

2013 MacEachern Symposium:
On a Collision Course? Health Care Integration and Antitrust

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“Why the Private Sector, Not the Government, Will Control the Future of Antitrust Analysis of Health Care Provider Integration”

Allen OK. Well, it’s my pleasure this morning to introduce Josh Soven. Josh is a partner in the Washington DC law firm of Gibson, Dunn & Crutcher, where he is a partner practicing antitrust law. Mr. Soven, from 2007 to 2012, was the Chief of the Litigation I Section of the Antitrust Division of the Department of Justice, meaning that at the Department of Justice he was responsible for all of the departments in antitrust enforcement involving hospitals, physicians and health insurance markets.

Prior to his service at the Justice Department, Mr. Soven was the Attorney Advisor to the Chairman of the Federal Trade Commission, Deborah Platt Majoras, where he advised the Chairman on antitrust matters involving hospitals, physicians and health insurers.

Josh earned his JD degree from the University of Virginia, and his BA from the University of Pennsylvania. And I can tell you that we who practice antitrust law in health care markets have viewed Josh as the brains at the Justice Department. And you should also know that Josh taught here at Kellogg. He taught health economics and antitrust at Kellogg. So, Josh... [Audience applause.]

Soven Thanks, Henry. Thanks very much everyone. It’s good to be here. What I’m going to do today is sort of straddle the two worlds I’m in, both the world I recently left – I worked, as Henry mentioned, in the government slightly less than forever, and recently left to join private practice. So I will bridge both worlds today, and then turn it over to David Marx, who has spent most of his recent time in private practice.

A couple of quick observations from that terrific last presentation, which I can't resist making. First, I never read *Time* magazine, and I did read that article and find it interesting. Second, regardless of what you think about antitrust, and whether you think it’s been a good thing or a bad thing, one of

my themes today will be the humility about antitrust, regardless of which side of the aisle you're on, is important. It is not a panacea or a silver bullet or the "out" from all of these other problems that people have been working on for years.

At the high water mark, as I'll talk about in a minute, it's about 100 people, economists and lawyers collectively, dealing with a \$2.7 trillion industry. There are far more resources on the private side of that line than there are in the government. And while the government agencies have truly demonstrated over the past 20 years that regardless of what you think about what they're doing, they can get better. They cannot begin to even tackle these problems on a small scale, much less solve them all. The role of antitrust is relevant, but it is one small piece of a much larger problem.

Second, as I always begin these talks – I did it in the government and I'll do it now – the finger pointing is pointless. It is easy to look for heroes and villains in all of this. It's not a useful exercise. It is \$2.7 trillion. These problems are huge. If there were easy solutions, they would have been solved a long time ago.

So with that, let me talk, get to my topic of the day, which is clinical integration. And it's a topic which sort of holds a special place for me because I arrived at the FTC in 2004, having done nothing but technology cases as an antitrust lawyer at the Justice Department. And those markets, for the most part, you know, notwithstanding a few big cases, are blazingly competitive. They are fierce; they are robust. No one is worried at the end of the day about the type of things that happen in the health care sector or the problems people face.

So when I got to the FTC, appropriately for this talk, one of the very first issues, which crossed my desk in the Chairman's Office, was a clinical integration issue. And knowing less than nothing about that, I went to some of the health care people and said, "Well, what's up with this clinical integration thing, and what are we going to do about that?" And I spoke to some very serious lawyers and economists who'd spent years working in the field, and they said, "Well, look, we don't really know." And they weren't joking. They said, "Look, it worked its way into the 1996 guidelines. It's there. It's an issue which people have given some thought about, but it's not as if we have figured it out." And ten years later, that's still the case.

So my theme today is that while understandably the private sector has been going to the Federal Trade Commission, and the Department of Justice to a slightly lesser extent, to say, "Look, we need more guidance." While I was there the AMA, the AHA, everybody would come and say, "Look, we need more as to what to do and how to do it." And I'm telling you, there's not much more to give. They can talk about their general construct, their general

framework, but, as I think most people know who work in this industry, the solutions, regardless of one's politics, will largely not come from government. They will come from the industry, from real people in real markets figuring that out.

And so with that by introduction, I'm going to sort of take you through the arc of antitrust enforcement in clinical integration, which both relates to physicians and hospitals, and then offer some solutions on the back end.

I think most people who survey the landscape would really think that the FTC, in particular, really has the wind at their backs. They are winning cases at an extremely high rate of frequency. They are aggressively bringing cases. They are pushing in all directions; they're even pushing in some new directions than they had before. And, at least in my work, providers, in particular, are understandably quite concerned: are we now sufficiently hamstrung that we can't do anything without worry of government investigation and potentially an enforcement action. And that concern is justified and understandable, but it was not always the case.

