PREPARED STATEMENT OF THE
FEDERAL TRADE COMMISSION

Before the

SUBCOMMITTEE ON CONSUMER 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.

[2] *See* U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, 19-20 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf (noting slight decrease from 2006-07, but a general increase in uninsured from 1987-2007).

[3] *See, e.g.*, The Business Roundtable, The Business Roundtable Health Care Value Comparability Study, Executive Summary at 2 (2009), *available at* http://businessroundtable.org/sites/default/files/BRT%20exec%20sum%20FINAL%20FOR%20PRINT.pdf (observing 23 percent "value gap" relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France).

Second, competition spurs innovation that improves care and expands access. Congress has charged the FTC with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce,[4] and the FTC has been a cop on the beat in this area for the past 30 years.

The touchstone of the Commission's enforcement in this industry has been to stop practices that are likely either to increase costs or to limit competition that could improve the quality of health care. For example, the FTC has prevented anticompetitive agreements among health care providers to fix the prices they charge to a health insurance plan, conduct likely to raise prices without improving care.[5] The Commission's enforcement efforts also have helped assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the marketplace.[6] The FTC has challenged hospital mergers that the Commission believed were likely to increase costs to consumers, such as the recently proposed merger of Inova-Fairfax and Prince William County Hospitals. After the Commission sued to enjoin that proposed merger in federal district court, the parties decided to drop the deal.[7] The FTC and its staff also have issued studies and reports regarding various aspects of the health care industry[8] and have analyzed competition issues raised by proposed state and federal regulation of health care markets.[9]

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[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] *See* Federal Trade Commission, FTC Antitrust Actions in Health Care Services and Products, *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

[6] *See id.*

[7] *See infra* note 30 and accompanying text.

[8] *See, e.g.*, FEDERAL TRADE COMMISSION, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf [hereinafter PBM STUDY]; FEDERAL TRADE COMMISSION, THE STRENGTH OF COMPETITION IN THE SALE OF CONTACT LENSES: AN

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; FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf [IMPROVING HEALTH CARE].

[9] *See* Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, "the Community Pharmacy Fairness Act of 2007," 110th Cong. (Oct. 18, 2007), *available at* http://www.ftc.gov/os/testimony/P859910pharm.pdf [hereinafter FTC Statement Concerning H.R. 971] (criticizing proposal to exempt non-publicly traded pharmacies from antitrust scrutiny).

[10] Some have argued that health care is "different," and that competition principles do not apply to the provision of health care services. Similar arguments that competition fundamentally does not work and is harmful to public policy goals have been uniformly rejected by the Supreme Court. *See, e.g., F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978). Beginning with the seminal 1943 decision in *American Medical Association v. United States*, 317 U.S. 519, 528, 536 (1943), the Supreme Court has recognized the importance of competition and the application of antitrust principles to health care.

[11] *See, e.g.*, FTC Statement Concerning H.R. 971, *supra* note 9 (criticizing proposal to exempt non-publicly traded pharmacies from antitrust scrutiny); Testimony of Robert Pitofsky, Chairman, Federal Trade Commission, on H.R. 1304, the "Quality Health-Care Coalition Act of 1999" (June 22, 1999), *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm (regarding federal legislation that would have exempted all health care workers from antitrust scrutiny); Letter from Federal Trade Commission Staff to the Hon. Dennis Stapleton, Ohio House of Representatives (Oct. 16, 2002) (criticizing proposed antitrust exemption for home health care providers), *available at* http://www.ftc.gov/os/2002/10/ohb325.htm.

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 services (PBMs) – further those goals.[12]

II. Physician Services: Price Fixing vs. Clinical Integration

Some have suggested that the antitrust laws act as barriers to health care provider collaborations that could lower costs and improve quality.[13] That is simply wrong. Properly applied, antitrust standards distinguish between price fixing by health care providers, which is likely to increase health care costs, and effective clinical integration among health care providers that has the potential to achieve cost savings and improve health outcomes.

