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Kaiser Foundation Health Plan
Government Relations

April 30, 2015

Federal Trade Commission
Office of the Secretary, Room CC-5610 (Annex X)
600 Pennsylvania Avenue, N.W.
Washington, DC 20580

RE: Health Care Workshop, Project No. P131207

Ladies and Gentlemen:

The Kaiser Permanente Medical Care Program (Kaiser Permanente) would like to thank the Federal Trade Commission (FTC) for hosting its second workshop on Examining Health Care Competition and for this opportunity to provide written public comments on the issues covered in the workshop. Kaiser Permanente is the largest private integrated delivery system in the United States, providing health care coverage and directly providing or arranging health care services to over 10 million members in eight states and the District of Columbia. In each operating region, Kaiser Permanente is conducted by three separate but closely cooperating entities: Kaiser Foundation Health Plan, Inc. or one of its subsidiaries (KFHP), a not-for-profit public benefit corporation that is the nation's largest not-for-profit health plan; Kaiser Foundation Hospitals (KFH), a not-for-profit public benefit corporation which owns and operates 38 hospitals and over 600 other clinical facilities and which also contracts with community hospitals and other clinical facilities; and a Permanente Medical Group (PMG), an independent multi-disciplinary group of physicians organized as either a professional corporation or a professional partnership that contracts exclusively with KFHP to provide or arrange medical services to KFHP members.

Kaiser Permanente has long supported the goal of universal health coverage and adoption of rules to increase the affordability of coverage by designing a market where health plans may compete on the bases of quality and service. The implementation of the Patient Protection and Affordable Care Act (ACA) has made a significant contribution towards meeting those goals. The cost of health care, however, remains a serious issue and has the potential to limit access to necessary care. Our comments in this letter will focus on several competitive or proposed regulatory activities that have had or may have a significant impact on our costs without increasing quality or service.

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Community Hospital Consolidations

We appreciate the fact that the FTC is already aware that hospital mergers and consolidations may significantly increase the prices that private health insurance plans and purchasers must pay to community hospitals (see, e.g., "FTC Wary of Mergers by Hospitals," New York Times September 18, 2014). In addition, we recognize that there is a growing body of evidence that hospital consolidations can increase price and hurt competition and consumer choice (see, e.g., AHIPcoverage.com/hospital-consolidation-and-costs). Our comments here are intended primarily to support the FTC's continued scrutiny of proposed hospital consolidations and to offer our assistance in any such efforts.

Because of the number of hospitals that we own and operate in our two largest operating Regions in California, our experience with hospital consolidations is unique. One change in the hospital contracting market in California that we have experienced is the closing or sale of specialized units of a hospital, such as chemical dependency units, psychiatric service units, or dialysis units. For the most part, we have been able to contract with the new owners of these specialized units in the community, but as the number of these facilities decrease, and as their ownership grows more concentrated and develops new relationships with payors and health care providers, we may find that contracting could become more difficult, and so we urge diligent review of this type of consolidation.

Both California Regions contract with a number of community hospitals to provide a wide variety of services to KFHP Members. Our Southern California Region (Greater LA Area, Orange County, and Inland Empire) has even gone one step further to designate a number of community hospitals as "plan" hospitals for KFHP Members in certain geographic areas where KFH does not own and operate its own hospitals. We have found that this approach can help to stabilize the health care delivery system in an area and can help to keep care affordable. This approach, however, is dependent on the existence of a competitive marketplace and again we commend the FTC for its work to preserve such competition, and we offer our willingness to give comments or any other help to the FTC as it carries out this important public service.

Drug Company Mergers and Acquisitions

There is substantial and growing evidence about the role that specialty drug prices are having on overall drug spending and health care insurance rates (see, e.g., Specialty Drugs: Issues and Challenges, AHIP Issue Brief, February, 2014). Kaiser Permanente is deeply concerned about the severity of this issue, and we have already spoken widely on this topic, noting, for example, that the cost of one specialty drug type alone, the all-oral Hepatitis C drug therapy, could ultimately cost Kaiser Permanente a total of more than $6 billion, more than twice our total annual budget of over $3 billion for all other outpatient prescription drugs. We believe that the size of specialty drug cost increases may necessitate a complete reconsideration of the traditional insurance model of drug purchasing and exploration of alternatives such as population-based

access programs, joint public/private purchasing arrangements, and new federal or state price and licensure regulations, and we will continue to address this issue internally within Kaiser Permanente and externally with all relevant stake-holders and concerned parties.

In this set of comments, however, we would like to reinforce a lesser, but still significant, factor in rising drug prices and that is the impact of drug company mergers and acquisitions on the prices of generic drugs. Again, we recognize and appreciate that the FTC is acutely aware of this issue, as noted in the Commission's analysis of the agreement containing consent orders *In the Matter of Actavis plc and Forest Laboratories, Inc.,* where it stated:

> In generic pharmaceutical product markets, price generally decreases as the number of generic competitors increases. Accordingly, the reduction in the number of suppliers within each relevant market would likely have a direct and substantial competitive effect on pricing.