I'm going to start at a time when things were different and work my way through to the present. So the 1990s, nothing was going all that right from the government perspective in terms of antitrust enforcement in the health care sector. To that reference about clinical integration that I made a few minutes ago, that made its way into the 1996 guidelines – not based on government initiative, but based on the private sector. The government at that point was comfortable with capitation, which is just code for financial risk sharing, but they were extremely squeamish about this softer form of integration and coordination. And so no one in the government, as people tell it to me, had any interest in putting that in the 1996 guidelines at all.

That got in there because the private sector thought hard about the issue, was pretty assertive in pushing it, and said you need to think about this more holistically; you're not simply pricing nails or software or cars. Medicine, as we all know, is more complicated. There's a quality component to this. We don't always want the lowest price. What we want is the most cost-effective service, and outcomes matter. And so clinical integration is something we should think about, and that's how it got in.

On the hospital side of things, it's difficult to think of a longer losing streak than the government had in the hospital sector than what they had in the 1990s. This was an equal opportunity losing streak. Back in that day both the Justice Department and the Federal Trade Commission did hospital merger enforcement – today it's only the FTC – and they lost everywhere and they lost often.

There were a few reasons why that was, but part of it was that health care costs were not rising as quickly at that point in time as they have been in recent years, so it was a less persuasive argument to the courts that government, particularly from Washington, needed to travel 1,500 and 2,000 miles away and really dive into a local market about which they knew relatively little.

And as a result, you got cases which said, look, the government's theory is just wrong. They are drawing these tight circles, which they claim are the relevant geographic space for analyzing competition. Looks good on the models; has no basis in reality. People will travel farther, particularly for high-end services, than the government is alleging. Their own models aren't supporting the results they're claiming. And the geographic market issue was a particularly big stumbling block for government enforcement action in the health care sector where they drew the tight market. The court said you're wrong; it's a required element of an antitrust case to prove a relevant market. Do not pass GO. You lose before you even get to the effects analysis.

They also lost because there was a fair amount of sympathy, not unanimous – the 7th Circuit of Chicago disagreed – but in a number of cases the courts said, well, look, are these really software companies? Is this really Eric Schmidt going against Bill Gates in the technology markets, or do these people have a different mission, a different perspective, a different approach to margins and costs, and we should consider, just like the tax code considers, the non-profit status of hospitals when making our decisions, and we are skeptical that they will always profit maximize in the way we think other sectors of the economy perform?

So that was then. Now a lot of you no doubt have spent many years in the health care sector, and have thought in no doubt of times as I have, have gotten a little bit discouraged as to whether there's a way out, and thought can one person really make a difference, or even a small handful of people, can they make a difference? And I'm here to tell you they can. You may agree with the outcome of that, you may agree with the policy perspectives and actions of that person, you may disagree, but they can matter.

Because the reason that 1990s losing streak turned around is directly attributable to one guy and that's Tim Muris, who was the chairman of the FTC in the first term of the second Bush administration. He was a Republican, not a Democrat. And what he did is he said, I think the courts are wrong. They are not thinking about these markets correctly. In fact, the normal profit maximizing incentives that affect technology and cars and industry apply here as well, and I'm going to prove they're wrong.

So he did an extraordinary thing, which really has never been done again at a government agency, at a government antitrust agency, and he went out and

said, I'm going to look at hospital mergers that have occurred in the past – in many cases years in the past – and I'm going to send subpoenas out and get data and get documents, and I'm going to revisit what has been done and finished for years.

And the result of that effort, which very few people could have pulled off, Republican or Democrat, was – the epicenter was right here, was in Evanston, Illinois, where the FTC, three years after the closing, opened an investigation, brought a lawsuit to challenge the merger of Evanston and Highland Park. And then four years after that did the extraordinary thing of ruling that that deal was illegal. And in that opinion you can see the blueprint of what the FTC is doing, or the origins of what the FTC is really doing in courts today.

He aggressively used empirical methods, rightly or wrongly, to attack the way the courts had defined geographic markets. The thesis of that was they are tighter and smaller than what the courts are thinking. People are not willing to travel as far as people think. If you want to have a viable commercial health insurance plan, you will have local hospitals.

And so he went ahead and successfully challenged a deal, which on a scale of things was pretty small time. It was a pretty big hospital buying a pretty small community hospital. He established, as I said, effective econometric methods and just completely wacked at this idea that non-profits are, in fact, not interested in profits.

The result was a winning streak like no one has ever seen before, just that is parallel to the losing streak of the 1990s. This is five cases in a row in federal court, not in administrative court, where the commission has come out on top of hospital deals. And what it reflects, regardless of what you think about the merits of the outcome, is a substantially more sophisticated system of economic analyses in the investigations, and in the litigation of these cases, and the courts have taken notice.

