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Perspectives from the Federal Antitrust Enforcement Agencies

Jeffrey W. Brennan
Ashley M. Fischer
David Marx, Jr.
Stephen Wu
Carrie G. Amezcua
James Buchanan Camden
Douglas Litvack
Michelle S. Lowery

The Antitrust in Health Care conference took place May 13 to 14, 2014, in Arlington, Virginia, where a number of the speakers were representatives of the Federal Trade Commission (FTC) or the Antitrust Division of the U.S. Department of Justice (DOJ). Collectively, the government speakers covered a wide range of "hot topics" relevant to the health care/antitrust field, but they all expressed one common theme: that the Affordable Care Act (ACA) and the antitrust laws are fully aligned in promoting lower costs, increased access and higher quality in health care through the principles of market competition. The conference was sponsored by the American Health Lawyers Association and the Antitrust Law and Health Law Sections of the American Bar Association.

FTC/DOJ Representatives Affirm ACA/Antitrust Alignment

FTC Chairwoman Edith Ramirez delivered the keynote speech. In it, she emphasized that antitrust enforcement and competition policy in health care continues to be a Commission "top priority." The FTC recognizes that health care markets are evolving, she said, but the agency also understands that restraints on competition in markets can result in higher prices and lower quality. The chairwoman acknowledged the ACA's laudable aims of promoting better quality and lower costs through efficiently integrated delivery, and said the FTC wants to ensure that efforts to provide coordinated care do not lead to anticompetitive effects that undermine the ACA's purpose by creating market power. She emphasized that the goals of health care reform can be achieved in ways that do not raise antitrust concerns. Citing the recent district court decision in the FTC's (and others') challenge to St. Luke's Health System's acquisition of Saltzer Medical Group in Idaho—which found that a merger was not necessary to achieve the intended objective of improving the delivery of health care and patient outcomes—Chairwoman Ramirez said that full consolidation is not always essential to achieving procompetitive benefits of higher quality and reduced cost. She urged market participants to consider other collaborative arrangements short of consolidation that could achieve the same benefits but not create market power.

Striking a similar theme, Markus Meier, assistant director, FTC Bureau of Competition, Health Care Division, said FTC staff rejects the argument he sometimes hears from parties that the ACA requires providers to join together in anticompetitive arrangements. He said that core ACA principles—lower costs, higher quality and increased access—also are core antitrust law principles. He added that health care, in many respects a highly regulated sector, requires no special "antitrust rules." The antitrust laws already provide the flexibility to account for those activities that are subject to regulation and those that are subject to competition, he said, and noted that antitrust is not a barrier to appropriate collaboration or formation of Accountable Care Organizations (ACOs). Meier rejected the idea that the FTC should provide more written guidance, asserting that the

antitrust agencies have issued more guidance in health care than in any other industry. Still, he added, parties are always welcome to talk to the staff about issues, and the staff will be as transparent and helpful as they can be. The agencies resist requests by industry members for instructions on how to organize, because industry members—not the government—are best suited to find arrangements that promote health care quality and cost-reduction. The agencies step in only when arrangements create market power.

Jeff Perry, assistant director, FTC Bureau of Competition, Mergers IV Division, discussed his views on health care market participant joint ventures. He found it notable that no applications have been filed for voluntary review of ACOs, even though providers and payers are forming ACOs all over the United States. He suggested that this indicates that antitrust laws are not a deterrent to ACO formation or achievement of the goals and requirements of the ACA. He stressed that, in his view, the central issue in determining whether the FTC or DOJ would view providers as sufficiently integrated in an ACO—and therefore best positioned to achieve quality and cost improvements—is whether the ACO induces changes in how providers deliver patient care.