In spite of FTC scrutiny, we have seen some astounding price increases after generic drug companies have merged or been acquired or drug company rights have exchanged hands. Some of these increases we have experienced include the following:

Drug	**Percentage Increase in Price**	**Following Listed Acquisition or Merger or Transfer of Rights**
Allopurinol tabs 100 mg. (used to treat gout or kidney stones)	656.6%	Endo Pharmacueticals' acquisition of Qualitest Pharmacueticals in 2010
Amitriptyline 10 mg tab (used to treat pain and a number of other conditions)	1034.9%	Endo Pharmacueticals' acquisition of Qualitest Pharmacueticals in 2010
Sulfacetamide sodium ophthalmic solution 10% (used to treat bacterial infections of the eyes)	369.8%	Valeant Pharmacueticals' acquisition of Bausch and Lomb in 2013
Erythromycin gel 2% (antibiotic)	292.1%	Savage merged with Sandoz in 2012
Eyrthromycin tab 250 mg. (antibiotic)	1052.4%	Arbor Pharmacueticals became sole supplier of erythromycin oral products after acquisition of rights from Abbott Laboratories in 2011
Lanoxin tabs 0.25 mg. (used to treat heart failure and atrial fibrillation)	607.5%	Clovis Pharma purchased rights for Lanoxin from GlaxoSmithKline in 2011

Other price increases and the general issue of soaring prices for generic drugs has also been noted recently in the Go60 newsletter dated February 2015 in an article entitled "Generic Drug Prices Soaring Sky High and No One is Sure Why – Or What to Do About It."

The prescribing of generic drugs has long been recognized as a way to help lower overall drug costs without affecting the quality or efficacy of drug treatments. It is therefore crucial that the

FTC continue its oversight over generic drug manufacturers to ensure that a competitive market is maintained in this area.

Federal Regulatory Proposals Regarding Network Adequacy

Although outside the FTC's traditional area of regulation, we want to state our concern with proposals by The Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS) regarding the regulation of network adequacy for qualified health plans. We are urging HHS to not develop health plan standards for network adequacy that concentrate on inflexible time and distance measures. We have found that the time and distance standards already adopted for Medicare support a fee-for-service model of health care delivery that discourages competition, innovation, and quality improvement efforts.

Independent quality review organizations consistently find that coordinated, integrated, provider-driven health plans provide significantly higher quality care to enrollees than plans relying on broad, fragmented networks of independent providers. Integrated care delivery systems such as Kaiser Permanente organize and deliver care through high-performing multispecialty medical groups and a tightly connected system of full-service medical centers and hospitals that are enabled by advanced medical technology and a robust electronic health record ("EHR") system. Together, these elements enable effective, efficient delivery of care that produces high quality outcomes and achieves high levels of patient satisfaction.

Measurement of provider accessibility must evolve to keep pace with and support the shift away from fragmented, fee-for-service-based models of care delivery toward more coordinated, integrated, quality-focused models, in line with basic goals of the ACA. If time and distance-based network rules are adopted, health plans would be required to contract with providers whose locations are distributed across their service area. Often this would mean that plans are required to include providers that cannot or will not fully participate in an integrated system of care delivery by sharing patient information through an integrated EHR system and providing team-based care, both of which have been shown to improve outcomes. Plans may also have to contract with providers on a fee-for-service basis, which incentivizes higher utilization of health care services and inhibits plans' ability to improve quality and control costs. This type of contracting also impedes the convenience and efficiency afforded by integrated systems of care, where providers and facilities are often concentrated so that members can see multiple providers, fill prescriptions and receive ancillary services in a single visit, as opposed to making several visits to multiple locations.

Furthermore, the practice of medicine today extends beyond bricks-and-mortar locations to include remote access to care from a patient's home, use of a clinical advice line, real-time telemedicine visits, and secure email to a doctor. Last year, for example, Kaiser Permanente physicians conducted 20 million e-visits – consulting with their patients by secure e-mail, which amounted to 13% of all of our appointments for 2014. Care is thus increasingly being provided

outside of physician offices and hospitals, thereby diminishing the validity of providers' physical locations as a meaningfully relevant metric of accessibility.

Rather than developing a set of federal network adequacy rules, we believe HHS should rely on the reviews already performed by state regulators and national accrediting organizations that have expertise in evaluating how well a plan's network is serving its members, taking local and regional factors into consideration. If, however, HHS does proceed to develop more specific network adequacy standards for plans for future years, we are urging HHS to develop standards appropriate for the shifting health care landscape toward more coordinated, integrated care delivery.

In short, we are concerned that proposed HHS rules on network adequacy based on time and distance requirements could have a significant and detrimental effect on the movement towards coordinated, integrated quality-focused health care delivery models. Because this is such a fundamental goal of the ACA we are bringing this issue to the attention of the FTC Workshop in the hope that all federal departments may work together to advance the goals of the ACA.

Summary

In conclusion, we acknowledge that there are many factors that are driving up health care costs faster than the general rate of inflation. With access to coverage guaranteed under the ACA, we are concerned that cost may become the greatest barrier to health care. We applaud the FTC's work to promote competition in health care, and we certainly can confirm that this is one way to help constrain costs. We appreciate the FTC for hosting this review of competition in health care and for the opportunity to submit comments to the workshop. If you would like to discuss any of these comments, please contact either me at Anthony.barrueta@kp.org or 510-271-6835, or Patricia Lynch, V.P. Government Relations, at patricia.m.lynch@kp.org or 510-271-2652.

Very truly yours,

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