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 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

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[1] Council of Economic Advisors, The Economic Case for Health Care Reform (June 2009) at 2,

number of acute-care inpatient providers from three down to tw

the detriment of consumers. Congress, in designing the Shared Shavings 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

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*