Remarks of Commissioner Edith Ramirez[1]
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I am delighted to be here in Santo Domingo at the Latin American Competition Forum and appreciate the opportunity to discuss the relationship between competition and the reduction of poverty from the perspective of the United States. In fact, we have long recognized the connection between the two. In 1890, during the debate leading to the passage of the seminal Sherman Act, Senator Sherman emphasized that monopolies "increase beyond reason the cost of the necessaries of life and business," which in turn "makes the people poor."[2]

Poverty is not as endemic in the United States today as it was in 1890, when 45% of industrial workers lived below the poverty line,[3] but it remains a significant problem. And the financial crisis made it considerably worse, with a record 15% of the population, or 46 million people, living below the official poverty line.[4] With poverty a pervasive social problem, protecting our most vulnerable citizens has always been central to the FTC's mission.

To illustrate this connection, I will discuss the area in which the Federal Trade Commission's competition efforts most explicitly benefit the poor—heath care.

I. Enforcement of Competition Laws Benefit the Poor

But before doing so, I want to emphasize an important point. Today, as antitrust enforcers we most often speak of maximizing economic efficiency and preserving well-functioning markets to improve overall consumer welfare. But we are also of the firm belief that, as a consequence, the poor benefit too.

For the most part, economic evidence bears this out. Greater competition leads to lower prices overall, higher output, better quality, and more innovation. The poor, like everyone else, benefit from these outcomes. Indeed, the underprivileged may benefit even more because they spend a greater proportion of their income on basic goods and services, and, as a result, price increases affect them more than others.

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[1] Translation of remarks delivered in Spanish.
[2] 21 Cong. Rec. 2461 (1890) (statement of Sen. Sherman quoting Sen. George), *reprinted in* THE LEGISLATIVE HISTORY OF THE FEDERAL ANTITRUST LAWS AND RELATED STATUTES 127 (Earl W. Kintner ed., 1978).
[3] ALAN TRACHTENBERG, THE INCORPORATION OF AMERICA: CULTURE AND SOCIETY IN THE GILDED AGE 90 (1982).
[4] U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010 14 (2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf.

II. FTC Enforcement Efforts

Now to my main topic. For the FTC, nowhere are the benefits to the poorest consumers more evident than through our enforcement and competition advocacy efforts in the health care sector.

Access to adequate medical care is an essential good. In the United States, no essential good costs anywhere near as much. According to the latest data available from 2010, health care expenditures represent a staggering 18 percent of GDP.[5] Last year, health care costs consumed a quarter of all federal outlays.[6] This rising spending has a profound effect on American standards of living.

A. FTC Hospital Merger Challenges

The FTC is particularly concerned with the effects of the recent increases in concentration among health care providers, particularly hospitals, on health care costs. There is strong evidence that hospital consolidation has resulted in higher prices. A 2006 Robert Wood Johnson Foundation study indicated that during the period from 1990 to 2003 consolidation drove hospital prices higher by between 5 and 40%, depending on the market.[7] The study's authors concluded that "monopolies may be the biggest impediment to cost control going forward."[8] Because hospitals represent the single largest driver of health care costs—over 31% of all health care expenditures—preventing anticompetitive hospital price increases can have a significant impact on overall health care spending.[9]

And there is little evidence that the higher costs resulting from mergers improve quality of care. To the contrary, looking only at hospital mergers that the FTC has recently challenged, there are countless examples of quality improvements hospitals made in direct response to competitors that they later tried to acquire. For example, one hospital dramatically shortened emergency room wait times after its only competitor began posting its average emergency room wait times on its website and billboards.[10]

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[5] CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURE DATA: 2010 HIGHLIGHTS 1, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/h ighlights.pdf.

[6] Lam Thuy Vo, *50 Years Of Government Spending, In One Graph*, NAT'L PUBLIC RADIO, PLANET MONEY BLOG, http://www.npr.org/blogs/money/2012/05/14/152671813/50-years-of-government-spending-in-1-graph.

[7] William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?* Synthesis Project No. 9, Robert Wood Johnson Found. 4 (Feb. 2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

[8] *Id*.

