agency, the DOJ, have issued considerable guidance over the years. Key sources of guidance include the Agencies' general guidelines on collaborations among competitors, as well as joint statements specifically addressing the application of the antitrust laws to the health care industry, including physician network joint ventures and other provider collaborations. *See* FED. TRADE COMM'N &U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/system/files/documents/public_statements/300481/000407ftcdojguidelines.pdf; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) [hereinafter DOJ & FTC, HEALTH CARE STATEMENTS], https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (Statement 8 regarding physician network joint ventures, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 6 regarding provider participation in exchanges of price and cost information). In addition, FTC staff has issued and made public numerous advisory opinion letters containing detailed analyses of specific proposed health care collaborations. These letters have helped the requesting parties avoid potentially unlawful conduct as they seek to devise new ways of responding to the demands of the marketplace. They also have provided further guidance to the health care industry as a whole. *See, e.g.*, Letter from Markus H. Meier, Fed. Trade Comm'n, to Michael E. Joseph, Esq., McAfee & Taft, Re: Norman PHO Advisory Opinion, Feb. 13, 2013, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun, Ober, Kaler, Grimes & Shriver, Re: TriState Health Partners, Inc. Advisory Opinion, Apr. 13, 2009, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf; Letter from Markus Meier, Fed. Trade Comm'n, to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Re: Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf.

[17] Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009. *See also* Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws."); Commissioner Julie Brill, Fed. Trade Comm'n, Keynote Address at the Catalyst For Payment Reform 2013 National Summit on Provider Market Power: Promoting Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs (June 11, 2013), https://www.ftc.gov/sites/

default/files/documents/public_statements/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos/130611cprspeech.pdf.

[18] Feinstein, *supra* note 17.

[19] DOJ & FTC, HEALTH CARE STATEMENTS, *supra* note 16, at Statement 6 (regarding provider participation in exchanges of price and cost information).

[20] *Id.* at A.

[21] *Id*.

[22] Pub. L. No. 111-148, § 3022, 14 Stat. 119, 395 ("Affordable Care Act").

[23] FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1010 (2013) (quoting FTC v. Ticor Title Ins. Co., 504 U. S. 621, 636 (1992)). *See also* North Carolina State Bd. Of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1117 (2015) ("The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.").

[24] *Phoebe Putney*, 133 S. Ct. at 1015 (state legislature's objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and "restrictions [imposed upon hospital authorities] should be read to suggest more modest aims."). As the U.S. Court of Appeals for the Fourth Circuit has observed, "[f]orewarned by the [Supreme Court's] decision in *National Society of Professional Engineers* . . . that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'" Va. Acad. of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 485 (4th Cir. 1980).

[25] In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public service aspect of professional practice controlling in determining whether § 1 includes professions." Goldfarb v. Va. State Bar, 421 U.S. 773, 787 (1975). *See also* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (Supreme Court rejection of argument that competition itself poses a "potential threat . . . to the public safety"); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

[26] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE, *supra* note 7, at 14.

[27] ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[28] Ramirez, *supra* note 17.

[29] Feinstein, *supra* note 17. There is a growing body of empirical research showing that increased concentration among health care providers results in higher prices without offsetting improvements in quality. *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.