

# Center for American Progress



## Reviving Competition in Healthcare Markets: The Use of Section 5 of the FTC Act

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I appreciate the opportunity to participate in today's important program about enforcement under Section 5 of the FTC Act. I think we all should take a moment and applaud the efforts of the FTC to examine the full range of its statutory powers. Too often in the past the FTC has perceived itself as the younger sister of the Antitrust Division of the Department of Justice, measuring its success and activities based on the enforcement agenda and approach of the Antitrust Division. There have been times when the FTC has focused its efforts, like the Antitrust Division on federal court litigation, and in doing so, has failed to perceive and fully utilize its unique range of statutory and adjudicative powers. To its credit the current Commission has revitalized the administrative litigation process, which under its new proposed litigation rules offers the potential of the Commission becoming the "Times Square" of antitrust litigation in the future. Determining the scope of the Commission's jurisdictional powers is equally as important. That is why the Commission's self-examination of its powers under Section 5 is vital to effective federal antitrust enforcement.

Moreover, the nature of competition in the general economy increasingly demands that the FTC, like other enforcement agencies, fully utilize their enforcement powers. Section 5 of the FTC Act which declares illegal "unfair methods of competition" and "unfair acts and practices" is critically important. To give just one example, Section 5 can be used to attack facilitating practices in oligopolistic industries, which cannot be challenged under the Sherman Act. Unfortunately because of relatively lax merger enforcement a far greater number of markets have become oligopolistic, significantly increasing the opportunities for firms to engage in forms of tacit collusion to raise prices. Not surprisingly numerous markets have shown consistently increasing prices. The fact that the Justice Department has brought a record number of explicit collusion cases suggests that the problems of collusion are become ever more pervasive. And facilitating practices offer a convenient venue to achieve the same goals, where firms want to avoid those severe criminal penalties.

Unfortunately since the early 1990s, the FTC has used Section 5 in a relatively modest fashion. The recent N-Data case is an important exception, but other than that the remainder of the actions are invitation to collude cases. Thus, this reexamination of the powers of Section 5 is vital to addressing the increasing problems in oligopolistic markets.

Today I will not focus on the oligopoly issue. Unlike the other speakers today, who will focus on some of the more difficult legal and policy issues concerning the scope of Section 5, I want to dwell on the use of Section 5 in a particular industry: healthcare intermediaries (*i.e.*, health insurers, group purchasing organizations and pharmacy benefit managers). I am focusing on this area for two reasons. First, enforcement efforts in this area offer the greatest potential benefit to consumers, because of the importance of healthcare intermediaries and the size of commerce involved. Healthcare after all accounts for one out of every seven dollars of the nation's budget. A single enforcement action in this area may offer substantial benefits to consumers in lower costs and greater choice.

Second, there appears to be a unique disconnect between the level of the federal antitrust enforcement and state antitrust and consumer protection enforcement. Anyone examining the federal antitrust report card involving healthcare intermediaries might reach the conclusion that these organizations are perfect antitrust citizens. The antitrust enforcement agencies have brought no enforcement cases against any healthcare intermediaries in the past eight years. Yet, anyone looking at the list of both private and state actions against these intermediaries would reach the exact opposite conclusion. For example, in the past several years:

- Each of the major pharmacy benefit managers has been sued by groups of states and the Department of Justice for fraudulent and deceptive actions that have harmed consumers and taxpayers funding federal programs. These cases were settled with penalties that exceeded \$300 million. Numerous multistate investigations against PBMs continue. Moreover, there have been numerous private suits filed against PBMs for anticompetitive, deceptive, and fraudulent conduct.
- In the medical device industry there have been several antitrust suits filed against dominant medical device manufacturers for engaging in a variety of anticompetitive activity. Many of these cases involve the use of kickbacks paid by the medical device companies to group purchasing organizations. The Senate Judiciary Committee has held a series of four hearings surrounding kickbacks and other forms of anticompetitive conduct.
- State enforcement officials, including state insurance and consumer protection enforcement officials have brought several cases against health insurance companies for a wide variety of anticompetitive and deceptive actions. In one recent case, the insurance commissioner in California imposed fines of up to \$1 billion against United Healthcare, the country's largest insurance company. There are also industry-wide private cases brought challenging conduct that undermines insurance markets.

