



United States of America
Federal Trade Commission

Protecting Consumer Welfare in the U.S. Health Care Sector

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**before
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Forum for EU-US Legal-Economic Affairs
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I. Introduction

Good afternoon. Thank you to Thomas Kosmo and The Mentor Group for inviting me to participate in this wonderful forum. I am delighted to speak to you today about the Federal Trade Commission's recent efforts to protect consumer welfare in the U.S. health care sector.

That sector happens to represent a significant portion of the U.S. economy. And, as I am sure you have heard, the U.S. health care sector is currently undergoing a non-trivial amount of change with the passage of the Patient Protection and Affordable Care Act,² often referred to as "Obamacare." Partly due to the Affordable Care Act, the health care sector has seen a fairly significant amount of consolidation – among hospital systems and among physician groups, as well as combinations of hospitals and physician groups.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct and regulation in health care markets has long been a key focus

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

² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

of FTC law enforcement, research, and advocacy. The FTC has investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, pharmaceuticals, and other health care goods and services.³ We regularly issue informal advisory opinions on the application of the antitrust laws to health care markets.⁴ In addition, we have conducted hearings, undertaken research, and issued reports and policy statements on various issues in health care competition, often in conjunction with the U.S. Department of Justice.⁵ Through this work, we have developed a substantial understanding of the competitive forces that drive innovation, costs, and prices in health care.

This afternoon, I would like to focus on a handful of recent FTC efforts that have demonstrated not only the importance we place on competition in the health care sector, but also the many tools that the agency has to address competitive issues that arise in the health care area or any other part of the economy. The FTC's tools include filing enforcement actions, engaging in competition advocacy, and issuing advisory opinions, among others. I will discuss recent examples of the FTC's use of each of these tools in the health care space.

³ See, e.g., FED. TRADE COMM'N STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2013), available at <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf>; FED. TRADE COMM'N STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN PHARMACEUTICAL SERVICES AND PRODUCTS (2013), available at <http://www.ftc.gov/bc/healthcare/antitrust/rxupdate.pdf>.

⁴ Information regarding the Commission's competition advisory opinion program is available at <http://www.ftc.gov/bc/advisory.shtm>.

⁵ See, e.g., FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM (2011), available at <http://www.ftc.gov/opp/aco/>; FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY IN HEALTH CARE (1996), available at <http://www.justice.gov/atr/public/guidelines/1791.htm>.

II. Enforcement Actions

A. Health Care Mergers and Acquisitions

First, as a law enforcement agency, the FTC brings enforcement actions to halt anticompetitive mergers and business conduct. Recent enforcement actions in the health care area have included challenges to mergers and acquisitions involving hospitals, surgery centers, and physician practice groups.

Before I discuss those matters, a brief historical review is necessary to put them in proper context. In 2002, on the heels of an eight-year period in which the FTC and Justice Department had lost seven consecutive hospital merger challenges, former FTC Chairman Timothy Muris announced a hospital merger retrospective project.⁶ The goals of the retrospective were to study consummated hospital mergers to determine whether any of them had resulted in higher prices and to update the agency's prior assumptions about the nature of competition in the health care sector. This project, and other subsequent work, helped show empirically that hospital consolidation could indeed lead to higher prices and lower-quality care. Following these studies, the FTC stepped up its enforcement program. The hospital retrospective ultimately deserves credit for not only the recent U.S. Supreme Court decision in *Phoebe Putney*,⁷ which I will discuss in more detail, but also several other recent favorable decisions in our hospital merger

⁶ See 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, 103 (2003).

⁷ *FTC v. Phoebe Putney Health Sys.*, 133 S. Ct. 1003 (2013).

challenges, including federal court victories in the *Rockford*⁸ and *ProMedica*⁹ cases and abandoned mergers in other matters.¹⁰

In *Phoebe Putney*, the Supreme Court issued a unanimous decision last February, siding with the FTC in its challenge of a merger that resulted in a near-monopoly in general, acute-care hospital services in the area around Albany, Georgia.¹¹ The Commission first sought to stop this merger in April 2011, but the federal district court denied the FTC's motion for a preliminary injunction.