[9] KAISEREDU.ORG, THE KAISER FAMILY FOUNDATION, U.S. HEALTH CARE COSTS: BACKGROUND BRIEF (2010), *available at* http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.

[10] *FTC v. Phoebe Putney Health Sys., Inc.*, No. 1-11-CV-00058-WLS (M.D. Ga. filed Apr. 21, 2011) (complaint) ¶ 80, *available at* http://www.ftc.gov/os/caselist/1110067/110426phoebeputneycmpt.pdf.

Based on the benefits of hospital competition to consumers, the FTC has responded to the recent rise in hospital mergers by stepping up its enforcement efforts. In the last two years, the FTC successfully challenged hospital mergers in both Toledo, Ohio[11] and Rockford, Illinois.[12] Both Midwest cities suffer from a declining industrial base, rising unemployment, and high rates of poverty and uninsured patients. Accordingly, by virtue of their geographic locations, these efforts provide particular benefits to less affluent patients.

In the blocked Toledo hospital merger, the proposed deal, combining two of Toledo's four hospitals, would have resulted in a hospital system with a market share of almost 60% in the broad general acute care services market and up to 80% in narrower markets for certain specific services.[13] While this structural case was sufficiently strong to establish a presumption that the merger was anticompetitive, in analyzing the competitive effects of the deal, the Commission also relied on economic evidence predicting steep price increases. Our economic models predicted that the deal would have provided the merged firm with enhanced bargaining leverage and resulted in overall price increases of at least 16%.[14]

Meanwhile, the challenged Rockford hospital merger would have combined two of the three hospitals serving the city, resulting in a 60% overall market share.[15] Moreover, because health plans did not believe they could successfully market a plan to customers in Rockford limited to just one of the hospitals, the deal would have similarly allowed the combined hospital to demand higher rates from payers.

If the FTC had not challenged these mergers, health plans would have simply passed those increased hospital costs on to their members through higher insurance premiums and higher copayments. This would have forced the insured working poor and near poor to pay more for health care coverage. Both deals would have also increased the financial burden on uninsured and underinsured low-income individuals seeking care. Moreover, consumers would have lost the beneficial competition that had spurred the hospitals to improve the quality of care and offer additional patient services to increase their business.

In an effort to generate support for proposed transactions, merging hospitals frequently argue that a proposed merger will allow them to provide more charity care to the poor. But we have found those arguments to be unsupported by empirical evidence. For example, the FTC's Bureau of Economics conducted a study in 2006 examining hospital competition and charity care in hospitals in Texas and Florida between 1999 and 2002. Our economists found no evidence that increased hospital competition led to reductions in charity care.[16] Another study published

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[11] *ProMedica Health Sys., Inc.*, Docket No. 9346 (Mar. 28, 2012) (opinion of the Commission), *available at* http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf.
[12] *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012), *available at* http://www.ftc.gov/os/caselist/1110102/120505rockfordmemo.pdf.
[13] *See ProMedica Health Sys.* at 26-27.
[14] *Id.* at 50.
[15] *See FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d at 1078.
[16] Chris Garmon, *Hospital Competition and Charity Care*, 12 F. FOR HEALTH ECON. & POL'Y 2 (2009).

in 2010 analyzed non-profit hospitals in California and also concluded that hospitals do not provide more uncompensated care when faced with less competition.[17]

B. FTC Professional Services Efforts

In addition to maintaining an active hospital merger enforcement agenda, the FTC also works to prevent doctors and other professionals from exploiting safety regulations to restrict competition from paraprofessionals and other forms of new competition.

Decreased competition among health care professionals can raise costs and deny the poor access to needed medical care. While the wealthy may be able to absorb additional costs resulting from these restrictions, the poor often cannot. Moreover, low income Americans face barriers to obtain health care beyond just high costs. One of the most significant barriers is the shortage of physicians, dentists, and nurses, particularly in poor and rural areas of the country.[18] Unnecessary restrictions on the ability of qualified health professionals to provide certain services only exacerbate these deficiencies.

