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World Congress Leadership Summit
New York, NY
February 28, 2005

THE FEDERAL TRADE COMMISSION: FOSTERING A COMPETITIVE HEALTH CARE ENVIRONMENT THAT BENEFITS PATIENTS

I am honored to be invited to speak to you today. You work in a field that is vital to each and every U.S. citizen. Your efforts have helped to make the quality and innovation in American health care a global standard and have revolutionized the way we cure the sick and promote health throughout our lives.

What is the Federal Trade Commission's role in this setting? It is a fair question. The FTC is charged with protecting consumers through enforcement of the antitrust and consumer protection laws. We are not medical doctors, and we do not research cures or approve new drugs, like some other federal agencies do. Instead, we serve health care consumers by battling anticompetitive restraints in health care markets and by challenging false and misleading health care claims. Together with our sister agency, the Antitrust Division of the Department of Justice ("DOJ"), we are, I suppose, the "competition doctors."

Law enforcement is our most potent instrument. At the FTC, we have an entire unit in our Bureau of Competition that is dedicated to conducting investigations and, when necessary, bringing enforcement actions in the markets for health care services and products. Other units also often handle health care matters – primarily mergers – as well. Likewise, our Bureau of

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[1] The views expressed herein are my own and do not necessarily represent the views of the Federal Trade Commission or of any other individual Commissioner.

Consumer Protection has been quite active in pursuing health care initiatives.

But law enforcement is not the only procedure we use to cure anticompetitive ailments. The FTC actively engages in advocacy before states and other federal agencies, urging the adoption of pro-competitive strategies for improving health care quality and bringing costs down. For example, a California Assembly member recently asked our opinion of a state bill on pharmacy benefit managers. The bill had intuitive appeal: it would have required pharmacy benefits managers to make disclosures about drug substitutions and certain other matters. But the bill might have had the unintended effect of confusing consumers, frustrating cost-savings measures, and fostering collusion among drug manufacturers, FTC staff noted in response.[2] Citing FTC staff comments, California's Governor Schwarzenegger vetoed the bill.[3] Such advocacy shows not only that the Terminator knows a thing or two about competition policy, but also that advocacy can be very effective. Competition advocacy like this can *prevent* legislation that might unintentionally injure competition – and raise patients' costs – from getting on the books in the first place.

Today I will focus on two of the ways that the FTC serves health care consumers: (1) our

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[2] Letter to Assembly Member Greg Ashazarian from FTC Bureau of Competition, Bureau of Economics, and Office of Policy Planning (Sept. 7, 2004), *available at* http://www.ftc.gov/be/V040027.pdf.

[3] Governor's Veto Message for the PBM Disclosure Bill, *available at* http://www.healthlawyers.org/hlw/issues/041001/Terminator_1960_veto.pdf. Although the FTC staff's work in this matter drew on the research of others in this field, the FTC has now initiated its own pharmacy benefit manager ("PBM") study on possible conflicts of interest. Specifically, the study will analyze whether it is more costly for group health plans to use mail-order pharmacies integrated with PBMs than to use non-integrated mail-order pharmacies or over-the-counter retail pharmacies. *See* FTC File No. P042111, *available at* http://www.ftc.gov/os/2004/03/040326pnpbm.pdf (Public Commission Notice).

challenges to anticompetitive conduct in the health care industry, and (2) our work to promote efforts to provide consumers with important health care information.

I. *Targeting Anticompetitive Conduct in the Health Care Industry.*

The hard work and dedication of caring physicians, and the inspired innovations of the gifted people who work in the pharmaceutical industry, have brought us enormous benefits in our health care. At the FTC, we appreciate how challenging medical practice can be, and how risky and expensive it can be to develop new drugs. But we also know that competition among physicians – and competition among pharmaceutical manufacturers – can reduce health care costs for consumers. For that reason, we work hard to protect competition from anticompetitive agreements between rivals or exclusionary conduct that would deprive consumers of that competition.

A. *Physician Price-Fixing Cases.*

For more than twenty-five years, the FTC has challenged physician groups and other health care providers for allegedly entering anticompetitive agreements – often involving price fixing – that raise the costs of health care for patients and their insurers. Since 2002 alone, the Commission has brought law enforcement actions against more than twenty physician groups.

I am not insensitive to physicians' concerns about their disparity in bargaining strength relative to big health plans. I appreciate the physicians' view that large health care organizations

[4] U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMMISSION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 2 at 20 (2004).