At issue was whether the Georgia legislature had shielded the local hospital authority from federal antitrust review by granting it general powers to acquire hospitals. Under the state action doctrine, actions of the state or its subdivisions are not subject to the federal antitrust laws if the legislature clearly articulates and affirmatively expresses a policy to displace competition with regulation. The district court found that the state action doctrine prevented the FTC from challenging the local hospital authority's approval of the merger, and an appellate court agreed. The Supreme Court, however, reversed, finding no evidence that the state legislature contemplated that Georgia hospital authorities would displace competition by consolidating

⁸ *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012) (*Rockford*) (granting FTC's motion for preliminary injunction). In November 2011, the FTC challenged OSF Healthcare System's proposed acquisition of Rockford Health System, which would have combined two of the three acute-care hospitals in the Rockford, Illinois area. On April 5, 2012, the district court granted the FTC's request for a preliminary injunction, pending a full administrative trial on the merits. OSF Healthcare subsequently abandoned the proposed transaction, and the FTC dismissed the complaint.

⁹ *FTC v. ProMedica Health Sys.*, 2011 WL 1219281 (N.D. Ohio Mar. 29, 2011) (granting FTC's motion for preliminary injunction). In January 2011, the FTC challenged the acquisition of St. Luke's Hospital by ProMedica Health System, arguing that the transaction would reduce the number of acute-care hospitals in the Toledo, Ohio, area from four to three. After the federal court granted the preliminary injunction, the matter was litigated before an administrative law judge, who ordered ProMedica to divest St. Luke's. The Commission affirmed this decision and the matter is currently on appeal to the Sixth Circuit.

¹⁰ *See, e.g.*, Press Release, Fed. Trade Comm'n, Statement of FTC Competition Director Richard Feinstein on Today's Announcement by Capella Healthcare that It Will Abandon its Plan to Acquire Mercy Hot Springs (June 27, 2013), available at <http://www.ftc.gov/opa/2013/06/capella.shtm>; Press Release, Fed. Trade Comm'n, FTC Approves Order Dismissing Administrative Complaint Against Inova Health System Foundation and Prince William Health System, Inc. (June 17, 2008), available at <http://www.ftc.gov/opa/2008/06/inovafyi.shtm>.

¹¹ *Phoebe Putney*, 133 S. Ct. 1003.

hospital ownership, but rather that Georgia had conferred on its hospital authorities only general powers routinely conferred on private corporations. The Court found that was insufficient to displace the antitrust laws, holding that the state action doctrine applies only when the displacement of competition was the inherent, logical, or ordinary result of the exercise of authority delegated by the legislature.¹² Although the FTC recently settled its case against Phoebe Putney without a divestiture of the acquired hospital,¹³ the Supreme Court decision on the state action doctrine obtained in this case remains a significant victory for consumers – not only in the hospital merger setting, but across all of the many industries subject to regulation by the states.

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 complaint, Reading Health was a dominant, vertically-integrated system in eastern Pennsylvania with several profitable medical facilities. Despite being small, the Surgical Institute had entered the area in 2007 and successfully challenged Reading in several surgical specialties. Its presence had pushed down rates for these procedures and increased quality of care, allowing it to draw significant volumes of surgical patients away from the Reading Health System.¹⁴

According to the FTC’s complaint, Reading pulled no punches in trying to eliminate the increased competition it faced from the Surgical Institute. Reading offered health plans

¹² *Id.* at 1012-13, 1017.

¹³ See Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment at 1, Phoebe Putney Health Sys., Dkt. No. 9348 (F.T.C. Aug. 22, 2013) (explaining that even “assuming a finding of liability following a full merits trial and appeals, the legal and practical challenges presented by Georgia’s certificate of need (‘CON’) laws and regulations would very likely prevent a divestiture of hospital assets from being effectuated to restore competition”), available at <http://www.ftc.gov/os/adjpro/d9348/130822phoebeputneyanal.pdf>.

¹⁴ Complaint ¶¶ 1-2, 22-25, Reading Health Sys., Dkt. No. 9353 (F.T.C. Nov. 16, 2012), available at <http://www.ftc.gov/os/adjpro/d9353/121116readingsurgicalcmpt.pdf>.

discounts to exclude the Surgical Institute from their networks. Reading also attempted to steer patients covered by its partially-owned health plan away from the Surgical Institute (a meaningful issue, considering Reading was the largest employer in the area). Reading's primary care doctors also refused to refer patients to Surgical Institute specialists, unless the surgeries took place at one of Reading's facilities.¹⁵ When these measures failed, Reading decided to buy its way out of the problem of increased competition.¹⁶ The FTC filed suit to block the transaction on November 16, 2012,¹⁷ and the parties announced their abandonment of the deal the next business day.