What does this disconnect mean? Is it that one set of enforcers or another are misguided? Is it that state and federal laws are inconsistent? Is it that nonproblematic conduct is mistakenly challenged by state enforcers and private parties?

I do not think any of those propositions are true. But I believe that federal enforcement can play a vital role in improving competition in these markets. The FTC should use Section 5 to challenge a variety of unfair methods of competition which undermine and threaten to the integrity and competitiveness of the healthcare intermediary system. In assessing the federal healthcare enforcement program the American Antitrust Institute observed in its transition team report that “[t]he priorities of the health care enforcement agenda need to be realigned with a greater focus on health insurers, PBMs, GPOs, and hospitals.”<sup>1</sup> That focus should include a renewed attention to the use of Section 5 to attack practices in this area.

The problem of the failure to use Section 5 to address unfair competitive conduct in healthcare markets was highlighted for me when I spoke at the Fifth Annual Seoul International Competition Forum earlier last month. Of course, since this was a Southeast Asia conference, we all held our breath when the representative of the Chinese antimonopoly authority spoke because we wanted to learn about how one of the world’s largest economies was implementing its new anti-monopoly law.<sup>2</sup> Where had the Chinese focused their new enforcement power? Commercial bribery that undermined healthcare markets. The speaker noted that:

It is found that the medical treatment, medicine and healthcare product selling are prone to commercial bribery. Some producers and retailers, including large multinational medical medicine manufacturers have acquired, through commercial bribery, unfair transaction opportunities and sought unreasonable super-profits, which naturally results in the price hike of medicines in healthcare products, and consequently, influences peoples’ fundamental demand for seeing doctor and healthcare, causing severe side effects in the society. Thus, [the competition authority] considers the investigation and handling of commercial bribery cases in medicine, healthcare industry as top priority.

The Korean competition enforcer raised similar concerns. Their major enforcement action is a case that the Korean FTC brought against ten large pharmaceutical companies in which it imposed a fine of 20 billion won for kickbacks including “providing undue private benefits to doctors and medical institutions, such as supporting their overseas travel expenses.” The Korean FTC concluded that “the provision of undue private benefits ultimately incurs consumer damage by hampering fair competition among pharmaceutical companies and offering a cause to raise drug prices.”<sup>3</sup>

Indeed, even FTC Commission Rosch noted that Section 5 might be an appropriate tool to use when looking at efforts that specialty hospitals engage in to cherry-pick the most attractive patients while leaving the more expensive charity-type patients for more traditional hospitals. He observed that many of the disputes surrounding specialty hospitals are over issues of fairness, and arguably are not straightforward antitrust violations; but that those types of violations fit within his own view of a potential Section 5 case.

Of course, I know what you are thinking—are these conventional antitrust cases, (at least the way we in the U.S. think of conventional antitrust cases)? Whether they are is a debate for another day. But what I think is illuminating is that competition authorities around the world have decided that it is important for the protection of consumers and the

integrity of the market to challenge this type of conduct that might not be a typical antitrust violation, but rather threatened to undermine the competitive process.

It is useful to remind us of the Commission's broad powers under Section 5 as elaborated in *FTC v. Sperry & Hutchinson*. Justice White speaking for a unanimous Court posed and answered two straightforward questions:

The question [of the reach of Section 5] is a double one: first, does Section 5 empower the Commission to define and proscribe an unfair competitive practice, even though the practice does not infringe either the letter or the spirit of the antitrust laws. Second, does Section 5 empower the Commission to proscribe practices as unfair or deceptive in their effect upon consumers regardless of their nature or quality as competition? We think the statute, its legislative history and prior cases compel an affirmative answer to both questions.