[5] *Id.*, Ch. 2 at 20.

[6] DEP'T OF JUSTICE & FEDERAL TRADE COMM

alleging that medical professionals in south-central New Mexico had unlawfully colluded.[12] The White Sands Health Care System was a physician-hospital association. According to the allegations of the Commission's complaint, White Sands' members included 80 percent of the independently-practicing physicians in the area, the only hospital in the area, and thirty-one non-physician health care providers, including all of the nurse anesthetists in the area.

White Sands claimed to operate as a "messenger model" organization, which is a paradigm contemplated by the Agencies' Health Care Policy Statements. A legitimate messenger model can provide efficiencies in the contracting process between payors and physicians, but the physicians in the network must decide individually – not collectively – whether to accept particular contract terms. The Commission complaint alleges, however, that White Sands actually facilitated horizontal agreements among member physicians on price and other terms. It further alleges that White Sands collectively negotiated with health plans, and that White Sands' members jointly refused to deal with health plans as individuals. In addition, the group offered no efficiency-enhancing integrations that might justify the price fixing.[13]

The result of the arrangement was predictable. Health plans faced higher prices from White Sands members. That, in turn, raised the cost of medical care to patients in the area.[14] Our consent decree sought to remedy this by prohibiting respondents from – among other things – entering into or facilitating agreements among health care providers to negotiate collectively

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[12] *In re White Sands Health Care System, L.L.C., et al.,* C-4130.

[13] Analysis of Agreement Containing Consent Order to Aid Public Comment, *In re White Sands Health Care System* (C-4130).

[14] *Id.*

with payors on the providers' behalf.[15] With that case – as with all such cases – the Commission wants to send the strong message that physician price-fixing hurts patients, and that the FTC will continue to put a stop to it.

B. *Recent Pharmaceutical Cases.*

In recent years, the FTC has also brought a number of cases challenging pharmaceutical manufacturers that were exploiting loopholes in the Hatch-Waxman Amendments to the Food, Drug and Cosmetic Act. The Hatch-Waxman Amendments were designed to promote

[15] Decision and Order, *In re White Sands Health Care System, L.L.C., et al.,* C-4130, *available at* http://www.ftc.gov/os/caselist/0310135/050114do0310135.pdf.

generic firm to make the agreement worth its while. The Hatch-Waxman Amendments

[16] *See, e.g., Bristol-Myers Squibb Company*, Dkt. No. C-4076, *available at* http://www.ftc.gov/os/caselist.c4076.htm; *Abbott Laboratories*, Dkt. No. C-3945 (May 22, 2000) (consent order), *complaint available at* http://www.ftc.gov/os/2000/05/c3945complaint.htm; *Geneva Pharmaceuticals, Inc*., Dkt. No. C-3946 (May 22, 2000) (consent order), *complaint available at* http://www.ftc.gov/os/2000/05/c3946complaint.htm; *Hoechst Marion Roussel, Inc*., Dkt. No. 9293 (May 8, 2001) (consent order), *complaint available at* http://www.ftc.gov/os/2000/03/hoechstandrxcomplaint.htm.

[17] *See In re Schering-Plough Corp., Upsher-Smith Laboratories, and American Home Products Corp.* (FTC No. 9297), *available at* http://www.ftc.gov/os/adjpro/d9297/index.htm.

[18] Timothy J. Muris, Prepared Statement of the Federal Trade Commission before the Judiciary Committee, U.S. Senate (June 17, 2003) at 5.

[19] *FTC v. Perrigo*, Civ. No. 4-1397 (D.D.C. 2004), *available at* http://www.ftc.gov/os/caselist/0210197.htm.

practices in the pharmaceutical industry."[21]

We have challenged gaming of the Hatch-Waxman system not only in litigation, but also in our advocacy work. In 2002, the FTC published a comprehensive study of pharmaceutical competition under the Hatch-Waxman Amendments.[22] In it, the Commission proposed two major amendments designed to curb the potential for abusing the Amendments: a requirement that brand-name drug manufacturers receive only one 30-month stay per product, and a

[21] Timothy J. Muris, Prepared Statement of the Federal Trade Commission before the Judiciary Committee, U.S. Senate (June 17, 2003) at 5.

[22] FEDERAL TRADE COMM'N, GENERIC DRUG ENTRY PRIOR TO PATENT EXPIRATION: AN FTC STUDY (2002).

