

**HEALTHCARE GRAND ROUNDS SPEECH
JULY 30, 2012**

Bending the Health Care Cost Curve:

The View from the Federal Trade Commission

Good morning everyone. Thanks to Dr. Weinstein for the warm words of welcome. It's good to be back in the calm and cool New Hampshire climate. As a Vermonter, I am not sure that I will ever acclimate to the summer heat in Washington, D.C.

For the past two years, I have been a Commissioner at the Federal Trade Commission. Before joining the Commission, I spent the previous 20 years as a Vermont Assistant Attorney General for Consumer Protection and Antitrust. During that time, my husband and I were fortunate to become the proud parents of two wonderful boys who were both born here at Dartmouth in what was then the new birthing center. They are 16 and 19 now – time certainly flies!

I imagine that some – if not most – of you are not sure what the Federal Trade Commission does. We like to say that we are a “small but mighty agency.” Small in headcount compared with many federal agencies, but our portfolio and people cover a lot of ground across broad sectors of the economy.

We are the only federal agency with both consumer protection and competition jurisdiction. Our dual mission is to prevent business practices that are anticompetitive, and to stop deceptive or unfair practices that harm consumers. We seek to accomplish our twin goals without unduly burdening legitimate business activity, and we do so through a variety of tools given to us by Congress, including effective law enforcement; policy and research development through hearings, workshops, conferences, and reports; and practical and plain-language educational programs for consumers and businesses.

On the consumer protection front, we deal with everything from privacy to telemarketing fraud to false advertising. With respect to consumer fraud issues that touch on health care issues, we work with HHS on data security breach notifications by hospitals and other HIPAA covered entities, and we prosecute scam artists seeking to sell bogus health insurance to vulnerable consumers. We even run the Do Not Call list, which Dave Barry has called the most popular government program since the Elvis stamp.

But I'd like to focus my discussion today on the FTC's competition work, especially our efforts that affect your mission as health care providers -- namely hospital mergers and Accountable Care Organizations. I will also briefly touch on some of our work in the pharmaceutical arena, another important plank in the FTC's health care platform.

But let me start with a little context because – as with so many things – context matters here.

You are all familiar with rising health care costs. You live with them every day in a way that most Americans do not. Health care costs are estimated to be 18 per cent of our GDP today, and are projected to climb to 25 per cent of GDP in the next 10-15 years.¹ We spend more per person per year on health care than any other country on earth – in fact, at least 50% more than Norway, the country with the next highest per capita health care costs.² And yet there is a confounding lack of evidence demonstrating that our high level of spending is delivering better outcomes for patients.

In the past several years, competition issues related to health care have become a core focus for our agency. Our tools vary depending on the issue we are tackling, but the goal is consistent: We strive to use antitrust enforcement and policy to preserve health care competition and to bring down health care costs wherever we can.

We are in this game for the long haul, as demonstrated by our decade-long effort against pay-for-delay deals in the pharmaceutical industry. Pay-for-delay is the name given to a practice where brand name drug companies enter into sweetheart deals with their generic competitors to settle patent litigation. These deals delay generic drug entry because the brand company pays its generic competitor to stay off the market. It's a practice where the pharmaceutical industry wins, but consumers lose. The brand company protects its drug franchise, the generic competitor makes more money from the sweetheart deal than if it had entered the market and competed, and consumers end up paying an estimated additional \$3.5 billion annually because of these deals.³

This is why the FTC has targeted pay-for-delay deals since they became common within the pharmaceutical industry over ten years ago. Until recently, the courts have not always agreed with us on this issue. But earlier this month, in a landmark decision, an appellate court in the Mid-Atlantic, with jurisdiction over a significant number of U.S. pharmaceutical firms, agreed with our position on pay-for-delay.⁴ We are deliberating over our next steps on this important issue – it may well go to the Supreme Court – but for now we are very pleased with this result.

Let's turn now to hospital mergers. While I do not know of any mergers Dartmouth is currently contemplating, it might be helpful for you all to hear about the FTC's work in this area for future reference.

Since 2008, the FTC has challenged several anticompetitive hospital mergers, while at the same time allowing many, many more to proceed without a challenge. Let me tell you about three of the recent mergers we have challenged.

Our most recent hospital merger challenge involved OSF Healthcare System's proposal to buy the Rockford Health System in Rockford, Illinois. This merger would have reduced the

¹ Council of Economic Advisors, *The Economic Case for Health Care Reform* (June 2009) at 2, *available at* http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

² *Countries That Spend the Most on Healthcare*, Wall Street Journal, <http://247wallst.com/2012/03/29/countries-that-spend-the-most-on-health-care/3/>. (visited July 23, 2012)

³ FTC, *PAY-FOR-DELAY: HOW DRUG COMPANY PAY-OFFS COST CONSUMERS BILLIONS 2* (2010).

