Everything Old is New Again: Health Care and Competition in the 21st Century

Prepared Remarks of

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*This speech does not necessarily reflect the views of the Commission or any other individual Commissioner.

Thank you for inviting me to address the 7th Annual Competition in Health Care Forum. Chicago is a singularly appropriate location for this forum – particularly the 7th such forum. The 7th Circuit Court of Appeals, which has issued a series of seminal opinions in health care antitrust, is located just a few miles from here. One can track many of the major developments in health care antitrust in the last few decades simply by listing the names of 7th Circuit cases, including *Indiana Federation of Dentists*,[1] *Ball Memorial Hospital*,[2] *Hospital Corporation of America*,[3] *Schachar*,[4] *Wilk Tf 0 t47Tf Q q /F2 8.25 Tf 0.375*

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development of antitrust law. These cases also had a powerful impact on public attitudes toward competition and the professions.

I will talk this afternoon about several subjects, including the nature of the current health care marketplace, the importance of competition in health care, the kinds of anticompetitive behavior the Commission is seeing,

anthrax tests and weight loss products when those products do not perform as advertised.[18]

A more general consumer protection problem in health care is the relative scarcity of information about cost and quality. Without good information, transaction costs and uncertainty increase dramatically. Consumers have great difficulty obtaining the goods and services they desire. The Commission has been a strong voice for allowing competition to deliver truthful and accurate information to consumers, and has long supported the voluntary disclosure of truthful non-deceptive information by market participants. Nobel Laureate George Stigler once observed that advertising is "an immensely powerful instrument for the elimination of ignorance."[19] Studies by the Bureau of Economics have confirmed that advertising provides a powerful tool to communicate information about health and wellness to consumers – and the information can change people's behavior.[20] Two months ago, the FTC staff responded to a request by the FDA for comments addressing whether its regulations, guidelines, policies, and practices comply with the First Amendment. These staff comments outlined the empirical evidence on the benefits to consumers from the free flow of truthful and non-deceptive commercial information.[21] These actions exemplify the Commission's commitment to consumer empowerment through information.

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[18] *See Tipping the Scales? Weight Loss Ads Found Heavy on Deception* (Sept. 2002), available at <http://www.ftc.gov/bcp/conline/features/wgtloss.htm>; *FTC Announces First Two Enforcement Actions Against Purveyors of Bioterrorism Defense Products* (Feb. 27, 2002), available at <http://www.ftc.gov/opa/2002/02/vitalraw.htm>.

[19] George J. Stigler, *The Economics of Information*, 69 J. POLIT. ECON. 213 (1961).

[20] *See* Pauline Ippolito & Jan Pappalardo, *Advertising, Nutrition & Health: Evidence from Food Advertising 1977-1997, FTC Bureau of Economics Staff Report* (Sept. 2002), available at <http://www.ftc.gov/opa/2002/10/foodads.htm>.

[21] *FTC Staff Provides FDA With Comments on First Amendment Commercial Speech Doctrine* (Sept. 22, 2002), available at <http://www.ftc.gov/opa/2002/09/fdacomment.htm>.

Much remains to be accomplished in this area of the law to ensure that the market for health care goods and services operates efficiently. If I surveyed the public about whether they had better information about their last purchase of health care services or their last car, we all know what the answer would be. Information about the cost and quality of a wide array of cars is readily available from car manufacturers, dealers, car andand

"the working of the market by deciding . . . that customers do not need that which they demand."[26]

So much for my title. Let me now address in greater detail the issues that bring us here today. As Bob Pitofsky, my good friend and immediate predecessor as Chairman, noted in a speech he gave five years ago, "in health care as in no other area, there appears to be a recurring need to return to first principles, and to talk about why competition and antitrust enforcement make sense."[27] As Bob correctly observed in the very next sentence of his speech, it is one of the singular ironies of work at the Commission that even "as markets have become more competitive and our antitrust analysis more sophisticated, and even as policy makers rely more and more on competition as a useful tool for improving the delivery of health care, the question continues to be raised: is competition a good idea in this context?"[28]

My perspective, both as Chairman of the FTC and as an academic, is that competitive markets systematically outperform all alternative forms of distribution. Problems in the market are always a matter of concern, and the Commission exists to address a variety of such problems. A comparative institutional perspective makes clear, however, that every arrangement for delivering goods and services is imperfect.[29] It is a classic nirvana fallacy to assume that because markets are not perfect, a market-replacing

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[26] *Indiana Fed'n of Dentists v. FTC*, 476 U.S. 447, 459 (1986). *See also* Robert Pitofsky, *Prepared Statement of Federal Trade Commission Concerning H.R. 1304* (June 22, 1999), available at <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm> ("The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace."). Of course, the presence of insurance complicates the picture, because the availability of coverage creates moral hazard problems by lowering the marginal cost of consuming particular health care services.