[23] *Id.*

[24] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, tit. XI, 117 Stat. 2066 (2003).

is one important way we strive to improve information in the health care marketplace. Take, for

[25] *See*

it is a remarkable improvement. Like serious dieters, we are going to stick with our fraud reduction program.

Enforcement efforts against deceptive and fraudulent claims in the health care market are important to the nation's health. Battling the national obesity trend calls for personal responsibility, governmental responsibility, and corporate responsibility. But consumers are best able to make the right personal choices if they have access to truthful information. By attacking fraud in the marketplace, we can help make sure consumers have the information needed to make the right choices.

Also to help ensure that consumers *get access* to the truthful, non-misleading information that can help them make better-informed decisions, we work with the Food and Drug Administration ("FDA") to help educate consumers about the foods they eat – and to facilitate competition based on a food's nutritional benefits. For example, in December 2003, FTC staff filed a comment with the FDA suggesting modifications to that agency's food labeling system. Consumers who want to reduce their calories benefit from truthful, non-misleading information about calories on food labels. Some of the calories-per-serving information on food labels, however, did not always give consumers accurate information about the calories they ingest with a product. For example, labels often treated a single twenty-ounce soft drink as two-and-a-half servings, even though consumers typically drink the entire soft drink. Staff suggested, among other things, that the FDA review whether the foods' listed serving sizes actually reflected the volume that consumers truly eat. In March 2004, the FDA embraced that FTC suggestion, along

with many others.[26]

Similarly, FTC staff has filed a number of comments about the FDA's Trans Fat Rule, which will allow additional truthful information about fats in food labeling. In addition to supporting the rule, FTC staff encouraged the FDA to develop a Daily Value metric for trans fat content. The Daily Value will not only help consumers understand the relative significance of trans fat in their total diet but also provide a basis for nutrient content claims and health claims.[27] This spurs companies to compete by reducing these fats, and it benefits consumers by encouraging a greater array of healthful choices. In short, whether in FDA advocacy, outreach efforts to the media, or other initiatives, our theme has always been to help consumers get access to truthful, reliable information they can use to maintain their good health.

B. *Health Care Report Cards.*

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[26] *See* FDA Staff Report, Calories Count: Report of the Working Group on Obesity (March 2004), *available at* http://www.cfsan.fda.gov/~dms/owg-rpt.html#v; Comments of the FTC Staff Before the FDA In the Matter of Obesity Working Group (Dec. 12, 2003), *available at* http://www.ftc.gov/be/v040003text.pdf.

[27] *See* FTC Staff Comments in the Matter of In the Matter of Food Labeling: Trans Fatty Acids in Nutrition Labeling; Consumer Research to Consider Nutrient Content and Health Claims and Possible Footnote or Disclosure Statements; Reopening of the Comment Period, (Apr. 2004), *available at* http://www.ftc.gov/os/2004/04/040416foodlabeling.pdf; FTC Staff Comments in the Matter of Food Labeling: Trans Fatty Acids in Nutrition Labeling; Consumer Research to Consider Nutrient Content and Health Claims and Possible Footnote or Disclosure Statements,(Oct. 9, 2003), *available at* www.ftc.gov/os/2003/10/fdafattyacidscommenttext.pdf; FTC Staff Comments in the matter of Food Labeling: Trans Fatty Acids in Nutrition Labeling, Nutrient Content Claims and Health Claims (Dec. 16, 2002), *available at* www.ftc.gov/be/v030003.htm; FTC Staff Comments In the Matter of Food Labeling: Trans Fatty Acids in Nutrition Labeling, Nutrient Content Claims and Health Claims; Proposed Rule Before the Food and Drug Administration, (Apr. 17, 2000), *available at* www.ftc.gov/be/v000003.htm.