A. Price Fixing and Group Boycotts Are Likely to Raise Prices and Harm Consumers.

For more than 25 years, the Commission has challenged price-fixing and boycott

[12] On multiple occasions, the Commission has provided Congress testimony on the dangers of pay-for-delay patent settlements between brand and generic companies and the costs they impose on consumers, employers, and the government. Today, the Commission is providing testimony on other important areas of health care competition.

[13] *See, e.g.*, Letter from Michael D. Maves, MD, Exec. Vice President, CEO, American Medical Ass'n, to the Hon. William E. Kovacic, Chairman, Federal Trade Commission, regarding Physician Network Integration and Joint Contracting (June 20, 2008), *available at* http://www.ftc.gov/bc/healthcare/checkup/pdf/AMAComments.pdf ("We are extremely concerned with what we see as the significant regulatory barriers that restrict physicians' ability to collaborate in ways crucial to improving quality and containing costs"); *cf.* Timothy Stolzfus Jost and Ezekiel J. Emmanuel, *Commentary: Legal Reforms Necessary to Promote Delivery System Innovation*, 299 JAMA 2561, 2562 (2008) (suggesting that uncertainty about forms of clinical integration permitted under the antitrust laws "could deter attempts to create accountable health systems.")

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 health care 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. 971, *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 health care 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 those 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

[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.' As 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 to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.[22]

In recent years, FTC staff have issued detailed advisory opinions on such programs to help inform the industry and demonstrate that the antitrust laws are not a

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unreasonable restraint on competition.")

[20] U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm [hereinafter *Health Care Statements*].

[21] *Id.* at 2.

[22] *Health Care Statements* at Statement 8, § B.1.

barrier to bona fide arrangements to improve quality and control costs through clinical integration.[23] In evaluating health care collaborations that claim likely efficiencies from clinical integration, FTC staff have focused on the programs' structural capabilities, systems, and processes for achieving such efficiencies, and the motivations and incentives for the participants to embrace the programs' goals.[24] Such collaborations often use programs such as electronic health records[25] and administrative and clinical support for care management and quality improvement,as means to achieve efficiencies and improved quality through, for example, collaboration among clinicians to create guidelines, measure their performance in relation to those guidelines, and agree on remedial measures and consequences for failures to achieve certain performance goals. These are the same types of measures proposed by advocates of health care reform as ways to reduce costs and improve quality. [26] As shown here, antitrust standards for evaluating health care collaborations also are consistent with and supportive of the goals of health care reform to reduce costs and improve quality.

III. Increased Merger Scrutiny

The Commission has worked vigorously to preserve competition in health care

[23] *See, e.g.*, Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun, Ober, Kaler, Grimes & Shriver 8 (April 13, 2009) [hereinafter TriState Letter], *available at* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf; Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun & John J. Miles, Ober, Kaler, Grimes & Shriver 7 (Sept. 17, 2007) [hereinafter GRIPA letter], *available at* http://www.ftc.gov/bc/adops/gripa.pdf.

[24] *See* note 25 *supra.*

[25] Clinical integration programs frequently use sophisticated health information technology (HIT) systems to help them implement their programs. However, the use of HIT systems or electronic health records alone is not sufficient to establish that a group has clinically integrated. It is how the collaboration uses those tools that counts for the antitrust analysis.

[26] Elliot S. Fisher et al., *Achieving Health Care Reform – How Physicians Can Help*, 360 NEW ENG. J. MED. 2495, 2496 (2009); *see also, e.g.*, TriState Letter, *supra* note 23 (discussing web-based HIT system, software, and clinical guidelines and review proposal); GRIPA Letter *supra* note 23 (regarding GRIPA's tablet computer, HIT system, and data sharing proposal).

markets via merger scrutiny as well. The FTC has challenged a number of proposed mergers and acquisitions involving, for example, hospitals, drug manufacturers, and medical device manufacturers.