Most recently, the Commission unanimously authorized its staff to file a lawsuit, together with the Idaho Attorney General, to block St. Luke's Health System's acquisition of Saltzer Medical Group.¹⁸ St. Luke's is the largest health care system in Idaho and also the state's largest employer, while Saltzer is Idaho's largest independent, multi-specialty physician practice group. This acquisition gives St. Luke's nearly a 60 percent share of adult primary care physicians in the Boise suburb of Nampa, Idaho. The FTC alleged that the transaction eliminated significant head-to-head competition between the merging parties and thereby increased St. Luke's ability and incentive to demand higher reimbursement rates from commercial health insurance providers. Before this transaction, health plans serving Nampa had been able to resist some of St. Luke's demands for higher rates by turning to an alternative network that included the Saltzer Group and a competing hospital, St. Alphonsus. This deal has eliminated the ability of health

¹⁵ *Id.* ¶¶ 27-28.

¹⁶ *Id.* ¶ 29.

¹⁷ The complaint alleged four relevant markets in which the acquisition threatened competitive harm: (1) inpatient orthopedic surgical services; (2) outpatient orthopedic surgical services; (3) outpatient ear, nose, and throat surgical services; and (4) outpatient general surgical services. *Id.* ¶¶ 4, 42-50.

¹⁸ Complaint, FTC v. St. Luke's Health Sys., No. 13-cv-116-BLW (D. Idaho filed Mar. 26, 2013), *available at* <http://www.ftc.gov/os/caselist/1210069/130312stlukescmpt.pdf>.

plans to create that alternative network of adult primary care physicians. As a result, the FTC has alleged that the transaction will lead to higher health care costs and a loss of valuable non-price competition in the relevant market.¹⁹

As these three recent matters show, the FTC remains vigilant in reviewing mergers and acquisitions in the health care space to ensure that consolidation – whether it involves hospitals, other medical facilities, or physician groups – does not result in harm to consumer welfare.

B. Health Care Provider Conduct

In addition to scrutinizing mergers carefully, the FTC investigates, and in some cases challenges as unlawful, certain business conduct by health care providers. One type of conduct that the Commission encounters all too frequently is blatantly anticompetitive behavior among groups of providers in the guise of joint negotiation. The Commission recently settled a matter involving price fixing and a group boycott by eight independent providers of nephrology services in southwestern Puerto Rico. Together, they represented about 90% of the available nephrologists in the region. The complaint alleged that these physicians agreed to fix the prices and conditions under which they would participate in Mi Salud, which is Puerto Rico's Medicaid program for providing health care services to indigent residents.²⁰

When Humana Health Plans of Puerto Rico, the administrator of the Mi Salud program, began reducing reimbursements relating to certain patients eligible for both Medicare and Medicaid, the eight nephrologists acted collectively to restrain competition. First, the physicians chose to negotiate prices collectively for higher reimbursement rates with Humana via multiple emails in which many of them copied one another.²¹ In case you are not familiar with our

¹⁹ *Id.* ¶¶ 1-3, 37-38, 43.

²⁰ Complaint ¶¶ 1-2, 12-13, Praxedes 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>.

²¹ *Id.* ¶¶ 14-19.

antitrust laws, this is called price fixing, and it is a problem, particularly because these physicians' practices were otherwise completely independent of each other. But, the physicians 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 transport to hospitals over sixty miles away.²² Thankfully, there were no fatalities. This latter negotiating tactic by the doctors is called, in antitrust parlance, a collective refusal to deal or group boycott.

After negotiations with FTC 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, however, did 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 unlawful joint negotiations in the future.²³

III. Competition Advocacy

Another important part of the FTC's mission is advocating for competition. This advocacy takes a number of forms, including providing testimony or comments on proposed federal and state legislation and regulations, advising other federal agencies on competition issues, filing amicus briefs in federal and state courts, and advocating for competition principles in public fora.

²² *Id.* ¶¶ 20-23.

²³ In August 2012, the Commission settled similar price fixing and group boycott charges against a Puerto Rican cooperative of pharmacy owners known as "Coopharma." Members of Coopharma own approximately 360 community pharmacies in Puerto Rico. Our complaint alleged that Coopharma harmed competition by negotiating and entering into agreements among its member pharmacies to fix prices and by acting collectively to pressure third-party payers to pay its members higher prices. Complaint ¶¶ 1, 11, *Cooperativa de Farmacias Puertorriquenas* ("Coopharma"), Dkt. No. C-4374 (F.T.C. Aug. 21, 2012), *available at* <http://www.ftc.gov/os/caselist/1010079/121107coopharmacmpt.pdf>.

