Remarks of FTC Chairman Jon Leibowitz (As Prepared for Delivery)
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Are Titanic Health Care Costs Sinking Us?
What the FTC is Doing to Keep Patients Afloat

I. Introduction

It is an honor to be with you again. You asked me to speak at this conference seven years ago, shortly after I began my work at the Federal Trade Commission. My former attorney advisor Seth Silber – who will moderate the "Hot Topics in Antitrust" panel tomorrow afternoon – reminds me that this was the first speaking gig he arranged for me, back in 2005.

Over the last few weeks, many of us have followed the coverage of the 100th anniversary of the sinking of the Titanic. Of course, we all know the story, and some of us have seen James Cameron's famous take over and over, even in 3-D. But this month's remembrances have resurfaced some interesting vignettes that, although they did not have the panache to make a verse in Celine Dion's anthem, are fascinating nonetheless.

One concerns the multiple warnings of floating ice that the Titanic crew received the day before the ship went down. The captain brushed these aside, relying on his assessment: "I cannot imagine any condition which would cause a ship to founder. . . . Modern ship building has gone beyond that."

Yet the great ship was felled by a predictable – and predicted – hazard.

Those early warnings of icebergs were brought to mind by a recent speech by Dr. Otis Brawley, the chief medical officer of the American Cancer Society. He pointed out that health care costs are 18 percent of our GDP and are projected to climb to 25 percent in the next 10-15 years. His stark assessment of that trend: "It's going to cause our economy to collapse."

As Dr. Brawley pointed out in his speech, we spend more per person per year on health care ($8,000) than any other country on earth – twice as much as the country with the next highest health care costs. Yet our outcomes – the quality of our health care – rank among the worst in the developed world. "I don't think," he said, "we get what we pay for."

Isn't this a classic definition of market failure – the cost of the product bears little relation to its quality? The price of health care too often seems disconnected from competitive market influences. A study appeared last week in the Archives of Internal Medicine that found the cost of an appendectomy in California can range anywhere from $1,500 to $180,000. And while some of the price variation could be explained by the overall health of the patient or the ease of diagnosis, the researchers found no explanation at all for a full one third of the cost differences they recorded.

Like the captain of the Titanic, most of us have a difficult time believing anything could bring down our ship of state. But our rising health care costs, even though they have flattened out a bit over the past two years, need to be taken very seriously: they are both unacceptable and unsustainable.

It is fair to say that, as a people and as a government, we do see the iceberg looming. Health care has been front and center in the FTC's work for at least the past decade – certainly in the seven years since we last spoke. The President and Congress spent two years debating the Affordable Care Act, putting the health care debate front and center on the national stage. Now, as we all know, health care has moved front and center on the Supreme Court's docket.

Yet despite everyone's efforts, we may still be steaming toward the iceberg. This is especially true, I believe, if the Supreme Court strikes down the Affordable Care Act.

So what can the FTC do?

At the Commission, we are determined to use antitrust enforcement to bring competition to the market and bring down health care costs wherever we can.

That means focusing on egregious practices like "pay-for-delay" pharmaceutical settlements. These are sweetheart deals in which brand name drug companies settle patent litigation by paying off generic firms to keep their products off the market. This is a win-win for the drug companies but a lose-lose for consumers. The brand wins because it avoids the destruction of its franchise. The generic wins because it makes more money than if it competes. But consumers lose because the agreement keeps the cheaper generic option off the market.

The average generic drug costs 85 percent less than its branded equivalent. By delaying the entry of cheaper generics, pay-for-delay deals cost Americans $3.5 billion annually and will add to the federal deficit. In fact, if unchecked, the deals will increase the nation's debt by almost $5 billion over the next ten years, according to the Congressional Budget Office. Taxpayers fund about one third of all prescription purchases through Medicare, veterans' programs, and the like.

The FTC has targeted pay-for-delay since its inception, under both Democratic and Republican leadership. But since 2005, spurred on by the several courts that mistakenly have blessed these anticompetitive settlements, they have become the new way of doing business. In 2005, only three potential pay-for-delay deals were pending. That number increased to 19 in 2009 and 28 in 2011.