Several recent hospital merger enforcement actions highlight the Commission's ongoing focus on competition among hospitals. If a hospital acquisition deprives patients of choices for health care, it can increase the health care costs to both patients and employers that purchase health insurance. For example, in 2007, the Commission ruled that Evanston Northwestern Healthcare Corporation's consummated acquisition of its competitor, Highland Park Hospital, was anticompetitive[27] because the acquisition resulted in substantially higher prices and a substantial lessening of competition for acute care inpatient hospital services in parts of Chicago's northern suburbs.[28] This challenge was based, in part, on information gathered during an empirical review of various consummated hospital mergers to examine their impact on markets; that review has found compelling evidence of adverse effects from mergers in certain instances.[29] More recently, a joint enforcement action by the FTC and the Virginia Attorney General stopped a merger of two hospitals in northern Virginia that, according to the complaint,

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[27] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Docket No. 9315 (Aug. 6, 2007) (Opinion of the Commission), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf (upholding with some modifications an October 2005 Initial Decision by an FTC Administrative Law Judge).

[28] *In the Matter of Evanston Northwestern Healthcare Corp.*, FTC Docket No. 9315 (Oct. 20, 2005) (initial decision), *available at* http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf.

[29] *See, e.g.*, Farrell, J., Pautler, P., and Vita, M, *Economics at the FTC: Retrospective Merger Analysis With a Focus on Hospitals*, REV. OF INDUS. ORG. (2009, forthcoming) (reviewing project and related FTC working papers); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, Federal Trade Commission Bureau of Economics Working Paper No. 293 (2008), *available at* http://www.ftc.gov/be/workpapers/wp293.pdf; Deborah Haas-Wilson and Christopher Garmon, Two Hospital Mergers on Chicago's North Shore: A Retrospective Study, Federal Trade Commission, Bureau of Economics Working Paper No. 294 (2009), *available at* http://www.ftc.gov/be/workpapers/wp294.pdf; Aileen Thompson, The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction, Federal Trade Commission Bureau of Economics Working Paper No. 295 (2009), *available at* http://www.ftc.gov/be/workpapers/wp295.pdf.

would have resulted in control of 73 percent of the licensed hospital beds in the area.[30]

The Commission also has acted to protect competition among kidney dialysis clinics to provide services to dialysis patients. In September 2007, the Commission challenged an agreement between two major dialysis clinics with facilities in the northeastern United States, American Renal Associates, Inc. (ARA) and Fresenius Medical Care Holdings, Inc. (Fresenius). Pursuant to that agreement, ARA would have paid Fresenius to close certain clinics nearby to competing ARA clinics, and ARA would have acquired other competitive Fresenius clinics. The Commission alleged that this agreement would have eliminated direct competition between ARA and Fresenius and resulted in ARA operating the only dialysis clinics in certain local markets in Rhode Island and Massachusetts. The parties terminated their agreement after Commission staff objected, and a Commission order prevents the parties from entering into similar agreements in the future.[31]

The Commission's merger scrutiny extends to other health care markets as well, including pharmaceuticals and medical device manufacturing. For example, in 2006, the Commission settled charges that Barr's proposed acquisition of Pliva would have eliminated current or future competition between Barr and Pliva in certain markets for generic pharmaceuticals treating depression, high blood pressure and ruptured blood vessels, and in the market for organ preservation solutions by requiring that Barr divest

[30] *See In the matter of Inova Health System Foundation and Prince William Health Systems, Inc.*, FTC Docket No. 9326 (Jun. 17, 2008) (Order dismissing complaint), a*vailable at* http://www.ftc.gov/os/adjpro/d9326/080617orderdismisscmpt.pdf.

[31] In the Matter of American Renal Associates, Inc., FTC Dkt. No. C-4202 (Oct. 17, 2007) (decision and order), *available at* http://www.ftc.gov/os/caselist/0510234/071023decision.pdf.

itself of certain key products.[32] In the medical device arena, the Commission charged that the merger of Boston Scientific and Guidant would have harmed competition and consumers in several coronary medical device markets.[33] In that matter, a consent agreement was achieved under which Guidant divested itself of intellectual property, plants, manufacturing technology, and other assets that had raised competitive concerns.[34]

IV. Pharmacy Benefit Management (PBM) Services

PBM services are another health care industry area in which the Commission has engaged in law enforcement, competition advocacy, and policy development, to ensure that competition benefits consumers. PBMs can help health care plans manage the cost and quality of the prescription drug benefits they provide to their enrollees. To varying degrees PBMs:

- negotiate rebates from pharmaceutical manufacturers;
- provide access to mail order pharmacies for health plan enrollees on maintenance medications;
- develop drug formularies[35] and help plan sponsors determine which drugs should be on the plan's formulary and whether and how to provide co-payment incentives to the plan's enrollees to use those drugs;

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[32] In the Matter of Barr Pharmaceuticals, Inc., FTC Dkt. No. C-4171 (decision and order) (Nov. 22, 2006), *available at* http://www.ftc.gov/os/caselist/0610217/0610217barrdo_final.pdf.