Broadly speaking, advocacy at the FTC involves the use of our expertise in competition, consumer protection, and economics to persuade other government actors to pursue policies that promote competition and consumer welfare. Sometimes, this advocacy is conducted in support of a particular law or regulation that would benefit competition and consumers. All too often, however, this advocacy is directed to proposed laws or regulations that would limit choices and make consumers worse off – by, for example, restricting certain business practices or prohibiting some business models altogether, or even seeking to immunize certain anticompetitive conduct from the federal antitrust laws. Even if well-intentioned, these government-imposed restraints can inflict as much, if not more, harm on consumers than private anticompetitive conduct. And, as statutes or regulations enacted by the government, these restraints are, of course, more durable than any private conduct could be.

Not surprisingly, a significant portion of the FTC’s competition advocacy work is focused on the health care sector. Within that space, we often encounter federal and state legislative proposals seeking to create antitrust immunity for certain health care providers to bargain collectively over reimbursement rates with health insurers and other third-party payers. The FTC has long advocated against such immunity because it is likely to harm consumers.²⁴

A recent letter issued by FTC staff addressed such a proposed exemption from the antitrust laws in the state of Connecticut.²⁵ The legislation there provided for the formation of so-called “health care collaboratives” or joint ventures comprising otherwise independent health care practitioners, such as physicians. The bill would authorize members of these collaboratives

²⁴ See, e.g., Prepared Statement of the Federal Trade Commission before the Subcommittee on Intellectual Property, Competition, and the Internet of the Committee on the Judiciary, U.S. House of Representatives concerning H.R. 1946, “Preserving Our Hometown Independent Pharmacies Act of 2011,” at 1-2 & n.2 (Mar. 29, 2012) (opposing H.R. 1946 and explaining FTC’s long-standing opposition to antitrust exemptions for health care providers), available at <http://www.ftc.gov/os/testimony/120329pharmacytestimony.pdf>.

²⁵ Letter from Fed. Trade Comm’n Staff, to Conn. Gen. Assemb. Labor & Pub. Emps. Comm. regarding Conn. H.B. 6431 (June 4, 2013), available at <http://www.ftc.gov/os/2013/06/130605conncoopcomment.pdf>.

jointly to negotiate prices and other terms with health plans. It also attempted to immunize these joint negotiations from scrutiny under the antitrust laws.²⁶

As the FTC staff acknowledged in their advocacy letter, collaborations among physicians and other health care professionals can be beneficial. At the same time, the letter made two primary arguments against the proposed bill. First, the antitrust laws are not a barrier to the formation of efficient health care collaborations that benefit consumers. As explained in extensive guidance issued by the FTC and the Justice Department, competitor collaborations – including health care provider collaborations – often are entirely consistent with the antitrust laws.²⁷ That is, the antitrust laws do not stand in the way of health care providers who form collaborative arrangements that are likely to reduce costs and benefit consumers through increased efficiency and improved coordination of care.

Second, a central purpose of the proposed legislation appeared to be to permit physicians to extract higher reimbursement rates from health plans through joint negotiations, not to integrate their practices to reduce costs or better coordinate care for their patients. The joint negotiations contemplated by the bill were likely to lead to increased health care costs and decreased access to services for consumers. Because procompetitive health care collaborations already are permissible under the antitrust laws, the bill's main effect thus would have been to foster precisely those types of collective negotiations that would not generate efficiencies and therefore would not pass muster under the antitrust laws. Given the substantial risk that the bill would encourage the

²⁶ *See id.* at 3.

²⁷ *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

formation of inefficient and anticompetitive collaborations among providers, FTC staff urged the legislators not to attempt to shield them from the antitrust laws.²⁸

Health care providers repeatedly have sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from health insurers and other payers, asserting that immunity for joint bargaining is necessary to “level the playing field,” so that providers can create and exercise countervailing market power. Our response has come down to the following point: reducing competition on one side of a market (that is, physicians or other health care providers) is not the answer to a perceived lack of competition on the other side of that market (that is, insurers and other third-party payers). The U.S. antitrust agencies have consistently opposed these exemptions because they are likely to harm consumers by increasing costs without improving quality of care, and I expect that we will continue to oppose these attempts to authorize departures from competition.