Legislative and judicial authorities alike convince us that the Federal Trade Commission does not arrogate excessive power to itself if, in measuring a practice against the elusive, considers public values beyond simply those enshrined in the letter or encompassed in the spirit of the antitrust laws.<sup>4</sup>

## Concerns of Healthcare Intermediary Markets

There are significant competitive concerns raised by health care intermediaries. Several intermediary markets are very concentrated and have significant barriers to entry. Where the practices of the intermediaries are not wholly transparent, there may be opportunities for deceptive conduct. Intermediaries can use their power to foreclose competition through a wide variety of exclusionary practices. As a series of articles in the *Wall Street Journal* observed, intermediaries have not functioned effectively in the health care context and middlemen often seem to exercise market power:

[W]hile the Internet, deregulation and relentless corporate cost-cutting have squeezed middlemen elsewhere, the health-care middlemen are prospering. The three largest pharmaceutical benefit managers, for instance, had net income of \$1.9 billion last year, a sum that exceeds the annual operating budget of New York's Sloan Kettering cancer center. In corners of the system such as Medicaid managed care and nursing-home drugs, little-known intermediaries rack up tens or hundreds of millions of dollars in profit.<sup>5</sup>

During the past administration, there have been no federal antitrust enforcement actions against intermediaries, including health insurers, PBMs, and GPOs. This is not to suggest that there are no competitive problems involving these firms. Indeed, there have been numerous private and state antitrust and consumer protection enforcement actions against these companies. As the AAI observed "[d]espite these efforts, the lack of federal enforcement results in higher prices and decreased choice for consumers."<sup>6</sup>

Let me focus on practices of PBMs, GPOs, and insurers that could be addressed under Section 5.

## Pharmacy Benefit Managers

PBMs play an important function in health care markets by setting up pharmaceutical benefit networks and adjudicating pharmaceutical claims. The PBM market is highly concentrated with three major PBMs with approximately 80 percent of the national market. The FTC has not undertaken any enforcement activity in the face of this market consolidation. In fact, the past two substantial PBM mergers—Caremark’s acquisition of AdvancePCS and CVS’s acquisition of Caremark—were approved without a significant investigation, despite leading to a significant increase in concentration.<sup>7</sup>

PBMs’ promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. The dominant PBMs have been characterized by opaque business practices, limited market competition, and widespread allegations of fraud. As a bipartisan group of state legislators noted:

We know of no other market in which there have been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.<sup>8</sup>

In an important decision upholding state regulation of PBMs, one federal court observed “[w]hether and how a PBM actually saves an individual benefits provider money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider.” The court elaborated:

This lack of transparency also has a tendency to undermine a benefits provider’s ability to determine which is the best among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.<sup>9</sup>

In the past four years alone, cases brought by DOJ and state attorneys general attacking unfair, fraudulent and deceptive have secured over \$300 million in penalties and fines against the three major PBMs.<sup>10</sup> A group of state attorneys general and DOJ are continuing to conduct several investigations of the three major PBMs, and several private actions challenging their conduct have been brought by unions and other customers. The current concentration of the national full

service PBM market only exacerbates these problems, increasing the need for government enforcement and potential regulation of the industry.

Some of the problematic practices challenged in these cases include:

- Secretly retaining most manufacturer payments, e.g., rebates, discounts and other fees, instead of passing through such payments to clients
- Switching plan members from low- to high-cost drugs
- Favoring higher-cost drugs on their formularies
- Manipulating generic (maximum allowable cost) pricing
- Entering into exclusivity arrangements with specialty pharmaceutical manufacturers that raise the prices of those drugs
- Conspiring with manufacturers to violate Omnibus Budget Reconciliation Act and “best pricing” regulations
- Committing other contract or fiduciary breaches

One chronic problem with PBMs is that of self-dealing. Plan sponsors purchase PBM services with the assumption they are a “fair broker” that will select the lowest cost, best product on an objective basis. These concerns of self-dealing were part of the reason the FTC challenged the acquisition of PBMs by pharmaceutical manufacturers in the mid-1990s—Merck’s acquisition of Medco and Lilly’s acquisition of PCS. The concern was that the pharmaceutical manufacturers would favor their own drugs on the PBM formulary. These cases were resolved with orders that protected plan sponsors from the risks of self-dealing.

