Remarks of Commissioner Julie Brill
Before the North Carolina Bar Association's
Antitrust and Trade Regulation Section
Cary, NC
February 9, 2012

1. Introduction

Hello everyone. I am so glad to be here today in North Carolina to talk to you about the FTC's role in the antitrust and healthcare arena.

For those of you unfamiliar with my ties to North Carolina, as George Sanderson mentioned in his remarks, right before my appointment as a Federal Trade Commissioner, I was the Senior Deputy Attorney General and Chief of Consumer Protection and Antitrust for your Department of Justice.

My ties to your state go back a long way. Prior to my time in North Carolina, during my time as a state enforcer in Vermont, I had the privilege of working closely with Attorney General Cooper and his staff on several consumer protection and antitrust issues, including his visionary work with his Iowa counterpart Tom Miller on the mortgage crisis leading to the 2008 economic downturn.

If only more people in Washington had listened to General Cooper back in 2003 when he first raised the issue of risky loans with the then Comptroller of the Currency.

Visionaries such as General Cooper serve as my inspiration in the work I do today at the Federal Trade Commission.

Founded in 1914, the FTC is a five member, bipartisan, independent federal agency, and the only agency in the United States empowered to enforce both competition and consumer protection laws.

A key item in the current Commission's agenda is healthcare antitrust, both in the enforcement and policy arenas. As we see it, there are few economic issues more important than curbing the rising cost of healthcare in the United States, and antitrust enforcement can be an effective tool in bending the healthcare cost curve in the long term.

We implement our healthcare antitrust agenda through several programs including: pay-for-delay enforcement actions and legislative proposals; hospital merger challenges; and our policy work alongside our sister antitrust agency, the Antitrust Division of the Department of Justice, regarding Accountable Care Organizations.

2. Pay-for-Delay

One of the Commission's top antitrust priorities is our continuing effort to end anticompetitive pay-for-delay agreements. For those of you unfamiliar with the term, pay-for-delay refers to a settlement of patent litigation in which a branded pharmaceutical manufacturer pays a generic manufacturer to keep its competing product off the market for a given amount of time. These settlements enable branded manufacturers to buy more protection from competition than the assertion of their patent rights alone would provide. Pay-for-delay agreements are a great deal for the branded drug companies and their generic counterparts. Unfortunately, they are a lousy deal for consumers. The FTC staff estimates that these agreements cost consumers $3.5 billion per year, or $35 billion over ten years, in the form of higher drug prices.

For the past 15 years, the Commission has taken the position—and this position has been bipartisan— that pay-for-delay deals violate the antitrust laws. Despite our efforts, since 2005 some courts have disagreed with us on the issue, but we continue the fight.

Currently, we have in place a two-pronged approach to tackle pay-for-delay. First, our enforcement actions continue. Second, we are encouraging Congress to adopt a legislative solution to the pay-for-delay problem.

We are currently in litigation in the Eastern District of Pennsylvania, where we are challenging several pay-for-delay settlements entered into by Cephalon with various generic firms. The evidence in the *Cephalon* case vividly illustrates the reason why the Commission continues to work towards putting an end to pay-for-delay agreements. In 2006, right after Cephalon entered into the settlement agreements at issue in our litigation, Cephalon's then-CEO told investors that, as a result of the settlements, the company was: "able to get six more years of patent protection. That's $4 billion in sales that no one expected."

Like I said, a great deal for the drug companies, but a lousy deal for the consumers left footing the $4 billion bill.

We believe that legislation would be the most effective way to curb these anticompetitive agreements, resulting in cost savings to consumers as well as to the federal and state governments that expend so much money on pharmaceuticals, through programs such as Medicare Part D.

3. Hospital Merger Enforcement

Another important tool in the FTC's efforts to contain healthcare costs is our hospital merger enforcement program. This program has recently been revitalized following a series of losses in federal district court in the late 1990's. Following those losses, former FTC Chairman Tim Muris initiated a hospital merger retrospective to study consummated mergers that had not been challenged by either antitrust agency, and the effect those mergers had on prices. This effort led to an administrative challenge in 2004 under the FTC's administrative adjudication rules to the consummated merger of two Chicago-area hospitals, Evanston Northwestern Healthcare and Highland Park Hospital. The approach taken in the Evanston case reinvigorated the FTC's hospital merger program, resulting in the Commission's successful 2008 challenge to the merger

between Inova and Prince William hospitals in Northern Virginia. Since then we have brought similar enforcement actions in Ohio, Georgia, and, most recently, in Illinois.