The FTC has initiated a number of cases in recent years targeting attempts by health care professionals to prevent lower-priced competition.[19] The FTC's successful action against the South Carolina State Board of Dentistry illustrates how these cases can benefit the poor. In 2000, the South Carolina legislature eliminated a requirement that a dentist examine each child before a hygienist could perform preventive dental care in a public health setting. The change permitted school children, particularly those from low-income families, to receive much needed preventive dental care. In response to the change, the dental board issued a regulation reinstating the restriction, which would have dramatically reduced the number of children receiving preventive dental care.

Ultimately, the case was resolved through a settlement, but not before the FTC showed that the dental board's action both conflicted with existing state law and would have denied needy students treatments without any associated health benefit.

In addition to this enforcement work, the FTC has also engaged in a significant amount of advocacy warning state governments about these kinds of barriers. Certain professional

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[17] Corey Capps, Dennis Carlton & Guy David, *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?* (Stigler Ctr. for the Study of the Economy and the State, Working Paper No. 232, 2010).

[18] *See, e.g.*, Annie Lowery & Robert Pear, *Doctor Shortage Likely to Worsen with Health Law*, N.Y. TIMES, July 29, 2012, *available at* http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html; KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE KAISER FAMILY FOUNDATION, IMPROVING ACCESS TO ADULT PRIMARY CARE IN MEDICAID: EXPLORING THE POTENTIAL ROLE OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS 1 (2011), *available at* http://www.kff.org/medicaid/upload/8167.pdf; Parija Kavilanz, *Doctor Starved: America's Heartland in Crisis*, CNNMONEY, Mar. 28, 2010, *available at* http://money.cnn.com/2010/03/26/news/economy/health_care_rural_care_country_doctors/index.htm.

[19] *See, e.g.*, *North Carolina Board of Dental Examiners*, Docket No. 9343 (2012), *available at* http://www.ftc.gov/os/adjpro/d9343/index.shtm; *South Carolina State Board of Dentistry*, Docket No. 9311 (2007), *available at* http://www.ftc.gov/os/adjpro/d9311/index.shtm.

licensure requirements and other regulations are unquestionably necessary to protect patients. But these requirements can also be used to thwart competition from highly-skilled para-professionals like advanced practice nurses and physician assistants. Accordingly, we frequently urge that state decision-makers weigh the value of those requirements against the benefits of improved access and lower costs resulting from the removal of restrictions.

Just last week, the FTC submitted testimony to the West Virginia state legislature urging it to reconsider legal requirements that advanced practice registered nurses, or APRNs, enter into collaborative arrangements with physicians to prescribe medications.[20] Prescribing drugs falls within an APRN's advanced medical training. In addition, several studies have shown that APRNs can prescribe medications safely absent these arrangements.[21] In fact, these collaborative arrangements require no specific level of physician oversight beyond a signed agreement. Despite the minimal burden, APRNs had difficulty finding physicians willing to enter into them. And those physicians who are willing often require substantial fees.

West Virginia is among the country's poorest states, and it suffers from a serious shortage of health care providers. Yet this requirement prevents APRNs from taking full advantage of their training to best meet the needs of their patients. Moreover, APRNs comprise a larger share of the primary care workforce in rural and lower income areas and are more likely to care for minority, uninsured, and Medicaid patients.[22] Easing the restrictions on APRNs, as urged by the FTC, can help alleviate these shortages, improve access, and encourage price competition, all of which would prove particularly beneficial to the underprivileged.

III. Conclusion

In sum, I believe that the FTC's experience in health care provider markets provides significant evidence that the enforcement of the competition laws both directly and indirectly benefits the poor. It also shows that enforcement need not be specifically designed to help the poor to provide them with significant benefits. What is needed are sound competition laws and policies, sufficient agency resources to enforce those laws, and a climate that respects the values of competition.

Thank you.

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[20] Prepared Statement of Fed. Trade Comm'n Staff, *The Review of West Virginia Laws Governing the Scope of Practice for Advanced Practice Registered Nurses and Consideration of Possible Revisions to Remove Practice Restrictions: Hearing Before Subcomm. A of the Joint Comm. on Health of the State of West Virginia Legislature* (Sept. 10-12, 2012), *available at* http://www.ftc.gov/os/2012/09/120907wvatestimony.pdf.

[21] INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMICS, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 98 (2001), *available at* http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx.

[22] KAISER COMM'N, *supra* note 18, at 3.