Unfortunately, these problems of self-dealing have continued to exist for PBMs. Almost all PBMs have their own mail order operations. Often, PBMs may favor drugs in which they receive a greater margin because they are dispensed by mail order, even though the plan sponsor or consumer may pay more. PBMs often seek to drive consumers to more highly profitable mail order distribution and away from independent pharmacies that offer the level of quality, advice and personal service consumers prefer. Consumers often suffer from the conversion to mail order: they are given little choice, there is a greater chance of adverse reactions, and there is little if any consumer service. Any consumer who has spent hours on the phone waiting for an answer on a mail order prescription sees little “efficiency” from these efforts to drive independent pharmacies from the market. Although an FTC study appeared to find little evidence of these problems of self-dealing, the recent state enforcement actions have demonstrated that these problems are ongoing.

This problem of self-dealing has worsened with the acquisition of PBMs by major pharmaceutical chains. These chains may use the information secured through their PBM operations to target other pharmacies, by attempting to steal customers. At times the PBMs owned by chain pharmacies have attempted to deceive consumers to drive them from their rivals.

Unfortunately, the FTC has failed to investigate or take any enforcement action against this anticompetitive, fraudulent, and deceptive conduct. Perhaps the FTC sees its enforcement powers as too limited. Even more problematic, when individual states have attempted to regulate PBMs to address the lack of enforcement, increase transparency or address forms of this deceptive conduct, the FTC has advocated on the side of the PBM industry in opposition to the proposed legislation.<sup>11</sup> This is a mistake. As the AAI report observed: “[c]onsidering the substantial number of enforcement actions and the severity of the PBM conduct, we believe these efforts at regulating PBMs are well founded and that the FTC’s advocacy has been ill-advised.”<sup>12</sup>

## Group Purchasing Organizations

GPOs negotiate contracts for their member hospitals with numerous entities, including medical device manufacturers. The original purpose of GPOs was to obtain better pricing on products than hospitals could obtain individually, and to provide value-added services. Although GPOs may reduce purchase costs by giving hospitals greater bargaining power, growing GPO consolidation and market power has increased the exclusionary potential of some of the GPO contracting practices.<sup>13</sup> Moreover, the payment of kickbacks is pervasive and undermines the product selection system.

Many small medical device manufacturing start-ups have claimed that contracting practices by GPOs have effectively foreclosed them from entering the market. Examples of alleged exclusionary practices include kickbacks, sole-source contracts, market share discounts, and bundling of products so hospitals must purchase the bulk of their supplies from a single vendor to qualify for a discount on any one product. Small manufacturers argue that incumbent suppliers, together with GPOs, use these practices to eliminate competition and preserve their market share.<sup>14</sup>

As in the Chinese and Korean cases suggest, particularly problematic are kickbacks paid by manufacturers to the GPOs. These kickbacks deceive buyers and third parties (including government entities) that are responsible for payment for the products of the real costs of the products. They may distort demand and provide the opportunity to artificially increase prices. Although there are regulations that prohibit kickbacks in many healthcare markets, the GPO payments fall into a safe harbor.

In the past seven years, the Senate Judiciary Committee has held four hearings concerning kickbacks and other exclusionary conduct by GPOs.<sup>15</sup> The FTC also addressed the issue in its 2003 health care competition hearings.<sup>16</sup> Over a dozen private suits have been brought, some successfully, by small innovative medical device manufacturers against exclusionary practices by GPOs and device manufacturers.<sup>17</sup> Yet the FTC has failed to bring any enforcement actions in this area.

Section 5 may provide a useful tool in two respects to cure the harmful practices in the medical device market. First, to the extent that potential enforcement actions against market share discounts, or other forms of de facto exclusivity seem deficient for some element necessary for a Sherman Act challenge, Section 5 may enable the FTC to overcome that deficiency. Second, the practices of kickbacks can be addressed under Section 5 as an unfair method of competition. A

gap in enforcement currently exists because of the difficulty in proving that a kickback scheme constitutes a violation of the Sherman Act. The Ninth Circuit, after acknowledging the existence of a kickback scheme by an alleged health insurance monopolist caused higher co-payments and premium payments, found no antitrust violation because of a lack of evidence of harm to the relevant market.<sup>18</sup> Carried to its logical extreme that decision would mean that the antitrust laws would not prevent every insurance company from engaging in kickbacks that raised costs to consumers. However, under Section 5 a kickback scheme could be an unfair method of competition particularly where there is evidence of consumer harm.

