Remarks by Deborah Platt Majoras[1]
Chairman, The Federal Trade Commission
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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

are presenting them with unfavorable terms and demanding that they "take it or leave it."[4] I recognize that some say that only by bargaining collectively can doctors counter the buying power (or "monopsony") of the giant health care organizations.[5]

Plainly, not all joint conduct by physicians is improper. To the contrary, physician network joint ventures can yield impressive efficiencies. Thus, the FTC (together with DOJ) committed long ago to using a balancing test (in our legal parlance, the "rule of reason") to evaluate those physician network joint ventures that involve significant potential for creating efficiencies through integration. Physician joint ventures involving price agreements can avoid summary condemnation (what we refer to as "per se illegal"), and merit the balancing analysis,

> if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.[6]

Financial risk-sharing and clinical integration can entail such integration and thereby render the venture likely to produce significant efficiencies. Our Health Care Policy Statements outline the analytical framework for this inquiry in greater detail.

But physicians must take note: provider agreements aimed simply at countering health care plans' bargaining power, we have found, are likely to raise health care costs for consumers without delivering offsetting benefits. As a threshold matter, it is not clear that the agreements

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[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'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE § 8(B)(1) (1996). *See also id.* § 9(A) (stating similar rule for multiprovider networks).

always counter monopsony power. A recent health care study by the Agencies concluded that "the available evidence does not indicate that there is a monopsony power problem in most health care markets."[7] Moreover, allowing doctors to collectively bargain with the health care plans would open the door to "doctors' cartels, raising physician fees ..."[8] The Congressional Budget Office has calculated that allowing physicians to collectively bargain in this manner "would increase expenditures on private health insurance by 2.6 percent."[9] It also estimated that it would increase direct federal spending on health care programs such as Medicaid by $11.3 billion over ten years.[10] (Health plans have estimated even greater costs; physician groups argue that the costs are quite modest.[11])

In short, while we recognize physicians' understandable desire for greater parity in their negotiations with large health care plans, they must understand that the touchstone for us is whether the conduct at issue here would hurt, or help, consumers. Our experience suggests that physician price-fixing – without integrative efficiencies – will raise consumer health care costs considerably, and that is why we have been so active in this area.

For example, last month, the Commission approved a final consent order in a case

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[7] DOSE OF COMPETITION, Ch. 2 at 20.

[8] *Id.*, Ch. 2 at 23 n. 167 (quoting *Prepared Statement Concerning the Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. 166 (1999) (Statement of Robert Pitofsky, Chairman, Federal Trade Commission), *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm).

[9] *Id.*, Ch. 2 at 24 (quoting CONG. BUDGET OFFICE, 106TH CONG., H.R. 1304: QUALITY HEALTHCARE COALITION ACT OF 1999, at 2 (Cost Estimate, Mar. 15, 2000), *available at* ftp://ftp.cbo.gov/18xx/doc1885/hr1304.pdf).

[10] *Id.*

[11] *Id.*, Ch. 2 at 24 & nn. 174-75.

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 competition in pharmaceutical markets, while also preserving incentives among drug manufacturers to invest in research and development for innovative new drug products. You are likely well aware, and studies have shown, that when a generic competitor enters the market, it does so at a lower price than the brand-name firm and quickly gains market share. Later generic firms enter at even lower prices. The Hatch-Waxman Amendments aimed to foster this price competition by encouraging the entry of new generic challengers.

Many pharmaceutical firms have laudably acted in good faith under this regime. Some, however, have sought to undermine it. The incentives to do so are clear. As the FTC has shown in its cases, the generic entrant gains smaller profits by competing than the brand-name firm loses once generic entry occurs. If the two rivals agree that the generic should delay its entry, then the brand-name firm can preserve its monopoly profits – and share some of it with the

[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 unintentionally make this strategy easier: under the Amendments, the first generic applicant's failure to enter may bar other firms from entering for a period of time. The FTC has brought several actions challenging agreements that delay entry.[16] For example, in *Schering-Plough*, the Commission found that the brand-name company unlawfully paid its generic competitors to defer their entry beyond the date that would have been expected absent the payment.[17] That case is currently on appeal.