⁴ *In re K-Dur Antitrust Litigation*, No. 10-2077, 2012 WL 2877662 (3d Cir. July 16, 2012).

number of acute-care inpatient providers from three down to two, and would have given OSF a 64 per cent market share in the Rockford area. In November 2011, we went into federal court seeking a preliminary injunction, which we were granted by the local federal judge.⁵ Shortly after that, the parties abandoned the merger.⁶

In another case involving a merger between ProMedica and St. Luke's in the Toledo, Ohio area, we challenged a merger that was already complete and that reduced the number of hospitals in the Toledo area from four to three. We believed that the merger would reduce competition and enable ProMedica to increase prices to commercial payers. Last spring, a local federal judge granted our request for a preliminary injunction and in early January this year an administrative law judge at the FTC ordered ProMedica to divest St. Luke's Hospital to a suitable buyer.⁷ This decision was affirmed by the Commission at the end of March in a decision I wrote on behalf of the Commission.⁸ The parties have chosen to appeal this decision, and so the case continues.

Another hospital merger we recently challenged involved the merger to monopoly of two hospitals in Albany, Georgia: Phoebe Putney and Palmyra. While no one can easily afford higher costs that come from an anticompetitive merger, Albany Georgia was a community that would be particularly hard hit. Albany, Georgia is located in one of the poorest counties in the United States, with a 2009 median per capita income of less than \$16,000. The FTC fought hard to challenge the merger, to the point where we successfully petitioned the Supreme Court to hear our case.⁹

The Phoebe Putney merger raises some interesting questions for the Supreme Court to consider that go to the heart of the relationship between state laws and federal antitrust enforcement. Under Georgia law, local governments in that state are authorized to establish "hospital authorities" with the power to own and operate hospitals or to lease them to private entities. In fact, a private group – not the state – has operated Phoebe Putney hospital for over 20 years, without supervision by the hospital authority or any other state entity. In late 2010 Phoebe Putney set out to buy its only other competitor in the Albany metropolitan area, Palmyra Park Hospital, for \$195 million. The deal was structured to appear as though the hospital authority had purchased Palmyra. However, evidence obtained by the FTC showed that the local hospital authority was not even aware of Phoebe's negotiations with HCA, Palmyra's owner. Worse still, our investigation showed that Phoebe's counsel described using the local hospital

⁵ *FTC v. OSF Healthcare System*, No. 11 C 50344, 2012 WL 1134731 (N.D. Ill. Apr. 5, 2012).

⁶ See Press Release, FTC, OSF Healthcare System Abandons Plan to Buy Rockford in Light of FTC Lawsuit; FTC Dismisses its Complaint Seeking to Block the Transaction (Apr. 13, 2012), *available at* <http://www.ftc.gov/opa/2012/04/rockford2.shtm>.

⁷ In re ProMedica Health System, Inc. FTC Docket No. 9346 (Jan. 5, 2012), *available at* <http://www.ftc.gov/os/adjpro/d9346/120105promedicadecision.pdf>

⁸ In re ProMedica Health System, Inc. FTC Docket No. 9346 (Mar. 28, 2012), *available at* <http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf> (Opinion of the Commission)

⁹ *FTC v. Phoebe Putney Health System Inc.*, No. 11-1160, 2012 WL 985316 (U.S. June 25, 2012).

authority as a “proven” method of avoiding antitrust scrutiny of the merger under what is known as “the state action doctrine.”

The state action doctrine stems from a 70-year-old Supreme Court case that stands for the principle that federal antitrust laws should not apply to activities by the state when it is acting as a sovereign.¹⁰ Now, as a former long-time state competition enforcer, I take states’ sovereignty very seriously. But I also don’t believe state legislation should be used to shield anticompetitive conduct or mergers from antitrust scrutiny unless it’s very clear that is what the state intended. I saw no such clarity in the Phoebe Putney case, and neither did my colleagues on the Commission. This is why, after we lost this case on appeal based on the state action issue, we decided to petition the Supreme Court to take it up. I am pleased that the Supreme Court recently recognized the importance of the issues at stake.

Mention of the Supreme Court creates a nice segue to the final topic I’d like to discuss today, namely Accountable Care Organizations as envisioned by the Affordable Care Act of 2010. As everyone who hasn’t been on intergalactic travel over the past two months knows, the Supreme Court recently upheld the Affordable Care Act.¹¹

Of course, you all don’t need me to tell you what an ACO is. After all, Dartmouth’s own Elliot Fisher – Director of the Center for Health Policy Research at the Dartmouth Medical School – coined the term ACO in 2006. However, a brief review of the legislative framework for ACOs under the Affordable Care Act might be helpful. The Act establishes a new Medicare Shared Savings Program.¹² The Act also authorizes the establishment of provider-controlled contracting networks, called Accountable Care Organizations, to participate in the Shared Savings Program by contracting with CMS to care for Medicare fee-for-service beneficiaries in a coordinated manner.¹³ The intention is to improve health-care quality by mandating that ACOs meet quality of care benchmarks established by CMS, while at the same time incentivizing ACO provider participants to reduce health care costs below those that would otherwise prevail through their sharing in the savings generated by increased provider coordination. When you consider that for most providers Medicare accounts for between 40 to 50 percent of revenues, ACO coordination has the potential to result in significant Medicare savings, money that could be put to good use elsewhere in the economy.