## Insurance Companies

Like PBMs and GPOs, the health insurance market has the factors that make it a fertile environment for harmful conduct—concentration and complexity. Almost every metropolitan health insurance market is highly concentrated. There have been over 400 health insurer mergers in the last decade and only three have been challenged by the Justice Department—with modest divestitures. The entire nation is basically dominated by four major insurance companies.

There are a wide variety of practices that insurance companies engage in which undermine and threaten to undermine the competitive process and ultimately harm consumers. Some of these practices are similar to the practices engaged in by PBMs in that they deprive buyers from securing sufficient information to make intelligent decisions and insure that the competitive marketplace works effectively. Other practices raise more straightforward competitive concerns by creating artificial barriers to entry and other forms of competition. Still, other practices either create or try to exploit market failures so that insurance companies can charge excessive prices or deny necessary services.

Health insurers possess a variety of tools to exercise their market power and reduce the choices of providers and consumers. For example, health insurers use “most favored nation” provisions to prohibit health care providers from entering into arrangements to sponsor new entry into the insurance market or facilitate expansion. “All products” clauses function like tying arrangements and may be used to coerce providers to participate in particular health plan programs.

Health insurers also engage in a variety of deceptive and fraudulent practices that limit consumer choice and maintain information asymmetries. Examples of health insurer practices that harm consumers are legion, including onerous preapproval requirements and preexisting condition policies. Many insurers prevent consumer choice by imposing “gag” clauses that prevent physicians from informing patients of insurance plans providing superior coverage. Some health insurers also manipulate their claims processing systems to the disadvantage of both consumers and providers.

Let me focus on some of the more straightforward forms of harmful conduct:

- **Most favored nations provisions.** Most favored nation provisions require healthcare providers to provide an insurer the best price that it offers any other insurer. Most favored nation provisions can raise competitive concerns because they may limit the ability of providers to engage in selective discounting, which may facilitate the entry of new



providers. Moreover, in other instances, most favored nations provisions can facilitate collusion among competitors. The Justice Department and the FTC properly attacked most favored nations provisions in a series of cases during the Clinton Administration. Unfortunately, no similar cases have been brought in the past several years even though these practices continue. To the extent that the agencies perceive that some aspect of the Section 1 violation is absent, Section 5 would enable an agency to challenge a most favored nation provision.

- **All products clauses.** An all products clause requires a provider to sign up for any healthcare plan sponsored by the health insurer. An all products clause effectively serves as a tying arrangement, which, again, may serve to stifle the ability of other insurers to effectively enter the market.
- **Silent networks.** Sometimes insurance companies engage in an even more pernicious form of all products clauses—that of automatically enrolling providers in networks in which they have not chosen to participate. Not only do these arrangements create structural problems by limiting entry, but they are also unfair to healthcare providers.
- **Interfering with the physician patient relationship.** Insurance companies use a variety of practices to deter the ability of physicians to adequately counsel and inform their patients. Some of these provisions limit the ability of the physician to provide information or solicit the patient when the physician changes plans
- **Fraudulent reimbursement schemes.** In February of this year, New York Attorney General Andrew Cuomo announced an industry-wide health insurance investigation into a fraudulent reimbursement scheme, and potential litigation specifically naming Ingenix, the nation’s largest health care billings information provider, as well as Ingenix’s parent company, UnitedHealth Group (“United”). Findings of the investigation revealed that Ingenix operates a “defective and manipulated database” which is utilized by most major health insurers to set reimbursement rates for out-of-network medical expenses. United used Ingenix’s data to “dramatically under-reimburse” their members for out-of-network medical expenses. By distorting the “reasonable and customary” rates, which are paid for out-of-network expenses, United kept the reimbursements artificially low forcing patients to burden a higher share of the cost. This distortion resulted in United effectively only covering roughly 30 percent of out-of-network medical expenses, leaving consumer to cover 70 percent of these expenses when they were promised 80 percent out-of-network coverage.
- **Improper claims payment and claims denials.** In February 2008, California regulators imposed a potential penalty of \$1.3 billion in fines against United for violating the law more than 130,000 times<sup>19</sup> after acquiring PacifiCare. Upon reviewing 1.1 million claims, the investigation found that after United acquired PacifiCare in 2005, United failed to pay claims in a timely manner and had over a 10 percent overall error rate in processing claims. United wrongfully denied claims for covered medical care, with regulators finding that 30 percent of reviewed HMO claims were denied incorrectly and 55 percent