Remarks from an FTC economist, Chris Garmon, on the role of economics in transaction analysis also reflected recognition for the health care sector's evolving state under the ACA. He observed that exchanges may cause a shift in how the government analyzes health insurance markets, and that larger employers are now able to choose networks. Many larger employers are now shopping for networks and can use their employee base to steer patients and change the payer-provider relationships. Garmon explained that the FTC's economic models do not necessarily build in data to account for individual insurance products purchased through the insurance exchanges or the negotiating abilities of large employers. FTC staff does, however, interview large employers and gather other forms of evidence, in addition to economic modeling, to support its decisions in merger cases. Ultimately, if the community favors the transaction, then the fact that the economic model may show large market shares will not be the deciding factor.

Peter Mucchetti, chief of DOJ's Litigation I Section (which handles health care investigations), presented a similar policy view. Mucchetti said that when DOJ reviews mergers between health insurance companies, it wants to ensure that the merger does not harm patient access to a network of desired providers. He agreed that the new health insurance exchanges may alter competitive effects analysis in mergers and conduct cases, and that the market may start to see narrower or tiered networks following the entry of exchanges. Staying with the same theme, Mucchetti did not suggest that the exchanges would change the method of competition analysis.

FTC Staff Perspectives on Programs of Clinical Integration and Accountable Care

Christine White, FTC staff attorney, discussed her views on elements of clinical integration programs (CIPs) and ACOs.

WHAT IS ENOUGH CLINICAL INTEGRATION?

Two questions predominate regarding CIP antitrust compliance: "What is clinical integration?" and "How much clinical integration is enough" to enable CIP providers to negotiate rates collectively with payers without violating the antitrust rule of *per se* illegality for price-fixing? White said there is no single solution to achieving clinical integration, stating, "if you have seen one CIP, you have seen only one CIP." There are many variations among CIPs, including their approach to risk sharing, financial incentives and evidence-based practices.

White and two other panelists provided high-level guidance on the factors providers should consider when determining if they are clinically integrated. Primarily, providers considering a CIP should be able to identify how patients and the practice will benefit from the integration. If providers' only or primary reason for forming a CIP is to negotiate collectively, then they should reconsider going forward with the network, because the agencies are likely to view joint negotiations without substantial financial or clinical integration as *per se* illegal. On the other hand, if the providers share financial incentives related to performance; develop best practices that are uniformly implemented throughout the CIP; and work towards identified, objective benchmarks to achieve higher quality of care and efficiencies, then the CIP's collective negotiations with payers are likely to be evaluated under the rule of reason.

White suggested, however, that the question of "How much integration is enough to be able to jointly negotiate?" is not the right question to ask when forming a CIP. Meeting any minimum antitrust requirements to support joint contracting should be secondary to improving quality of care and generating efficiencies. White and the panelists stressed that joint negotiations must be ancillary—not primary—to achieving the CIP's benefits for payers and patients.

The panel advised that a better question might be "*When* can the CIP start negotiating jointly with payers?" Although there is no bright line, the guidance is that providers in the CIP must be practicing interdependently to such a degree that the organization is achieving (or at least significantly progressing towards) the performance standards it has established.

PAYER RESPONSE

According to White and her panel, payer response is a key to the CIP's likelihood of success. Whether and to what extent commercial payers are interested in the product that the CIP plans to develop is relevant to how the FTC will analyze the CIP's competitive effects. The CIP must sell a network or services that payers want to buy. If the CIP is not yet sufficiently integrated to provide services at a quality level that attracts payers, then forcing payers to negotiate may cause the government to view the conduct as *per se* illegal joint price-setting. On the other hand, if the CIP's benefits are cognizable to payers and make them willing to pay for higher quality or expanded services, then the CIP operation's procompetitive benefits are likely to outweigh any anticompetitive effects that might result from the providers' collective negotiations.