[27] Robert Pitofsky, *Thoughts on Leveling the Playing Field in Health Care Markets*, National Health Lawyers Association Twentieth Annual Program on Antitrust in the Health Care Field, Washington, D.C., (Feb. 13, 1997), available at <http://www.ftc.gov/speeches/pitofsky/nhla.htm>.

[28] *Id.*

[29] *See* Neil K. Komesar, *Imperfect Alternatives: Choosing Institutions in Law*, 1994 ECONOMICS AND PUBLIC POLICY 204 ("Bad is often best because it is better than the available alternatives.").

alternative necessarily will be better.[30] Unfortunately, such reasoning prevails far too often in discussions of health policy – a fact that helps

state, and local spending accounts for 45% of the total; private insurance and other private spending accounts for 40%; and consumer out-of pocket spending accounts for 15%. The amount spent on health care rose substantially during the 1970s and 1980s but stabilized during most of the 1990s at around 13.5% of GDP.[32] The last few years have seen the return of dramatic cost increases, some attributable to increased utilization and some attributable to increased prices.[33] Hospital care just surpassed pharmaceuticals as the key driver of increased health care costs.[34]

The $1.3 trillion spent by Americans on health care every year purchases a wide array of medical goods and services. Approximately 32% goes to in-patient hospital care. That figure has declined substantially over the past twenty years, as outpatient care has increased and hospitalization rates and lengths of stay have declined. Only 22% is spent on physician and clinical services, although physicians affect a far larger percentage of total expenditures on health care. Prescription drugs account for about 9%, a figure that has increased substantially over the past decade. The remaining 37% is split between long-term care, administrative, and other expenditures.

Quality presents a more variable picture. At its best, American health care is *the* best in the world. Our markets for innovation in pharmaceuticals and medical devices are second to none. People from all over the world come to the United States to receive cutting-edge treatments from physicians using the most sophisticated technology available. American know-how has made it possible for millions of people with health problems to live productive, pain-free lives.

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[31] *See* Centers for Medicare & Medicaid Servs., *U.S. Health Care System*, available at <http://www.cms.gov/charts/series/sec1.pdf>, page 6.

[32] *Id*. at 3.

[33] *Id*. at 5. *See also*

Nevertheless, health care quality varies tremendously without regard to cost, source of financing, and patient preferences. Local practice norms play a significant role; in health services research circles, experts believe that "geography is destiny" in determining the care one receives.[35] The Institute of Medicine reports on medical error and patient safety attracted wide attention, but several decades of health services research literature documents pervasive quality shortcomings, whether one considers acute care, chronic care, or preventative care.[36]

On the access side, approximately 65% of the under-65 population, or roughly 177 million Americans, obtain health insurance through their employers.[37] Most employees of large and medium-sized corporations are offered employment-based coverage, although not all choose to purchase it. Dependents of employees can usually obtain coverage through the working member of the family.[38] Employment-based coverage is much less available to those who work in certain industries (e.g., agriculture, retail, and food service), temporary and part-time employees, and those who work for

[35] Dartmouth Atlas of Health Care in the United States

small businesses.[39] Medicare, Medicaid, and other governmental programs cover approximately 75 million Americans. Approximately 40 million Americans are uninsured in any given year. Relatively few Americans are chronically uninsured, however, and the uninsured do have some access to medical care, including emergency care.[40]

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policy enforcement. Because of innovation, a growing number of medical conditions can now be treated more effectively with drugs and drug therapy than with hospital stays and surgery. The development of new drugs is risky and costly, which obviously raises the

A generic drug manufacturer wishing to enter the market with a generic version of a branded drug must provide the FDA with certain information, including certifications regarding each patent listed in the Orange Book.[50] A "Paragraph IV certification" asserts that the patent in question is invalid or not infringed and that the generic applicant seeks entry prior to the patent's expiration. If a patent holder brings an infringement suit against the generic applicant, the filing of that suit triggers an automatic 30-month stay of FDA approval of the generic drug.[51] Unless the patent litigation is resolved in favor of the generic drug manufacturer, it cannot enter the market during this period.