of certain claims were incorrectly denied as duplicate submissions when they were not in fact duplicate submissions.

## Conclusion

The Congress that enacted the FTC Act created Section 5 to enable the FTC to utilize its expertise to challenge practices that were not technical antitrust violations. The FTC should begin to use those powers in a careful and prudent fashion, bringing enforcement actions that will bring significant benefits to consumers. The FTC should start by addressing conduct involving PBMs, GPOs, and health insurers.

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<sup>1</sup> The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44<sup>th</sup> President (Albert A. Foer ed., 2008).

<sup>2</sup> Ruibin Jiang, Deputy Director General, State Administration for Industry and Commerce, China, Remarks Before the Seoul International Competition Forum (Sep. 3, 2008).

<sup>3</sup> Hockhyun Kim, Director General, KFTC, "Korea's Antitrust Enforcement Strategy in Medical and Pharmaceutical Markets" (Sep. 3, 2008).

<sup>4</sup> *FTC v. Sperry & Hutchinson*, 405 U.S. 223, 239, 244 (1972). See also *FTC v. Brown Shoe Co.*, 384 U.S. 316, 321 (1966) ("[t]his broad power of the Commission is particularly well established with regard to trade practices which conflict with the basic policies of the Sherman Act and Clayton Acts even though such practices may not actually violate these laws . . ."); *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 454 (1986) (observing that the standard for "unfairness" under the FTC Act is, "by necessity, an elusive one, encompassing not only practices that violate the Sherman Act and the other antitrust laws, but also practices that the Commission determines are against public policy for other reasons.").

<sup>5</sup> Barbara Martinez et al., *Health-Care Goldmines: Middlemen Strike it Rich*, Wall St. J., Dec. 29, 2006, at A1.

<sup>6</sup> The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44<sup>th</sup> President (Albert A. Foer ed., 2008).

<sup>7</sup> The American Antitrust Institute provided a white paper assessing the structural issues posed by the proposed Express Scripts/Caremark merger. See American Antitrust Institute, *Express Scripts' Proposed Acquisition of Caremark* (2007), available at [http://www.antitrustinstitute.org/archives/files/AAI\\_Express%20Scripts\\_Caremark\\_2-14\\_021520071110.pdf](http://www.antitrustinstitute.org/archives/files/AAI_Express%20Scripts_Caremark_2-14_021520071110.pdf). The law firm that represented one of the parties in the Caremark/AdvancePCS merger observed that the investigation was closed on a "quick look" review. See Jonesday.com, Experience Details: Caremark, [http://www.jonesday.com/experience/experience\\_detail.aspx?exID=\\$9298](http://www.jonesday.com/experience/experience_detail.aspx?exID=$9298) (last visited July 1, 2008). The CVS/Caremark merger was resolved without the FTC's issuing a second request.

<sup>8</sup> Letter from Mass. State Senator Mark Montigny to FTC Chairman Deborah Platt Majoras (May 11, 2005).

<sup>9</sup> *Pharm. Care Mgmt. Ass'n v. Rowe*, 2005 U.S. Dist. LEXIS 2339, at \*7-8 (D. Me. Feb. 2, 2005), *aff'd*, 429 F.3d 294 (1st Cir. 2005).