EXCLUSIVITY

For a CIP or ACO to be viewed as non-exclusive, payers must have the ability to contract with individual providers if they choose not to contract with the network. This does not preclude a network from requiring its participating providers to be bound by a network contract once the network has entered into a payer contract. Not all networks must be non-exclusive. Networks with small market shares can achieve efficiencies through exclusivity and do not pose the same potential for competitive harm as networks with higher market shares. CIPs with higher market shares have less flexibility, and the agencies likely will expect non-exclusivity.

OPT-OUTS

A corresponding issue to exclusivity is the ability of individual providers to opt out of joint contracts. A provision allowing participating providers to opt out of individual contract opportunities may undermine the network's ability to argue that joint contracting is ancillary to—that is, reasonably necessary to achieve the legitimate purposes of—the collaboration. The rationale is that it is difficult for a network to argue that it must collectively negotiate to motivate its providers to participate in the CIP, if its providers are allowed to pick and choose which contracts they will participate in through the network.

FINANCIAL INCENTIVES

Developing financial incentives for physicians to join the CIP and work towards improving quality and outcomes by developing and adhering to evidence-based practices is one way to demonstrate that a CIP is integrated. Generally speaking, financial incentives that relate to the CIP's overall performance indicate that the CIP is more likely to be sufficiently integrated than incentives based on the individual performance of the providers in the CIP. White and the other panelists recognized, however, that basing financial incentives solely on shared performance would not be enough to incentivize all physicians. Thus, a CIP design that combines shared performance and individual performance-based incentives may still be viewed as sufficiently integrated to justify a single-signature contract on behalf of participating providers.

PARTICIPANTS

The composition of a network is another issue to consider. The FTC advisory opinions addressing proposed programs of clinical integration primarily pertain to contracting networks composed of competing physicians, not networks through which competing hospitals propose to clinically integrate to collectively negotiate. White cautioned that the formation of a CIP among providers with facilities may be a slippery slope, because the providers may be tempted to allocate services among themselves, which, in the absence of a full merger or a joint venture, could run afoul of antitrust laws as a *per se* unlawful market allocation agreement. Whether and to what extent hospitals or other facility-based providers would be viewed to be clinically integrated will depend on the hospitals' ability to articulate what they are going to do together that they could not do individually. For example, hospital systems can

generally take steps to reduce their costs independently. Thus, cost reduction is not a sufficient reason on its own to form a CIP.

FTC GUIDANCE

White suggested, as other enforcers at the conference also did, that the agencies have issued considerable guidance on CIPs, including Informal Advisory Opinion Letters, Business Review Letters and policy guidelines. She stressed that reviewing this material would be helpful for any providers thinking about forming a CIP. She also suggested that the agencies are willing to provide informal guidance by talking with providers about their plans to form a CIP. While the agencies would not be able to give legal advice, they could ask questions and identify issues for the providers to consider. In addition, informal guidance is much quicker, less intrusive and less expensive than requesting a formal Advisory Letter, which could take upwards of 18 months to obtain.

FTC Special Counsel Offers Merger Litigation Insights

Thomas Greene, special litigation counsel at the FTC and counsel for the FTC in *St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, shared lessons from recent merger cases and responded to criticism surrounding the FTC's arguments in merger litigation.

NON-REPORTABLE MERGERS

Greene reminded providers that just because a transaction is not reportable under the Hart-Scott-Rodino Act, providers should not infer that the transaction will not be challenged. Greene cited recent litigation surrounding non-reportable mergers and noted that below-threshold transactions can still be competitively significant, particularly in the health care field.

PRESUMPTION OF ILLEGALITY

Some conference panelists objected to the "presumption of illegality" afforded to the FTC under the *Philadelphia Nat'l Bank* case if a merger results in an increase in market concentration above the thresholds identified in the Horizontal Merger Guidelines issued by the FTC and DOJ in 2010. Greene defended the presumption by citing recent merger cases in which the increase in market concentration as a result of the mergers exceeded the Horizontal Merger Guidelines thresholds by substantial margins. In those situations, Greene argued, the FTC is entitled to the presumption of illegality.