Hatch-Waxman also provides 180 days of marketing exclusivity to the first generic drug manufacturer that files its application with the FDA and receives approval to market a particular generic drug prior to the expiration of the branded drug's products.[52] After the 180 days, the FDA is free to approve subsequent generic applicants, assuming other regulatory requirements are met.

Although many branded and generic manufacturers have acted in good faith, others have allegedly attempted to "game" this system, securing greater profits for themselves without providing a corresponding benefit to consumers. The Commission has attacked such alleged conduct with cases brought against both branded and generic drug manufacturers. The Commission's first generation of pharmaceutical litigation focused on agreements between branded and generic drug manufacturers that allegedly delayed the entry of generic drugs. These agreements settled patent infringement

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[50] The filing is technically called an "Abbreviated New Drug Application" or ANDA. The purpose of the ANDA is to establish the bioequivalency of the generic drug with the branded drug.

[51] If the patent holder does not bring suit within 45 days, the FDA must approve the ANDA immediately, if other regulatory conditions are fulfilled.

[52] The 180-day period is calculated from the date of the first commercial marketing of the generic drug product or the date of a court decision declaring the patent invalid or not infringed, whichever is sooner.

The Commission has also scrutinized agreements among manufacturers of generic drugs not to compete against one another. The Commission has brought one such case and will pursue others as the facts warrant.[58]

Physicians

In the past year, the Commission has reached settlements with five groups of physicians for allegedly colluding to raise consumers' costs.[59] Three of the cases are in Denver; one is in Napa; and one is in Dallas-Fort Worth. The number of physicians involved ranged from eight in Napa to more than twelve hundred in Dallas-Fort Worth. To resolve these matters, the physicians agreed to refrain from engaging in similar conduct in the future, to take certain measures to ensure compliance with the consent judgment, and, in one instance, to dissolve the organization through which the physicians conducted their alleged anticompetitive activity. In three of the cases, the FTC also obtained relief against the consultants who were involved in coordinating the alleged collusive conduct.[60]

Those who would justify such conduct suggest that it is necessary to counter the monopsony power of insurers. A recent *American Medical News* editorial referred to the

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[58] *See Consent Order Resolves Charges That Biovail and Elan Agreement Unreasonably Restrained Competition In Market for Generic Anti-hypertension Drug* (June 27, 2002), available at <http://www.ftc.gov/opa/2002/06/biovailelan.htm>.

[59] *See, e.g.*, *System Health Providers*, Dkt. No. C-4064 (Oct. 24, 2002) (consent order); *R. T. Welter & Assocs., Inc. (Professionals in Women's Care)*, Dkt. No. C-4063 (Oct. 8, 2002) (consent order); *Physician Integrated Servs. of Denver, Inc.*, Dkt. No. 4054 (July 16, 2002) (consent order); *Aurora Associated Primary Care Physicians, L.L.C.*, Dkt. No. 4055 (July 16, 2002) (consent order); *Obstetrics and Gynecology Medical Corporation of Napa Valley*, No. C-4048 (May 14, 2002) (consent order).

[60] In addition to these enforcement efforts, this year, the FTC staff also has filed comments with three state legislatures opposing legislation that would allow physician collective bargaining. *FTC Staff Opposes Ohio Bill To Allow Physician Collective Bargaining* (Oct. 21, 2002), available at <http://www.ftc.gov/opa/2002/10/physicians.htm>; *FTC Staff Opposes Washington State Proposal to Allow Physician Collective Bargaining* (Feb. 14, 2002), available at <http://www.ftc.gov/opa/2002/02/washphys.htm>; *FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining* (Jan. 31, 2002), available at <http://www.ftc.gov/opa/2002/01/alaskaphysicians.htm>.

"competition of physician Davids against health plan Goliaths," and suggested that federal antitrust enforcement has "unfortunately favored the big guys."[61] Yet the AMA's own data indicates that insurer market concentration is not a problem in either Denver or Dallas-Fort Worth – the markets which accounted for four of the five physician price-fixing cases brought by the Commission in the past year.[62] In the Denver market, the AMA has calculated that the combined HHI for HMOs and PPOs is 1,336. In the Dallas-Fort Worth market, the AMA has calculated that the combined HHI for HMOs and PPOs is 1,377. Thus, even the AMA's data does not suggest excessive payor concentration in the markets where the Commission has identified collusive physician conduct. Bluntly stated, this conduct had everything to do with physician self-interest and little or nothing to do with insurer monopsony power.