And though these are exactly the sort of competition-quashing practices that the FTC is determined to root out of the health care market, I will not spend too much time on them today, primarily because some of you have already heard me talk about pay-for-delay, perhaps ad nauseam.

Instead, I'll start with the FTC's renewed focus on hospital merger enforcement, segue into a discussion of the state action doctrine, including an FTC case in which the U.S. Supreme Court

could accept certiorari as early as next month, and end with some thoughts about health care reform and accountable care organizations.

II. Hospital Merger Enforcement

In the late 1990s, the Commission and the Department of Justice lost a string of challenges to hospital mergers in federal court, after which Justice got out of the business of hospital reviews entirely. But our concerns continued. In 2002, then-FTC Chairman Tim Muris announced that Commission economists would undertake a study of four consummated hospital mergers to determine whether they in fact resulted in higher prices or lower quality.

That effort led to the Commission's 2004 administrative challenge to the merger of Chicago's Highland Park Hospital with Evanston Northwestern Healthcare's two hospitals. A unanimous Commission found that prices for acute inpatient hospital services in the Evanston area had doubled and tripled post-merger, evidence that astounded us and reaffirmed our commitment to staying engaged.

Just after the Evanston decision, the Commission stopped what we believed to be an anticompetitive hospital merger in Northern Virginia, this one in 2008. In that case, the dominant hospital system in the region, Inova, tried to purchase the independent Prince William Hospital. After we filed suit, Inova abandoned the transaction. Prince William Hospital was concerned that without Inova, it would not be able to raise money for development. But as often happens when we challenge a transaction (in any industry), at the end of the day, Prince William found another suitor: a North Carolina hospital corporation that provided Prince William with an infusion of capital without posing competitive concerns.

In just the last 18 months, we have challenged three other hospital mergers.

Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court – less than two percent of all hospital mergers over the last five years.

Our most recent case challenged OSF Healthcare System's proposed acquisition of Rockford Health System, a 3 to 2 merger in Rockford, Illinois. OSF would have controlled 64 percent of general acute-care inpatient services in the Rockford area post-acquisition and would have faced only one competitor. In November 2011, we went into federal court seeking a preliminary injunction, which we won just a few weeks ago. Shortly thereafter, the parties abandoned the transaction.

In another recent case – ProMedica/St. Luke's Hospital in the Toledo, Ohio area – we challenged a consummated 4 to 3 merger (except for obstetrical services, where it is 3 to 2) that we alleged would reduce competition and enable ProMedica to raise prices for general acute-care and inpatient obstetrical services. Last spring, we won a preliminary injunction from a federal

district court judge, and in early January, an administrative law judge ordered ProMedica to divest St. Luke's Hospital. The decision was appealed to the Commission, which at the end of March affirmed liability and ordered divestiture. The parties last week announced their intention to appeal our decision to the Sixth Circuit, so the final chapter here has not been written.

III. Boundaries of the State Action Doctrine

Now, reasonable people may disagree about whether a 4 to 3 hospital merger may substantially lessen competition. Some might even contend that a 3 to 2 merger may not be problematic under some circumstances. But there is rarely disagreement about merger to monopoly. That was precisely what we confronted in Albany, Georgia in the Phoebe Putney/Palmyra matter.

Albany, Georgia is in Dougherty County, one of the poorest counties in the United States, with a 2009 median per capita income of $15,761. This is a community at risk of being sunk beneath the weight of recession and rising health care costs.

Under a Georgia healthcare statute adopted in 1941, local governments in Georgia are authorized to establish "hospital authorities" with the power to own and operate hospitals or to lease them to private entities. One such authority owned Phoebe Putney since 1941. In 1990, the authority rented the hospital to a private non-profit, ceding full control (though nominally continuing to own the hospital).

