PREPARED STATEMENT OF THE
FEDERAL TRADE COMMISSION

Before the

SUBCOMMITTEE ON CONSUM ER PROTECTION, PRODUCT SAFETY, AND INSURANCE
COMMITTEE ON COMMERCE, SCIENCE & TRANSPORTATION
UNITED STATES SENATE

On

"The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care"

July 16, 2009

I. Introduction

Chairman Pryor, Ranking Member Wicker, and members of the Subcommittee. I am Richard A. Feinstein, Director of the Bureau of Competition at the Federal Trade Commission (FTC). I appreciate the opportunity to testify on behalf of the Commission about the relationship between competition and antitrust enforcement, on the one hand, and lower health care costs and higher health care quality, on the other.[1] The magnitude of health care costs and the importance of health care quality demand our urgent attention. On a daily basis, millions of Americans require health care goods and services to maintain their basic quality of life. We have all seen the stories about the 46 million uninsured,[2] and the fact that the U.S. health care system spends more per person, yet generates lower health care quality than health care services in many other developed countries.[3] Health care costs burden both employees and employers, large and small, as well as federal, state, and local governments that pay for care under various government programs.

Antitrust enforcement improves health care in two ways. First, by preventing or stopping anticompetitive agreements to raise prices, antitrust enforcement saves money that consumers, employers, and governments otherwise would spend on health care.

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and responses are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

Not surprisingly, some health care providers have long sought antitrust exemptions that would protect them against competitive pressures to lower costs and improve quality.[10] The Commission consistently has opposed legislative proposals to exempt certain types of conduct, such as price fixing, from antitrust scrutiny, because such conduct will increase health care costs without benefitting consumers.[11] At the same time, as detailed below, the Commission has provided extensive guidance on how health care providers can collaborate in ways consistent with the antitrust laws, precisely because such collaborations have the potential to reduce costs and improve quality.

The Commission recognizes that competition alone is not a panacea for all of the problems in health care markets. Although FTC antitrust enforcement has prevented anticompetitive conduct that would further increase health care costs, maintaining competition cannot alone achieve the health care reform goals on which Congress may

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FTC STUDY (2005), *available at* http://www.ftc.gov/reports/contactlens/050214contactlensrpt.pdf

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agree. The Commission's purpose here is to explain that the FTC is a partner in efforts to reduce costs and improve quality in the delivery of health care. The testimony will describe how our activities in three important areas – (1) health care provider clinical integration, (2) proposed health care mergers involving hospitals, pharmaceutical manufacturers, and medical device manufacturers, and (3) pharmacy benefit management

agreements through which health care providers jointly seek to increase the fees that they receive from health care plans.[14] Such arrangements typically involve competing health care providers agreeing to charge the same high prices and collectively refusing to serve a health plan's patients unless the health plan meets their fee demands. Such conduct is considered to be *per se* unlawful because it is so likely to harm competition and consumers by raising prices for health care services and health care insurance coverage. Hence, in its 1982 *Maricopa* decision, the U.S. Supreme Court held that agreements among competing physicians regarding the fees they would charge health insurers for their services constituted *per se* unlawful horizontal price fixing.[15] Just last year, the Fifth Circuit, citing *Maricopa*, affirmed the Commission's conclusion that the activities of the North Texas Specialty Physicians, an organization of independent physicians and physician groups, amounted to horizontal price fixing that was unrelated to achieving any efficiencies such as cost savings or increased health care quality.[16]

The Commission explained the clear consumer harms of health care price fixing agreements in 2007 testimony before Congress regarding a proposed antitrust exemption for this type of conduct by certain health care providers[17]:

> The Commission's experience indicates that the conduct that the proposed exemption would allow could impose significant costs on consumers, private and governmental purchasers, and taxpayers, who ultimately foot the bill for government-sponsored healthcare programs. Past antitrust challenges to collective negotiations by health care professionals show that groups have often sought fee increases of 20 percent or more. For example,

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[14] *See* FTC Bureau of Competition, Overview of FTC Antitrust Actions in Health Care Services and Products, *available at* http://www.ftc.gov/bc/0608hcupdate.pdf

[15] *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 356-57 (1982).

[16] *In the Matter of North Texas Specialty Physicians*, FTC Dkt. No. 9312 (Nov. 2005) (Opinion of the Commission), *available at* http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf, *aff'd sub nom. NTSP v. F.T.C.*, 528 F.3d 346 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1313 (U.S., Feb. 23, 2009) (No. 08-515).

[17] *See* FTC Statement Concerning H.R. 911, *supra* note 9.