EFFICIENCIES

Greene also responded to criticism from the panelists about the difficulty merging parties have establishing an "efficiencies" defense. He reiterated that claimed efficiencies are a *defense* to the FTC's *prima facie* case that a merger will harm competition. In other words, it is not the FTC's burden to discredit the efficiencies; defendants must prove that their claimed efficiencies will be substantial and merger-specific, such that they offset the anticompetitive effects of the merger.

DIVESTITURE

Providers have recently argued that if a court finds that a merger violates the antitrust laws, an "*Evanston*-style" remedy of separate negotiating teams with payers is a more appropriate remedy than divestiture. Greene reiterated that recent merger decisions have rejected that remedy and instead ordered divestiture.

FTC and DOJ Lawyers Offer Advice Regarding Meeting with FTC/DOJ Staff

Markus Meier (FTC) and Peter Mucchetti (DOJ) also discussed best practices when meeting with agency staff regarding potentially problematic transactions. Meier encouraged lawyers and their clients to be "cooperative, credible and prepared." Following that advice, he said, will help make the investigation run smoother and possibly faster. He advised counsel to bring only "reasonable" arguments to their meetings with staff, or risk damaging their (and their client's) reputation. He also reminded counsel that if they request a meeting with FTC staff, staff will expect counsel to be prepared for an interactive, two-way conversation—do not, he said, expect staff to carry the entire discussion by providing details into their investigation. Parties should not expect the FTC staff to outline their arguments and issues if the parties themselves are not prepared to engage in a back-and-forth discussion on the issues.

Mucchetti agreed with Meier. He also encouraged payers and their counsel to consider DOJ staff as a fact-gathering resource, particularly when the antitrust laws might prohibit the payer itself from independently gathering the information

necessary to support its arguments. For example, a payer meeting with DOJ staff to discuss potential antitrust issues regarding a merger may have heard rumors about a potential new market entrant that might affect DOJ's analysis of the merger's competitive effects. In that event, the payer should ask DOJ staff to reach out to the potential entrant to confirm its plans. Mucchetti noted that DOJ staff can and do refine (and sometimes change) their theories of anticompetitive harm as the investigation proceeds. Mucchetti stated that counsel should not be surprised if the DOJ decides to change its direction mid-investigation, and should not "hold it against" the DOJ in later discussions.

Takeaways

The FTC and DOJ clearly do not hold the view that the ACA provides a green light for anticompetitive consolidation and conduct among health care market participants. Providers and payers alike should continue to analyze every acquisition, collaborative arrangement, contract or unilateral action under the traditional framework of antitrust law. The ACA provides goals for participants to work collectively to achieve pro-competitive benefits, such as higher quality and lower costs. The antitrust laws provide the flexibility for providers and payers to enter into mergers and various collaborations—such as ACOs, CINs, other joint ventures and contractual arrangements—to try to meet the ACA goals while avoiding a position of market power. The FTC and DOJ are willing to discuss formally or informally any plans participants might have to do so.

Nonetheless, the FTC and DOJ will continue to scrutinize carefully a transaction's potential anticompetitive effects, and to weigh those effects against any suggested procompetitive benefits, regardless of the transaction's form or the identity or number of its participants. Providers and payers should be prepared to articulate their motivations for the transaction or integration, and to identify specific, cognizable (not theoretical) benefits that the transaction or integration will generate that could not be achieved by the participants on their own. Moreover, the agencies' recent litigation successes have only enhanced their willingness to challenge transactions and conduct in court. They do so with the aim of protecting health care consumers from market power caused by a reduction in competition due to a merger, joint venture or unilateral action by a health care provider to exclude competitors.

Jeffrey W. Brennan, a partner in our Washington, D.C., office, co-chaired this conference. David Marx Jr., a partner in our Chicago office, participated as a panelist.