The alleged conduct I have described is naked price fixing, plain and simple. Such conduct is summarily condemned under the antitrust laws, because it has no pro-competitive justifications. Of course, it does not follow that all collective conduct is problematic, even though some physicians suggest that the antitrust laws prevent them from delivering high quality care. The antitrust laws actually provide a considerable degree of flexibility in dealing with efficiencies and quality, as long as the conduct in question is, on balance, pro-competitive and the efficiencies derive from the challenged conduct. If anything, competition law has played a major role in ensuring the delivery of

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[61] Editorial, *It's about time: Insurers facing antitrust scrutiny*, AMERICAN MED. NEWS, Oct. 14, 2002, available at <http://www.ama-assn.org/sci-pubs/amnews/amn_02/edsa1014.htm>.

[62] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, at 13 (Nov. 2001). The AMA did not calculate an HHI for Napa Valley. The Horizontal Merger Guidelines treat an HHI of 1300 as at the low end of a moderately concentrated market. United States Department of Justice and Federal Trade Commission, *1992 Horizontal Merger Guidelines*, available at <http://www.ftc.gov/bc/docs/horizmer.htm> ("the spectrum of market concentration as measured by the HHI into three regions that can be broadly characterized as unconcentrated (HHI below 1000), moderately concentrated (HHI between 1000 and 1800), and highly concentrated (HHI above 1800)").

high quality care, by assuring consumers a range of different health care products and services, empowering purchasers to define quality for themselves, and improving access through price competition.

Quality is obviously an important part of the competitive mix when purchasing health care, and competition law does not hinder the delivery of high quality care. The Commission is always willing to consider arguments about how a particular transaction or conduct will improve quality, and it will pay close attention to such arguments in weighing the competitive implications. Moreover, because quality is so important in health care, we should err on the side of conduct that promises to improve patient care.

Clinical integration that increases quality of care is one example of permissible

Hospitals

As you already know, in the last eight years the Commission and Department of Justice are 0 for 7 in hospital merger cases.[63] Obviously, the template for trying hospital merger cases that was used with such great success in the 1980s and early 1990s no longer works. Although some have suggested the Commission should just fold its tent and ignore hospital mergers, I do not believe that response is acceptable.

Accordingly, last summer, the Commission established a new merger litigation task force.[64] The task force will screen targets, select the best cases, and develop new strategies for trying them. The merger task force will also take a hard look at which strategies worked and which did not in the prior hospital merger cases.

In addition, the Commission is in the midst of a retrospective study of consummated hospital mergers. The Bureaus of Economics and Competition are evaluating the effects of hospital mergers in several cities. The agency will announce the results of these studies regardless of the outcome. If the studies find efficiencies associated with some or all of the mergers, the staff will say so. If, on the other hand, the studies indicate that the mergers were anticompetitive, then Commission will carefully consider whether administrative litigation is appropriate. Whether or not there is an appropriate remedy will obviously influence the Commission's analysis of whether to pursue such a proceeding.

In either event, the agency will obtain useful real-world information, allowing the Commission to update its prior assumptions about the consequences of particular

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[63] *See* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF., Apr.-Mar. 2002, at 185, 186.

[64] *See Federal Trade Commission Announces Formation of Merger Litigation Task Force* (Aug. 28, 2002), available at <http://www.ftc.gov/opa/2002/08/mergerlitigation.htm>.

transactions and the nature of competitive forces in health care. In

of monopsony power.[68] When monopsony power exists, the correct response is to address it directly, rather than to rely collusiaeS18.create(count) Tj 9 f36 cD 1r 12 aeSetbl2the

monopsony power over providers.[71] The DOJ also plans to focus on collective or unilateral activity by health insurers that may raise competitive concerns, depending on the insurer's market power and other relevant market conditions. For example, the Department of Justice recently scrutinized the health insurance market in a major metropolitan area for possible evidence of coordination or collusion among managed care plans operating there.[72] The Department of Justice has also investigated "all products" and "most favored nations" clauses in insurance contracts – in some instances forcing insurers to remove them from their contracts when they have a dominant market position and their use raises anticompetitive concerns.[73]

The Commission's Research Agenda

As my earlier remarks reflect, the Commission has brought and will continue to bring cases against anticompetitive practices affecting the health care industry. Besides bringing cases, the Commission also conducts studies, holds hearings, and issues reports to Congress and the public. The Commission's deliberative and research capacities are particularly helpful in health care because the agency can study and evaluate the evolving marketplace and selectively intervene when it discovers anticompetitive conduct. The agency also uses its deliberative and research capacities to obtain a broader and deeper understanding of the facts that emerge in enforcement matters. The Commission then uses this understanding to inform its enforcement decisions.