> in 1998, an association of approximately 125 pharmacies in northern Puerto Rico settled FTC charges that the association fixed prices and other terms of dealing with third-party payers, and threatened to withhold services from Puerto Rico's program to provide healthcare services for indigent patients. According to the complaint, the association demanded a 22 percent increase in fees, threatened that its members would collectively refuse to participate in the indigent care program unless its demands were met, and thereby succeeded in securing the higher prices it sought.[18]

As this excerpt shows, antitrust enforcement against agreements that have no purpose except to increase the fees received by the health care providers involved are not only consistent with, but also reinforce, the cost-reducing goals of any health care reform.

B. The Antitrust Laws Promote Health Care Collaborations that Can Reduce Costs and Improve Quality.

The antitrust laws treat collaborations among health care providers that are bona fide efforts to create legitimate, efficiency-enhancing joint ventures differently. The Commission asks two basic questions with respect to such collaborations. First, does the proposed collaboration offer the potential for pro-consumer cost savings or qualitative improvements in the provision of health care services? Second, are any price or other agreements among participants regarding the terms on which they will deal with health care insurers reasonably necessary to achieve those benefits? If the answer to both of these questions is "yes," then the collaboration is evaluated under an antitrust standard that takes into account any likely procompetitive or anticompetitive effects from the collaboration.[19] As long

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[18] *See* FTC Statement Concerning H.R. 971, *supra* note 9 (internal citations omitted).

[19] This standard is known as the "rule of reason." *See Maricopa County Medical Soc.*, *supra* note 15, at 343 ("since Standard Oil Co. of New Jersey v. United States, 221 U.S. 1 (1911), we have analyzed most restraints under the so-called 'rule of reason.' Its name suggests, the rule of reason requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an

as such collaborations cannot exercise market power, they are unlikely to raise significant antitrust concerns, precisely because they have the potential to benefit, not harm, consumers.

The FTC and the Department of Justice Antitrust Division issued Health Care Statements in 1993, and supplemented them in 1994 and 1996,[20] to provide guidance about the antitrust analysis the agencies will apply to various types of health care arrangements. As noted in the 1996 *Health Care Statements*, "[n]ew arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payers' desire for more efficient delivery of high quality health care services."[21] Statement 8 explains that bona fide clinical integration by health care providers with the potential for significant cost savings and quality improvements may be demonstrated by:

> the network [of health care providers] implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely further these efficiency objectives; and (3) the significant investment of capital, human [illegible] services 21 [illegible] 16.615 -1.15 Td [(est8uality 665)9(ficiency00

barrier to bona fide arrangements to improve quality and control costs through clinical integration.

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would have resulted in control of 73 percent of the licensed hospital beds in the area.

itself of certain key products.[32] In the medical device ar

- provide drug utilization reviews that include analyses of physician prescribing patterns to identify physicians prescribing high-cost drugs when lower cost, therapeutically equivalent alternatives are available; and
- provide disease management services by offering treatment information to and monitoring of patients with certain chronic diseases.

In the U.S., the PBM industry has evolved from one of numerous, small claims processing firms to a more mature industry with comprehensive service offerings. Roughly 95 percent of patients in the United States with a drug benefit receive their benefits through a PBM. There are approximately 40 to 50 PBMs operating in the United States, with three large, full-service PBMs of national scope: Medco, Express Scripts, and Caremark.[36] In addition to these three PBMs,

pharmaceuticals. Ongoing Commission scrutiny of competitive issues in the PBM area – including those posed by both private conduct and public intervention – is essential to maintaining the benefits of competition for consumers.

Of particular relevance is the Commission's "Conflict of Interest Study" regarding PBM practices. In response to a request from Congress, the FTC analyzed data on PBM pricing, generic substitution, therapeutic interchange, and repackaging practices. The study examined whether PBM ownership of mail-order pharmacies served to maximize competition and lower prescription drug prices for plan sponsors. In its 2005 report based on the study (PBM Study), the FTC found, among other things, that competition affords health plans substantial tools with which to safeguard their interests in lower prescription drug prices.[39]

The FTC is mindful of the potential harm from aggregations of market power by purchasers in the health care sector. In 2004, the FTC conducted a thorough investigation of Caremark Rx's acquisition of Advance PCS, two large national PBM firms. As part of its analysis, the agency carefully considered whether the proposed acquisition would be likely to create monopsony power with regard to PBM negotiations with retail pharmacies and ultimately determined it would not. The Commission closed the investigation because it concluded that the transaction was unlikely to reduce competition.[40] In addition, FTC staff have analyzed and commented on proposed PBM legislation in several states.[41]

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[39] PBM STUDY, *supra* note 8, at 58 (noting diverse audit rights and reporting under PBM contracts).

[40] *In the Matter of Caremark Rx, Inc./AdvancePCS*, File No. 0310239 n. 6 (Feb. 11, 2004) (statement of the Commission), *available at* http://www.ftc.gov/os/caselist/0310239/040211ftcstatement0310239.pdf

[41] *See, e.g.*