[28] U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMMISSION'

consumers do not know how to judge a doctor's clinical skills.[31] And patients often choose a hospital not on the basis of its quality but because their doctor practices there, or simply because it is near their home.[32]

I am encouraged, however, by the recent growth of public and private sector initiatives to publish "report cards" on providers. These report cards publicly disseminate information about the quality of health care providers, a move designed to educate consumers about health care provider quality. Consider these success stories:

- Just three years after New York started making available provider-specific outcomes for cardiac surgery, one study showed that risk-adjusted mortality had decreased by 41 percent statewide – and the mortality rate continues to fall, according to further studies.[33]
- Pennsylvania likewise saw improved health care results when it started collecting and publishing risk-adjusted report cards.[34]
- Since 1996, when certain public reporting measures began, there has been a substantial drop nationwide in the number of dialysis patients who have received inadequate dialysis or suffered anemia.[35]

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[31] *Id.*, Ch. 1 at 18 n. 78 (citing Astrid Meghrigian, Remarks at the Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy (Sept. 24, 2003), at page 84). Hereinafter, citations to transcripts of these health care hearings state the speaker's last name, the date of testimony, and relevant pages. Transcripts of the hearings are available at http://www.ftc.gov/ogc/healthcarehearings/index.htm#Materials.

[32] *Id.*, Ch. 1 at 18 n. 78 (citing Tirone 5/29 at 233).

[33] *Id.*, Ch. 1 at 19-20.

[34] *Id.*, Ch. 1 at 20.

[35] *Id.*, Ch. 1 at 19.

We recognize, of course, that there are potential problems with provider report cards. In our 2003 health care hearings, panelists told us, for example, that providers may shy away from treating high-risk patients if their results will lower their report card scores.[36] This possible gaming of the system could end up harming consumers, not educating them. Still others worried that health care report cards will simply confuse patients and foster malpractice litigation.[37]

It is important to keep these costs and limitations of health care report cards in mind. But done properly and published in a manner that the public can understand, health care report cards can significantly improve patient care by spurring market-driven improvements in health care quality.[38] As one panelist put it, "we want to be sure that consumers are focusing on [the question of] [h]ow much health am I getting for my health care dollar?"[39] Health care report cards help give consumers the tools to do just that.

C. *Tiered Payment.*

I also appreciate your industry's work on another innovative means of encouraging consumers to be better health care buyers: through tiered payment systems. The Agencies' health care report praised the recent trend of allowing consumers to choose among a tiered array of health care delivery options. Today, patients can choose the degree of health care financing

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[36] *Id.*, Ch. 1 at 23.

[37] *Id.*, Ch. 1 at 23.

[38] *Id.*, Ch. 1 at 16-25.

[39] *Id.*, Ch. 1 at 23 n. 104 (quoting O'Kane 5/30 at 66).

that suits them best, paying more out-of-pocket for less restrictive options. They can, for example, choose more tightly managed health care plans like HMOs; preferred provider organizations; point-of-service plans; or "concierge" care, which offers extra services like same-day appointments and home drug delivery for an additional fee. This wide array of options "expose[s] consumers to an increased share of the economic costs of their decisions" in the

[40] *Id.*, Ch. 1 at 8.

[41] *Id.*, Ch. 1 at 7-8.

[42] *Id.*, Ch. 3 at 35 n. 193 (citing James C. Robinson, *Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-135, 137).

[43] *Id.*, Ch. 3 at 35 n. 193 (quoting Jill M. Yegian, *Tiered Hospital Networks*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-147, 147, *available at*

To be sure, hospital tiering presents some difficulties. Consumers facing a choice between bearing a higher percentage of the price of one hospital's services, and a lower percentage of another's, need to know the price of each hospital's services (to say nothing of the quality of each) to make an intelligent choice. But it is very difficult to get that information as a patient. Hospitals rarely make their prices public, and in any event typically charge different payors different prices, leaving patients to wonder which price would be relevant for them.[44] In addition, some hospitals object that tiering stigmatizes low-cost hospitals as poor quality, or high-cost hospitals as inefficient.[45] Or tiering may pressure hospitals to drop expensive medical services – such as burn units and trauma care – which may drive them into less attractive tiers.[46]

Nevertheless, the underlying principle behind hospital tiering is sound: informing patients of the relative costs of being cared for at different hospitals, and lyin7otiering stigm1.335osts i3ii1 Tc-0

http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.147v1.pdf).

[44] *Id.*, Ch. 3 at 36 & n. 198.

[45] *Id.*, Ch. 3 at 34.

[46] *Id.*, Ch. 3 at 34-35.

[47] *Id.*, Ch. 3 at 35.

Conclusion. At bottom, the FTC shares your strong commitment to the welfare of patients. For our part, we will work to ensure that the marketplace remains competitive, thereby rewarding those who make health care as affordable as possible, and that consumers have the benefit of clear and accurate health care information that can guide them in making decisions about their health.

Thank you.