Moreover, we have challenged similar agreements between generic manufacturers. The first and second generic entrants face a similar set of economic incentives to eliminate timely competition. The first generic enters at a lower price than the brand-name firm, but the second generic entrant often enters at an even lower price.[18] At least in the short term, agreements between the first and second entrant that delay the second firm from entering can keep prices from falling. Thus, in 2004, we settled charges against Perrigo and Alpharma for entering into such an anticompetitive agreement involving over-the-counter children's ibuprofen.[19] After the

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[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.

two entered into the agreement to limit competition, not surprisingly, prices went up. Our settlement with the firms require them to pay back the profits gained through this illegal agreement.

In the same vein, we have challenged other conduct that undermined the competitive goals of the Hatch-Waxman Amendments. For example, in our action against Biovail Corporation, we argued that Biovail, by wrongfully listing a patent in the FDA's so-called "Orange Book," improperly forestalled competition. Under the Amendments, would-be generic rivals must assert to the FDA that their drug does not infringe any valid patents that the brand firm has listed in the Orange Book. If a brand-name manufacturer with a patent listed in the Orange Book sues a generic for infringement, the Amendments award the brand an automatic 30-month stay of FDA approval of the generic's product. Biovail had allegedly acquired one 30-month stay this way, but – anticipating the expiration of that stay – improperly sought a second 30-month stay. It acquired and listed in the Orange Book a new patent, one that allegedly did not claim the drug's current formulation and therefore should not have been listed in the Orange Book. That compelled the generic to assert to the FDA – again – that its drug did not infringe any valid patents in the Orange Book, and offered Biovail an opportunity – again – to sue for infringement and obtain another 30-month stay.[20] We reached a consent order with Biovail that not only addresses the wrongful conduct but, in the words of my predecessor at the FTC, "send[s] a strong message that the Commission will act decisively to eliminate anticompetitive

[20] *Biovail Corp.*, Dkt. No. C-4060, *complaint available at* http://www.ftc.gov/os/2002/04/biovailcomplaint.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 requirement to notify the Commission of certain kinds of drug company agreements.[23] Congress adopted both of these recommendations when it passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[24]

II. *Promoting Efforts to Provide Consumers with Clear and Accurate Health Care Information*

A. *Bogus Weight Loss Claims*

The Commission has also done substantial work to promote efforts to provide consumers with clear and accurate health care information. The Commission's fraud enforcement program

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[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 example, the area of obesity. I do not need to tell you that obesity is a growing health concern. According to the Surgeon General, sixty-one percent of American adults are overweight, and obesity among adults has doubled since 1980. Because excess body weight increases the risk of serious health problems – including heart disease, diabetes, sleep disorders, hypertension, and certain cancers – the need for action is clear.

This means that Americans need good about diet and nutrition, exercise, and weight loss information. But, with some 70 million Americans trying to lose weight, some unscrupulous marketers find it all too tempting to peddle bogus weight-loss products. We have all seen advertisements for products like "Fat Trapper" and "Exercise in a Bottle" that promise fast and easy weight loss and make claims that you can "eat what you want and never - ever - ever - ever have to diet again."

With fraudulent claims like these, scam artists make millions of dollars, but consumers pay dearly. More than consumers' money is at stake here. It is their health. By holding out false hope that a bogus weight-loss product will provide effortless weight loss, the advertisements induce some consumers to put off undertaking the difficult work of diet and exercise that can actually help them slim down.

We have attacked these fraudulent claims using a combination of law enforcement, consumer education, and business education, and we are getting results.