<sup>10</sup> See, e.g., *United States v. Merck & Co.*, Case No. 00-CV-737 (E.D. Pa., filed Feb. 10, 2000) (final settlement in this case was reached with Merck-Medco agreeing to pay \$155 million); *United States v. AdvancePCS, Inc.*, Case no. 02-cv-09236 (E.D. Pa., filed Dec. 20, 2002) (defendant agreed to a \$137.5 million settlement and a five-year injunction); *Ohio v. Medco Health Solutions, Inc.*, Case No. A 0309929 (Hamilton Cty., Ohio 2005) (verdict finding Medco liable for constructive fraud and awarding \$7.8 million total, \$6.9 million in damages plus \$915,000 for the State Teachers Retirement System); *West Virginia v. Medco Health Solutions, Inc.*, Case no. 02-C-2944 (Kanawha Cty., W.Va., 2002) (\$5.5 million settlement).

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<sup>11</sup> Letter from Maureen K. Olhausen, on behalf of the Fed. Trade Comm'n, to Sen. Richard L. Brown, North Dakota Senate (Mar. 8, 2005), *available at* <http://www.ftc.gov/os/2005/03/>

050311northdakotacomnts.pdf.

<sup>12</sup> The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44<sup>th</sup> President (Albert A. Foer ed., 2008).

<sup>13</sup> *See Hospital Group Purchasing: Has the Market Become More Open to Competition?: Hearing Before the S. Comm. on the Judiciary*, 107th Cong. 3—4 (2003) (statement of Lynn James Everard).

<sup>14</sup> *See, e.g., Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovation?: Hearing Before the S. Comm. on the Judiciary*, 107th Cong. (2002) (statement of Joe E. Kiani, President and CEO, Masimo Corp.).

<sup>15</sup> *Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovation?*, *supra* note 14; *Hospital Group Purchasing: Has the Market Become More Open to Competition?*, *supra* note 13; *Hospital Group Purchasing: How To Maintain Innovation and Cost Savings: Hearing Before the S. Comm. on the Judiciary*, 108th Cong. (2004); *Hospital Group Purchasing: Are the Industry's Reforms Sufficient To Ensure Competition?: Hearing Before the S. Comm. on the Judiciary*, 109th Cong. (2006).

<sup>16</sup> Fed. Trade Comm'n, Health Care and Competition Law and Policy Public Comments (2003), *available at* <http://www.ftc.gov/os/comments/healthcarecomments2/index.shtm>.

<sup>17</sup> *See* Masimo Corp. v. Tyco Healthcare Group, LP, Case No. 02-CV-4770 (C.D. Cal. 2002). *See also* Genico, Inc. v. Ethicon, Inc., No. 04-CV-00229 (E.D. Texas 2004); Rochester Medical Corp. v. C.R. Bard Inc., Case No. 5:04-CV-060 (E.D. Tex. 2004); Applied Med. Res. Corp. v. Johnson & Johnson, Inc., No. 03-CV-1329 (C.D. Cal. 2003); ConMed Corp. v. Johnson & Johnson, Inc., No. 03-CV-8800 (S.D.N.Y. 2003); Medtronic AVE Inc. v. Cordis Corp., Case No. 03-CV-212 (E.D. Tex. 2003); Retractable Techs., Inc. v. Becton Dickinson & Co., Case No. 5:01CV00036 (E.D. Tex. 2001); Kinetic Concepts, Inc. v. Hillenbrand Industries, Inc., Case No. 5:95CV00755 (W.D. Tex. 1995).

<sup>18</sup> *See* Forsyth v. Humana, Inc., 114 F.3d 1467, 1477-79 (9th Cir. 1997) (rejecting a claim that an insurance company's alleged kickback scheme caused antitrust injury to group health insurance customers where the evidence showed the scheme caused higher co-payments and premium payments, but did "not explain how the scheme reduced competition in the relevant market"), *aff'd on other grounds*, 525 U.S. 299 (1999).

<sup>19</sup> Girion, Lisa, *Health Plan Faces Fines of \$1.33 Billion*. Los Angeles Times. January 29, 2008