Both the Ohio and Illinois cases illustrate the extent to which FTC merger enforcement has been reinvigorated in recent years.

The Ohio case concerned the 2010 consummated acquisition by ProMedica Health System of St. Luke's Hospital in Lucas County, Ohio. The FTC staff went to federal district court in Ohio, and obtained a hold separate order from that court pending a full trial on the merits under the FTC's administrative adjudication rules. The matter is currently before the full Commission, and just this week Oral Argument was heard before the full Commission.

Whatever the outcome of the administrative case, the *ProMedica* district court decision[1] holds significance for policy reasons. You see, the district court opinion in *ProMedica* was the first time that the 2010 DOJ/FTC Horizontal Merger Guidelines were cited by a judge, and he did so extensively. As many of you will know, the DOJ/FTC Merger Guidelines establish the framework under which the federal antitrust agencies analyze mergers. The Guidelines were last updated in 1992, and were in need of a refresh. The 2010 Guidelines mark a step away from the use of market definition, market structure, and market shares as gating issues, and instead give appropriate weight to the actual effect of a merger, which really is the key analytical question to be answered in a merger review. The new Guidelines also provide important guidance about the kinds of evidence we and DOJ will look at in analyzing competitive effects. I was pleased to see the district court judge agree with our change in emphasis in the *Promedica* decision.

Meanwhile, in Illinois, FTC staff just completed a two day district court hearing in their bid to obtain a preliminary injunction enjoining the proposed acquisition by OSF Health System of the Rockford Health System. That case is scheduled to come before the FTC administrative law judge in April this year.

The recent FTC Georgia hospital challenge – *Phoebe Putney* - will be of particular interest to state level practitioners since it raised important questions about the intersection between state regulation and federal antitrust law under the state action doctrine. This doctrine played a starring role in the *Phoebe Putney* case.

As you will no doubt hear in some detail later on today, the state action doctrine has evolved from a 70 year old Supreme Court decision in which the Court determined that federal antitrust laws do not apply to acts of the state as sovereign.[2]

The Court has since refined the doctrine to further permit a state to delegate its sovereign ability to pursue anticompetitive market regulation to non-sovereign actors, such as counties or even private actors. However, non-sovereign actors can avail themselves of the immunity only if they can show that their actions were both taken pursuant to a clearly articulated and affirmatively expressed state policy, and actively supervised by the state itself. The commonly used shorthand for this two-pronged test is "clear articulation" and "active supervision."

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[1] *FTC v. ProMedica Health Sys., Inc.*, No. 3:11-cv-47, 2011 U.S. Dist. LEXIS 33434 (N.D. Ohio Mar. 29, 2011).
[2] *Parker v. Brown*, 317 U.S. 341 (1943).

The FTC believes the state action doctrine is intended to protect valid state interests. We do not support the application of the doctrine to acts of private actors in a way that the Supreme Court could not have intended. This is why the FTC challenged Phoebe Putney's December 2010 acquisition of the Palmyra Park hospital in Albany, Georgia.

In our complaint, we alleged that the merger was an anticompetitive merger to monopoly that ought not to be shielded from the Federal antitrust laws by the state action doctrine. We did so because we had reason to believe that the state action there amounted to the improper use of a state entity – the Hospital Authority of Albany-Dougherty County – as a straw man to avoid antitrust scrutiny.

Another aspect of *Phoebe Putney* that will be of interest to practitioners was the role played by the Georgia State AG as co-plaintiff in the case. The FTC has long enjoyed a high level of cooperation with state enforcers in fulfilling our mutual antitrust and consumer protection missions. I was myself active in this sphere for many years before I joined the Commission, and can attest to it from extensive personal experience.

What was perhaps unusual about the *Phoebe Putney* case was not only the high level of cooperation between FTC staff and the Georgia AG's office, but, more importantly, the fact that the Georgia AG joined the case with the FTC and specifically argued against providing state action immunity to the merging parties.

I cannot speak for the Georgia AG, but I think his decision to join us rested in large part on the strength of the evidence underpinning our argument that the state actor – the Hospital Authority of Albany-Dougherty County – was a straw man, coupled with the Georgia AG's concern about the effect of a merger to monopoly in his backyard.