Most recently, we filed a series of six lawsuits against promoters of fraudulent weight loss products as part of "Operation Big Fat Lie." Just to give you a flavor of some of the facially ludicrous claims that the targeted companies were making: one of them promoted a dietary

supplement that contains Nepalese Mineral Pitch, "a paste-like material" that "oozes out of the cliff face cracks in the summer season" in the Himalayas. It promised to deliver fast, substantial weight loss without the need to reduce calories or increase exercise. Another company offered a diet tea that, according to one endorser, helped her lose 64 pounds in 10 weeks. She said that she lost weight so fast, her doctor ordered her to slow down. A third company promoted a diet tablet that "works faster than a hunger strike! Even if you eat nothing, you won't slim down as fast." Our enforcement actions have eliminated a number of these false claims.

In addition to aggressive enforcement, we try to reach at-risk consumers before they are harmed, through consumer education. For example, we have our own "teaser" website, which imitates the fraudulent sites by marketing our staff's own creation: Fat Foe, an eggplant extract that guarantees easy weight loss. One click leads the viewer to a page revealing that the advertisement is a fake posted by the Federal Trade Commission, and teaches the viewer "how to tell the difference between a rip-off and the real thing!"[25]

We took our efforts in this area one step further by asking the media to partner with us in screening out bogus weight-loss advertisements. The FTC identified seven "red flags," that is, common weight loss clams that are always false. Then we asked the media to help us – and more importantly, their audience – by "red flagging" the advertisements that made those claims and refusing to run them.

And we have made good progress. Our nonscientific surveys indicate that – in just the first six months of the program – the number of weight loss product advertisements with facially false claims had fallen from almost 49 percent to 15 percent. Fifteen percent is still too high, but

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[25] *See* Fat Foe Fat Blocker, *available at* http://wemarket4u.net/fatfoe.

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.

I am pleased that the health care industry has helped improve consumer access to truthful, reliable health care information, I applaud your innovative efforts in this area, and I urge you to continue that effort.

Recently, the Commission, along with the Department of Justice's Antitrust Division, conducted a major study of competition in health care markets. For that study, we sponsored a workshop in 2002, hosted twenty-seven days of hearings over the course of nine months in 2003, and canvassed the literature exhaustively. We heard from about 250 panelists, including representatives from physician groups, hospital networks, other health care provider groups, insurers, employers, advocates for patient welfare, and attorneys. We invited the views of leading academics in areas such as antitrust, economics, health care quality, and informed consent. We reviewed the sixty-two written submissions that the hearings elicited, and pored over almost forty-eight hundred pages of transcript generated from the hearings. Based on this extensive effort, we issued a comprehensive report on the state of competition and health care, weighing in at over three hundred pages.[28] (The report and the underlying material for it is available on our website: www.ftc.gov.)

Our study made a disturbing finding: right now, "[t]he public has access to better information about the price and quality of automobiles than it does about most health care services."[29] Consumer information about the quality of health care providers is hard to find and not always reliable.[30] Without good, reliable information, patients are often at sea. Many

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

[29] *Id.*, Executive Summary at 6.

[30] *Id.*, Ch. 1 at 18.

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 health care market.[40] It gives consumers greater information and greater choice when it comes to health care payment systems, and allows the market to respond to consumer demand for higher quality – and lower cost – health care.[41]

The Agencies' health care report noted a similar trend in the payment of hospital services. Some hospitals have higher prices than others, but in the past, insurance plans largely shielded patients from the cost implications of their choosing one hospital over another.[42] That has perhaps begun to change with some payors' introduction of hospital tiering. Such payors rank hospitals into tiers according to price, and sometimes quality. Patients can then choose the hospital they want and pay accordingly. For example, patients may have to assume a 25 percent copayment to use high-cost hospitals in one tier but only a 15 percent copayment for lower-cost hospitals in another. The idea behind such tiering is to "allow consumers to decide whether a high-cost facility merits additional out-of-pocket spending."[43]

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[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 giving them economic incentives to choose a hospital that provides good value.[47] Those choices will provide a market signal that, it is hoped, will encourage hospitals themselves to become even more efficient at delivering health care to patients.

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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.