IV. Advisory Opinions

Finally, lest you think we always say “no,” I would like to address a recent collective effort by health care providers that the FTC staff found could actually benefit consumers on balance. One of our goals in the health care area should be to try to foster the efficiencies and other potential benefits that can come from the clinical integration of providers while guarding against the possibility of provider market power, collusion, or other conduct that could harm consumers. Both the FTC and the Justice Department can do this through their respective advisory opinion programs, under which providers and other interested parties can seek the views of agency staff regarding proposed business arrangements and conduct. At the FTC, this process can result in an advisory opinion letter from Commission staff indicating that they do not

²⁸ The Connecticut General Assembly did not enact the bill into law during the 2013 legislative session, which adjourned on June 5, 2013.

have any present intention to challenge the proposed arrangement or conduct as unlawful.²⁹ FTC staff typically rely on the representations of the party seeking an advisory opinion; thus, staff retain the right to change their enforcement views in the event that the actual operations deviate from the proposal or otherwise prove to have anticompetitive effects.

The FTC staff recently issued an advisory opinion to a physician hospital organization, or PHO, in Oklahoma.³⁰ There, the Norman PHO 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. In its proposal, the PHO represented that it would operate as a non-exclusive network, meaning that if any health plan, 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.³¹ Norman’s proposal also contemplated, among other things, the creation of a new organizational structure with (1) specialty advisory groups that would be responsible for developing and updating clinical practice guidelines, (2) a mentor’s committee to oversee quality improvement planning across the network, and (3) a quality assurance committee to establish performance benchmarking, monitor compliance with the network’s standards, and administer corrective actions, including, if necessary, expelling participating physicians from the network for non-compliance with the PHO’s clinical practice guidelines or other requirements.³²

These measures, and others, appeared to our staff to offer the potential for a high degree of interdependence and cooperation among the participating physicians and to generate

²⁹ See *supra* note 4.

³⁰ Advisory Op. Letter from Fed. Trade Comm’n Staff, to Michael E. Joseph, Esq. regarding Norman Physician Hosp. Org. (Feb. 13, 2013), available at <http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf>.

³¹ *Id.* at 10-11.

³² *Id.* at 5-6.

significant efficiencies in the provision of their services to patients. In addition, staff observed that the contemplated joint contracting activities were subordinate to the network's integrative activities and reasonably necessary to implement the program and achieve its efficiencies. Ultimately, staff indicated to Norman that it had no present intention to recommend an enforcement action against the PHO.³³ We hope we will see some efficiencies realized from this collaboration. Further, the Norman advisory opinion letter, although not representing the views of the Commission, should offer some meaningful guidance to other providers looking to integrate clinically without running afoul of the antitrust laws.

V. Conclusion

To conclude, while we take a cautious approach to intervening in the markets, our role in encouraging best practices will become even more important as the U.S. implements the Affordable Care Act and its call for increased clinical integration and use of accountable care organizations, or ACOs. The Act's emphasis on greater clinical integration opens up the possibility of enhanced quality and more efficient care – the potential consumer benefit that can result from providers working together more closely and efficiently. I hope, however, 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 to mitigate the possible adverse effects of potential increases in provider market power, prevent tacit pricing coordination, and minimize the risk of outright collusion.

Unfortunately, many people, including health care providers, seem to confuse or misunderstand the Affordable Care Act's emphasis on clinical integration and pursuit of efficiency and quality gains as a call for increased consolidation without regard to the antitrust laws. These folks see a significant tension between the Act and our enforcement of the antitrust

³³ *Id.* at 2, 20.

laws. In my view, however, the antitrust laws and the Act simply are not at odds. The goals of the Act include fostering greater efficiencies for patients – that is, higher quality at lower cost – through increased coordination of care, while FTC challenges to anticompetitive consolidations of hospitals or providers serve to protect competition that creates efficiencies and benefits patients. Further, the Act does not call for consolidation as an end in itself, and there is certainly no legal immunity from antitrust law under the Act or its implementing regulations. Thus, I fail to see any material tension between the goals of the Act and our antitrust enforcement efforts.

Finally, as an FTC Commissioner, I will continue to support our efforts to prevent harm to consumers resulting from anticompetitive consolidations or collective actions involving hospitals, physicians, or other health care providers. Whether it is in the health care sector or elsewhere, the FTC has used and should continue to use its law enforcement, competition advocacy, and advisory opinion tools in these efforts. Thank you very much. I look forward to hearing your questions and comments.