Unfortunately, we were not successful in persuading the lower courts to issue the preliminary injunction, due to the difficult precedent in the 11th Circuit on the state action doctrine.

Of course, I cannot leave a discussion of the state action doctrine without mentioning the great state of North Carolina. In the ongoing *North Carolina Dental* case, the FTC has challenged the North Carolina State Board of Dental Examiners' rules preventing non-dentists from providing teeth-whitening services to consumers, making the services harder to obtain and more expensive.

The Board filed a motion with the Commission in November 2010, seeking to dismiss the FTC's charges based on the state action doctrine. The Commission denied the motion, concluding that the state action doctrine did not exempt the Dental Board from antitrust scrutiny.[3] The Commission's decision turned on the issue whether the Board was actively supervised by the state at the time it adopted the relevant rules. The Commission found no convincing evidence of active supervision, and concluded that the Federal antitrust laws reached the Board's conduct. Following this decision, the case continued to a full trial under the Commission's administrative rules, resulting in a unanimous Commission decision in December last year finding the Board in

[3] N.C. Bd. of Dental Examiners, 151 F.T.C. 607 (2011), *available at* http://ftc.gov/os/adjpro/d9343/110208commopinion.pdf.

violation of Section 5 of the FTC Act.[4] Separately, the North Carolina Dental Board has appealed the Commission's 2010 state action decision, and that appeal is pending before the 4th Circuit.[5]

4. Accountable Care Organizations

Taking a step away from our healthcare enforcement actions, the FTC also seeks to curb rising healthcare costs through our policy work, most recently in connection with the administration's Healthcare Reform efforts, otherwise known as the Patient Protection and Affordable Care Act of 2010. The Affordable Care Act seeks to improve quality and reduce health care costs through a variety of mechanisms, including encouraging physicians, hospitals, and other health care providers to become accountable for a patient population through integrated health delivery systems, such as Accountable Care Organizations (ACOs).

ACOs will serve Medicare fee-for-service beneficiaries through the Medicare Shared Savings Program. But as these integrated groups begin to act in the marketplace, they could potentially gain market power and reduce competition. In other words, some ACOs could, depending on a number of variables, interface with the antitrust laws in the future.

The FTC has worked with the Department of Justice to provide antitrust guidance to ACOs. Just four months ago, in October 2011, the FTC and DOJ issued our final joint Statement of Antitrust Enforcement Policy.[6] This guidance is intended to ensure that the antitrust laws are flexible to the concept of ACO formation, while at the same time ensuring that the benefits from the increased collaboration created through ACOs will not be lost to anticompetitive conduct.

To this end, the Policy Statement makes clear that the antitrust analysis of ACO applicants to the shared Medicare Shared Savings Program seeks to protect both Medicare beneficiaries and commercially insured patients from anticompetitive harm, while allowing ACOs the opportunity to integrate to achieve significant efficiencies.

The Policy Statement seeks to accomplish four things. It (1) describes when the Agencies will apply rule of reason antitrust analysis to ACOs; (2) establishes an antitrust safety zone for ACOs; (3) identifies potential ACO conduct that might raise competitive concerns that ACOs should therefore avoid; and (4) provides additional antitrust guidance to ACOs outside the safety zone.

The Policy Statement also creates a process through which newly formed ACOs may take advantage of a voluntary expedited review process in order to obtain comfort from the agencies that their ACO passes muster under the antitrust laws.

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[4] N.C. Bd. of Dental Examiners, FTC Docket No. 9343 (Dec. 7, 2011), *available at* http://www.ftc.gov/os/adjpro/d9343/111207ncdentalopinion.pdf.

[5] N.C. Bd. of Dental Examiners, FTC Docket No. 9343 (Jan. 13, 2012), *available at* http://www.ftc.gov/os/adjpro/d9343/120113respappstayordpendreview.pdf. I was recused from the North Carolina Dental case.

[6] *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, Federal Trade Commission and Department of Justice (October 20, 2011).

My hope is that our ACO Policy Statement will aid the healthcare industry in forming ACOs to the extent they make sense for the marketplace. As some of you may know, there were some concerns with the initial draft ACO Policy Statement, to which we listened very carefully during our public consultation process, and reacted appropriately. And I think that the end product was good policy that, alongside our enforcement work, will play a relevant and long lasting role in bending the healthcare cost curve.

Thank you.