The private group operated Phoebe Putney for 20 years, without supervision by the hospital authority or any other state entity. Then in 2010, Phoebe Putney sought to buy its only competitor in the five-county Albany metropolitan area, Palmyra Park Hospital. Tellingly, the authority initially was not even aware of Phoebe's negotiations with HCA, Palmyra's owner.

Under the agreement eventually struck by Phoebe and HCA, the hospital authority would purchase Palmyra for $195 million with Phoebe's money and then immediately lease Palmyra to Phoebe for $1 a year, effectively consolidating the only two hospitals in the Albany area. Phoebe's deal with HCA stipulated that it would pay HCA a $17.5 million termination fee if the hospital authority did not acquiesce in the Phoebe/HCA deal exactly as it had been negotiated. This termination fee was in addition to a $35 million break-up fee should the merger be enjoined.

In business documents, Phoebe's counsel and consultant described using the hospital authority structure as a "proven" method of avoiding antitrust scrutiny of the acquisition.

In the preliminary injunction proceeding, Phoebe and the hospital authority did not dispute the Commission's competitive effects allegations. Instead, Phoebe asserted it was immune from antitrust oversight under the state action doctrine.

Many of you know that the Eleventh Circuit has long held a view of the state action doctrine that is out of line with the other circuits. So we were not surprised when we lost on state action in district court and again on appeal. But even the Eleventh Circuit acknowledged that on the facts alleged, the merger would substantially lessen competition or tend to create a monopoly.

We don't ask for certiorari every day. But here we believed, and the Solicitor General agreed, that the questions are so important that they warrant going to the Supreme Court. The questions extend beyond Albany, Georgia. As the SG explained to the Supreme Court in our cert. petition, the Phoebe case "is representative of a frequently litigated fact pattern" where hospital authorities have asserted state action defenses to federal antitrust challenges.

Let me assure you: if this decision is permitted to stand, it will undermine the very basis of the state action doctrine, that is, the sensible notion that the antitrust laws should apply to the conduct of private businesses and individuals and not to government. And at least as importantly, it will drive up health care costs in Albany, Georgia, and create a roadmap for doing so elsewhere.

Nearly 70 years ago, in *Parker v. Brown*, the Supreme Court determined that the federal antitrust laws should not apply to states acting as sovereign. And in a line of cases since then, the Court has modestly expanded the state action doctrine to permit a state to delegate its authority to cities or even private concerns, but only so far as their actions are taken pursuant to a clearly articulated and expressed state policy to displace competition and the state itself actively supervises the conduct of private parties. That did not happen in Phoebe Putney, a decision that as it stands today is disturbingly, jarringly wrong.

IV. Health Care Reform and ACOs

Over the years, the FTC and DOJ have provided substantial constructive guidance to practitioners who want to work together, in the form of our Statements of Antitrust Enforcement Policy in Health Care, Guidelines for Collaborations Among Competitors, advisory opinions, and other outreach and informal consultations. Now, in its creation of ACOs, the Affordable Care Act gives incentives and permission to health care practitioners to join together in ways that may reduce costs and improve care. We have developed guidance here, too.

When we see gathering clouds of collaboration, as with ACOs, we understand that those do not always portend a dangerous storm. In fact, ACOs may offer hope for smooth sailing, not stormy weather. Just last Sunday, the *New York Times* reported that many experts believe the movement toward accountable care may be at least part of the reason for slower growth in health care spending over the past few years, the recession being the principal one.

We have all experienced the fragmented American health care system, where patients, or the patients' relatives, have to convey the same information from one health care provider to the next, all the while trying to make sure that physicians do not prescribe conflicting treatment regimens or duplicative tests. ACOs can change that by getting many of the relevant providers – for example, a primary care doctor, a cardiologist, a gastroenterologist, and an orthopedist – to work together and coordinate their care of a patient. Add to that the goal of compensating providers on the basis of quality, not quantity, and – we hope – patients will see better results.