[33] In the Matter of Boston Scientific Corp. and Guidant Corp., FTC Dkt. No. C-4164 (complaint) (Apr. 20, 2006), *available at* http://www.ftc.gov/os/caselist/0610046/0610046cmp060420.pdf.

[34] In the Matter of Boston Scientific Corp. and Guidant Corp., FTC Dkt. No. C-4164 (decision and order) (Jul. 21, 2006), *available at* http://www.ftc.gov/os/caselist/0610046/060725do0610046.pdf.

[35] A formulary is a list of plan sponsor-approved drugs for treating various diseases and conditions. This list will often be broken down into "tiers," which correspond to different co-payment levels for enrollees. For instance, a three-tier formulary may consist of a generic tier, a preferred brand tier, and a non-preferred brand tier. Whether a brand is preferred may depend on whether a generic alternative is available and also upon the financial terms available to the PBM on drugs in the same therapeutic class.

- 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, several large insurers manage pharmacy benefits internally. Large retail supermarket/pharmacy chains also own PBMs, and several local and regional PBMs can compete with national PBMs for contracts with smaller employers or health plans that are geographically limited.[37] The three large national PBMs are the major players in many regional markets, but typically one-third to one-half of each market is serviced by other, smaller PBMs. The FTC found, in its most recent antitrust investigation of the PBM industry, that competition among PBMs for contracts with plan sponsors is "vigorous."[38]

Pharmacy services – like other parts of the chain of pharmaceutical manufacturing, marketing, and distribution – represent an important area of competitive concern, given the large and increasing share of health care spending devoted to

[36] *See* PBM STUDY, *supra* note 8, at 2-3.

[37] *See* IMPROVING HEALTH CARE: A DOSE OF COMPETITION, *supra* note 8, at 14-15 (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; Kaiser Family Foundation, Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain, at 16 (Mar. 2005), *at* http://www.healthstrategies.net/research/docs/Follow_the_Pill.pdf.

[38] *Inthe 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. The Commission closed the investigation because it concluded that the transaction was unlikely to reduce competition.

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.*, Letter from FTC staff to Hon. Nellie Pou, New Jersey Assembly (Apr. 17, 2007), *available at* http://www.ftc.gov/be/V060019.pdf; Letter from FTC staff to Virginia Delegate Terry G. Kilgore (Oct. 2,

The Commission's oversight of PBM industry participants is not confined to antitrust matters, but also includes vigorous enforcement of the FTC Act to protect consumer privacy. For example, CVS Caremark recently settled FTC charges that it had failed to take reasonable and appropriate security measures to protect the sensitive financial and medical information of its customers and employees in violation of the FTC Act.[42] The Commission will remain vigilant not only in policing competitive markets, but also in engaging in strong consumer protection enforcement.

IV. Conclusion

Thank you for this opportunity to share the Commission's views on these vitally important issues. The Commission looks forward to working with the Subcommittee to ensure that competitive health care markets deliver on the promise of competitively priced health care goods and services and increased innovation and quality.

2006), *available at* http://www.ftc.gov/be/V060018.pdf.

[42] *In the Matter of CVS Caremark Corp.*, FTC Dkt. No. C-4259 (Feb. 18, 2009) (decision and order), *available at* http://www.ftc.gov/os/caselist/0723119/090623cvsdo.pdf (respondent allegedly "discarded materials containing personal information in clear readable text (such as prescriptions, prescription bottles, pharmacy labels, computer printouts, prescription purchase refunds, credit card receipts, and employee records) in unsecured, publicly-accessible trash dumpsters on numerous occasions.") Respondent independently agreed to pay $2.25 million to resolve HHS allegations that it violated HIPAA.