These are worthy goals, and they are consistent with the FTC’s determination to play its role in helping to contain health care costs. Yet whenever competitors come together to collaborate, they must be careful to not run afoul of antitrust laws. ACOs formed between otherwise independent providers can give rise to two competition concerns: first, they can become vehicles through which providers can fix prices for their services – less of an issue for Medicare than commercial payers, but an issue nonetheless; and second, the formation of ACOs might create market power in a local market or allow market power to be used in new ways to

¹⁰ Parker v. Brown, 317 U.S. 341, 362 (1943).

¹¹ Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

¹² Affordable Care Act of 2010, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010).

¹³ *Ibid.*

the detriment of consumers. Congress, in designing the Shared Savings Program and ACO participation, specifically preserved antitrust enforcement to guard against these concerns.

So last fall the FTC, along with our sister competition agency, the US Department of Justice, developed an antitrust enforcement policy regarding ACOs.¹⁴ Our goal was to give members of the health care community clear guidance about these competition issues, and help health care providers form ACOs that have the potential to achieve efficiencies without bumping up against the antitrust laws.

Broadly speaking, our guidance creates safe harbors within which health care providers can collaborate free from antitrust concerns, and provides clear rules of the road for those ACOs not within the safe harbors. And we created a voluntary and expedited 90 day review process for ACOs.

We have sought where possible to be flexible in our approach. For example, we have responded to feedback from rural providers, and other stakeholders regarding the need for flexibility in a rural setting. The ACO policy statement permits ACOs in rural areas to include one physician or physician group in each specialty in the ACO from a “rural area,” regardless of the resulting market share, as long as that physician or group practice participates in the ACO on a non-exclusive basis. Rural hospitals may also participate in an ACO regardless of their market share, again as long as they participate in the ACO on a non-exclusive basis.

The other initiative we took in our ACO policy statement was to give providers clear examples of some practices that ACOs with market power will want to avoid. Some of these practices have long been considered troublesome by antitrust regulators.

Here are some of the practices we urge providers with market power to avoid:

- Sharing sensitive business information between competitor members of the ACO;
- Preventing or discouraging private payers from steering patients to certain providers through anti-steering clauses;
- Tying sales of the ACO’s services to a private payer’s purchase of other services outside the ACO;
- Contracting on an exclusive basis with ACO providers so that the providers are not available to contract with payers outside the ACO arrangement either individually or through other ACOs; and
- Restricting a private payer’s ability to make available to its enrollees information about cost, quality, efficiency, or performance that could aid enrollees in electing providers in the health plan.

¹⁴ FTC & U.S. DEP’T OF JUSTICE, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM (2011), *available at* http://www.justice.gov/atr/public/health_care/276458.pdf.

Our flexible approach to ACO formation is something of an experiment for us, but we are willing to engage in this effort because CMS will be collecting data in real time from each ACO to determine whether the Shared Savings Program has in fact improved quality of care and reduced costs to Medicare. The results of CMS's monitoring will allow the antitrust agencies to separate legitimate collaboration from that which might be considered problematic by us.

Earlier this month, Health and Human Services Secretary Kathleen Sebelius announced that 89 new ACOs have entered into agreements with CMS.¹⁵ I was pleased to see that included in this number were Vermont- and New Hampshire-based groups, such as the Accountable Care Coalition of the Green Mountains; Circle Health Alliance of Massachusetts and New Hampshire; and Concord Elliot ACO of Central and Southern New Hampshire. The 89 new ACOs brought the total number of organizations across the land participating in Medicare shared savings initiatives to 154. In all, as of July 1, 2012, more than 2.4 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

The Affordable Care Act encouraged the creation of these new ACOs. Once the ACO initiative is fully implemented, it is estimated that the program will save the federal government – and taxpayers – up to \$940 million over four years.¹⁶ We are not there yet, but the view from the FTC is that we will continue to play our role in helping to make this happen.

¹⁵ Press Release, Dep't of Health and Human Services, HHS Announces 89 new Accountable Care Organizations (July 9, 2012) available at <http://www.hhs.gov/news/press/2012pres/07/20120709a.html>.

¹⁶ *Ibid*