The *Times* article offers some reason for optimism. According to research by Leavitt Partners, there are already more than 160 so-called "accountable organizations" in the United States. Many, if not most, of these are serving insureds in the commercial market, where hundreds of

insurers and health systems have adopted some features of accountable care, such as assigning specially-trained nurse practitioners to keep patients with multiple chronic conditions out of the hospital by ensuring they take their medicine, follow their treatment regimen, and show up for check-ups. And now, ACOs for Medicare beneficiaries are starting to be approved under the Shared Savings Program and the Pioneer ACO Program.

As many of you know, last fall the FTC and the DOJ developed antitrust enforcement policies about ACOs. At the same time, CMS and other agencies put out their regulations and policies for ACOs. Our goal is to help health care providers form cooperative associations that have the potential to achieve efficiencies without running afoul of the antitrust laws.

Of course, ACOs are subject to the antitrust laws, and it is important to keep in mind that the Affordable Care Act does not encourage *all* kinds of collaboration. For example, there is nothing in the Affordable Care Act that suggests that hospitals need to merge to become ACOs, and CMS has made that clear in its regulations. We will continue to analyze hospital mergers under our merger guidelines; they are not subject to our ACO policy statement.

Moreover, the policy statement makes it clear that antitrust concerns can arise when cooperation between competitors, such as physicians with the same specialty, risks creating market power that could undermine or offset any efficiency of the ACO. ACOs that coordinate across different types of service and different types of care have the greatest potential to benefit patients without risking anticompetitive harm.

Put differently, the introduction of ACOs does not change the basic rules of the game, but it does introduce a few new twists to the state of play.

First, we worked with CMS to ensure that its requirements for ACOs are broadly consistent with the criteria we use to analyze whether an ACO is per se illegal or a legitimate joint venture. This allows the ACOs that meet CMS's criteria and participate in the Shared Savings Program to know that we will evaluate them under the rule of reason (which, as you know, takes procompetitive, as well as anticompetitive, effects into account) in Medicare markets, and in commercial markets, if they operate in substantially the same way as in Medicare markets.

Second, the statement actually identifies some practices that ACOs may wish to avoid in order to steer clear of the antitrust laws, practices that might prevent private payers from getting lower prices and better quality service. One example: if an ACO restricted a health plan's ability to share information about the cost and quality of providers with its enrollees, this could prevent patients from making better, more informed decisions.

Third, CMS will be collecting data from each ACO to see whether it has improved quality and reduced costs. The results of this monitoring: we are going to learn whether ACOs are on course toward cutting costs and improving quality – in which case we will sail onward. Or whether ACOs are hopelessly adrift – in which case they will be dry-docked.

Interestingly, a short while ago, stakeholders were worried that the proposed CMS rules were so stringent that it was uncertain whether or not we would see any ACOs formed. The final CMS rules are not as onerous. It turns out that we will see ACO formation.

In fact, in the last six months, we have seen 65 CMS-approved ACOs. The 27 just approved this April already cover about 375,000 Medicare beneficiaries in 18 states across the United States and include more than 10,000 physicians, 10 hospitals, and 13 smaller physician-driven organizations in both rural and urban areas. CMS estimates that eventually, the 65 CMS-approved ACOs will serve more than 1.1 million Medicare beneficiaries.

We will be following all ACOs closely, watching to see how well they improve the quality of health care and lower costs. We have every hope that ACOs will become lifeboats for the millions of elderly, low-income, and other Americans drowning in mounting health care bills.

V. Conclusion

At a sermon delivered soon after the sinking of the Titanic, the Bishop of Winchester said, "The Titanic, name and thing, will stand for a monument and warning to human presumption."

As we sail closer to our own iceberg, and as we heed the warnings of those like Dr. Brawley who are willing to state clearly that health care costs could well sink an America most of us are used to thinking of as unsinkable, let us not presume that laissez-faire will be able to hold us to a safe course without vigorous protection of competition.

At the FTC, we are committed to that goal, both to fulfill our mission protecting consumers and to play our part in safely navigating this century's greatest challenge to our health and well-being.