AUTHORS

For more information, please contact your regular McDermott lawyer, or:

Jeffrey W. Brennan
+1 202 756 8127
jbrennan@mwe.com

Ashley M. Fischer
+1 312 984 7766
amfischer@mwe.com

David Marx, Jr.
+1 312 984 7668
dmarx@mwe.com

Stephen Wu
+1 312 984 2180
swu@mwe.com

Carrie G. Amezcua
+1 202 756 8309
camezcua@mwe.com

James Buchanan Camden
+1 202 756 8255
jcamden@mwe.com

Douglas Litvack
+1 202 756 8378
dlitvack@mwe.com

Michelle S. Lowery
+1 312 984 2139
mslowery@mwe.com

For more information about McDermott Will & Emery visit www.mwe.com

Office Locations

BOSTON
28 State Street
Boston, MA 02109
USA
Tel: +1 617 535 4000
Fax: +1 617 535 3800

BRUSSELS
Avenue des Nerviens 9-31
1040 Brussels
Belgium
Tel: +32 2 230 50 59
Fax: +32 2 230 57 13

CHICAGO
227 West Monroe Street
Chicago, IL 60606
USA
Tel: +1 312 372 2000
Fax: +1 312 984 7700

DÜSSELDORF
Stadttor 1
40219 Düsseldorf
Germany
Tel: +49 211 30211 0
Fax: +49 211 30211 555

FRANKFURT
Feldbergstraße 35
60323 Frankfurt a. M.
Germany
Tel: +49 69 951145 0
Fax: + 49 69 271599 633

HOUSTON
1000 Louisiana Street, Suite 3900
Houston, TX 77002
USA
Tel: +1 713 653 1700
Fax: +1 713 739 7592

LONDON
Heron Tower
110 Bishopsgate
London EC2N 4AY
United Kingdom
Tel: +44 20 7577 6900
Fax: +44 20 7577 6950

LOS ANGELES
2049 Century Park East, 38th Floor
Los Angeles, CA 90067
USA
Tel: +1 310 277 4110
Fax: +1 310 277 4730

MIAMI
333 Avenue of the Americas, Suite 4500
Miami, FL 33131
USA
Tel: +1 305 358 3500
Fax: +1 305 347 6500

MILAN
Via dei Bossi, 4/6
20121 Milan
Italy
Tel: +39 02 78627300
Fax: +39 02 78627333

MUNICH
Nymphenburger Str. 3
80335 Munich
Germany
Tel: +49 89 12712 0
Fax: +49 89 12712 111

NEW YORK
340 Madison Avenue
New York, NY 10173
USA
Tel: +1 212 547 5400
Fax: +1 212 547 5444

ORANGE COUNTY
4 Park Plaza, Suite 1700
Irvine, CA 92614
USA
Tel: +1 949 851 0633
Fax: +1 949 851 9348

PARIS
23 rue de l'Université
75007 Paris
France
Tel: +33 1 81 69 15 00
Fax: +33 1 81 69 15 15

ROME
Via A. Ristori, 38
00197 Rome
Italy
Tel: +39 06 462024 1
Fax: +39 06 489062 85

SEOUL
18F West Tower
Mirae Asset Center1
26, Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
Tel: +82 2 6030 3600
Fax: +82 2 6322 9886

SHANGHAI
MWE China Law Offices
Strategic alliance with
McDermott Will & Emery
28th Floor Jin Mao Building
88 Century Boulevard
Shanghai Pudong New Area
P.R.China 200121
Tel: +86 21 6105 0500
Fax: +86 21 6105 0501

SILICON VALLEY
275 Middlefield Road, Suite 100
Menlo Park, CA 94025
USA
Tel: +1 650 815 7400
Fax: +1 650 815 7401

WASHINGTON, D.C.
The McDermott Building
500 North Capitol Street, N.W.
Washington, D.C. 20001
USA
Tel: +1 202 756 8000
Fax: +1 202 756 8087