The generic drug study, which I mentioned earlier, exemplifies the latter approach. After initiating

study to examine whether such anticompetitive conduct was limited to the cases already identified. The study also examined the performance of the Hatch-Waxman Amendments more broadly to determine the nature and extent of anticompetitive impediments to generic entry. The study involved gathering information from more than 90 companies and took more than a year to complete. The report was issued in July 2002, and it immediately became the gold standard for what is known about the actual performance of the Hatch-Waxman Amendments. As I noted previously, last month, the President proposed regulations to curb the most important problem the Commission's study identified.

The Bureau of Economics is also working closely with several outside academics to study quality of care, so the Commission can factor non-price competition into its analysis of future cases. With the assistance of these academics, the Commission is studying the impact of regulation and competition on quality. This research will help provide a sound empirical basis to assess the interaction of competition and health care quality.

The health care workshop held by the FTC on September 9-10, 2002, was also an important part of the Commission's research agenda. The workshop featured presentations by academics, providers, insurers, employers, patient groups, and representatives of the Commission, Department of Justice, and state attorneys general. The workshop had more than a dozen speakers and five panel discussions. The panels focused on clinical integration, payor/provider issues, group purchasing organizations, generics and branded pharmaceuticals, and direct-to-consumer advertising of pharmaceuticals. Each panel presented a broad range of views on each of these subjects

from knowledgeable panelists. Several hundred people attended the workshop. The staff is already using some of the information obtained at the workshop in pending investigations. The workshop also made clear that there is a considerable diversity of views on the appropriate role and priorities for the Commission and other enforcement agencies.

The Commission's research agenda remains a work in progress. I am pleased to announce that the Commission has authorized an extended set of hearings on health care and competition policy, commencing in February 2003 and continuing through the year. The hearings broadly will examine the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of the citizenry for high-quality, cost-effective health care. The hearings will examine some of the subjects covered in the September 9-10, 2002, workshop at greater depth, and will also address a broader range of issues. The Department of Justice will co-host the hearings.

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delivery markets. Although the Commission has considerable expertise in dealing with snake-oil, the agency is interested in evaluating whether there is a broader consumer protection role for the Commission, similar to its role in other areas of the economy. Thus, the hearings will consider the disclosure of costs, risks, and benefits by manufacturers of medical devices and pharmaceuticals (both prescription and over-the-counter), and by providers of professional services in connection with advertising and other forms of information dissemination.

Quality will be a major item on the hearing agenda. The hearings probably

accordingly will include some consideration of the comparative competitive effects of explicit and implicit contracts for quality.

As with the workshop held in September, the agency will invite representatives of industry, academia, other branches of government, antitrust practitioners, and patient groups to participate. There will be at least twenty days of hearings, primarily at the Commission's headquarters in D.C. The Commission will prepare an extensive report, which will help ensure that everyone recognizes the significance of the "first principles" alluded to by Bob Pitofsky. The report will also lay out the costs and benefits of various policy options we face as a nation in dealing with health care – a sector of our economy that accounts for 1 in every 7 dollars in the GDP.

Conclusion

From my perspective as Chairman of the FTC, it is somewhat surprising to hear so much skepticism about the application of competition law and policy to health care. Clearly, much remains to be done to explain the benefits of markets, both in theory and in practice, for the financing and delivery of health care and the role of the Commission in ensuring that outcome.

Happily, health care is the area of the economy in which the promise implicit in the creation of the Commission has been most fully met. There are substantial consumer welfare benefits and synergies from creating an agency combining administrative expertise and enforcement authority, addressing antitrust, consumer protection, and competition advocacy. Since 1975, when the Commission sharpened its focus on this area, through six presidents and eight Chairmen, the Commission has maintained a leadership role in implementing competition law and policy in health care.

I was proud to participate in this endeavor at the outset in the Commission's Policy Planning Office. As Director of the Bureau of Competition in the early 1980s, I was proud to play a role in consolidating the Commission's leadership in this area, with cases like *Indiana Federation of Dentists*. As Chairman, I am proud to maintain and extend the Commission's important work.

Vigorous competition can be quite unpleasant for competitors. Indeed, as Judge Easterbrook noted in *Ball Memorial*, "competition is a ruthless process."[76] Yet ruthless competition is exactly what the drafters of the Sherman, Clayton, and FTC Acts mandated when they wrote these three statutory charters of economic freedom.[77]

The job of the FTC is to protect competition from those who would interfere with its efficient operation to the detriment of consumers. The Commission's enforcement and research agenda makes me quite confident the agency will successfully meet the challenges of applying