How have they done it? They've done it by being selective, picking the low-hanging fruit, and choosing their battles very carefully. First of all, and probably most important, these cases are brought in places where it is relatively easy to define the geographic markets. They are less densely populated areas, which, regardless of where you draw the circle, the Commission had a pretty good argument that the markets were highly concentrated.

You don't see these cases in L.A. You don't see these cases brought against Sutter. You really don't see these cases even in federal court brought in Chicago. They're brought in relatively small places where the commission

could control the debate over the relevant geography. The markets were pretty concentrated.

A particularly critical factor: the state AGs were on board with all of these cases, which reflects the changing dynamic of health care costs. In the past, local officials often opposed government enforcement action in the hospital sector. Today they support them and that's no doubt had a powerful impact on the federal courts.

The winning streak in the hospital sector, parallel with that was a long run of successful price fixing cases against physicians. What these cases unambiguously showed, and they affect clinical integration while we'll get to in just a second, is that simply getting together to fix prices in order to increase revenues, those are a non-starter, and they probably should be a non-starter.

These were cases, which from the FTC's perspective, were really straight forward. There was nothing on the positive side of the ledger, and the effect was substantial. Most of these cases have now diminished, not because they're not doing them anymore, but because they've succeeded in deterring them, and so this conduct has stopped to a significant degree.

Then finally what rounded out the winning streak was a significant narrowing of the "state action" doctrine. And in English, what that means is providers cannot look to regulation by the state to be a shield against the antitrust laws. The Supreme Court on a unanimous basis has agreed with the Commission and scaled that back, so if hospitals, physicians, and ambulatory centers want the protection of regulation, they will have to be willing to submit to substantially more stringent requirements than have been done today.

So given all that, and given what I said about, at the beginning, that antitrust is not going to fix this, how is all this really going to work? Because notwithstanding the success, I do not believe that antitrust really has the ability to make these markets more efficient, to lower costs, to improve quality and the like. And that's for the very simple reason that antitrust lawyers and economists are not participants in this market. They work within a basic economic structure and framework. They are able to identify what are potentially the most significant abrogations and exercises of market power, but they have no idea, nor would they say they have any idea, how to make the system more efficient.

And so when people say, well, look, you're an antitrust lawyer, you must practice law, there is some truth to that but not all that much, because at the end of the day there is really very little law in antitrust. And so my syllogism is antitrust law equals antitrust, which is basically just a word for market

facts. And in the antitrust realm, he or she who knows the facts best almost always wins, and in this case providers and members of the industry know the facts exponentially better than the antitrust agencies do, and they simply just fail to utilize them today to really move the ball forward.

So as I said, I mean if you look at sort of the comparative resources on both sides of the line, the DOJ and the FTC literally, notwithstanding the sense that they seem omnipotent these days in terms of their success record, it's a hundred guys and gals who are doing this work in a huge market. They can't be everywhere. They're not trying to be everywhere. A lot of activity going on, which some people think is harmful, some people may think is benign, is occurring completely under the radar screen of the antitrust laws because they simply don't have the resources to catch up.

Those who hope for, rightly or wrongly, for antitrust really to discipline these markets, to lower prices, to improve quality, it's not going to happen. And so what providers need to do, both as a defense against future antitrust enforcement, but equally if not more significant, as a way to move the ball forward toward the policy objectives about which there's unanimity, they need to better utilize the knowledge they have, the skill they have, and the resources they have to work in ways that get at these problems. And as I'll talk about in a moment, antitrust is not a barrier to doing this.

But if you look at those cases I was talking about, none of those cases, from their perspective, are the ones that are really on the margin. Those were the simple stories where you had a combination where there seemed to be nothing on the "apple pie" side of the ledger, where they thought they could control the facts and get an outcome that they wanted. But most of the coordination and the collaboration and the joint work that goes on in the market really are immune from the antitrust laws as a practical matter. And what providers need to do is realize that and work with both themselves and with government to get to better outcomes, and they can do that.

So, clinical integration. A lot of people think, and a lot of people told me when I was in government, look, you're hamstringing the industry. We have no flexibility in those 27-page, single-spaced letters that the FTC puts out that read like a telephone book. I don't know how to work with that; that's too hard. Do I really have the freedom to go out and innovate?

And I'm telling you, you do. If you look at the slate, the slate is actually a lot blanker than people think, based on what the FTC's work has done. So those are some criteria that are set forth in the 1996 guidelines. On the one hand they say, maybe, yeah, you have to do all this stuff, but the way I read those, those are the most general terms imaginable that are out there, and that people [who] were working sincerely to lower costs can use those criteria to do pretty much what they want.

The only restriction, really the only one is the whole point of the activity can't be to raise revenue and do nothing else that lowers cost or improves quality. But if there is a plausible justification for lower prices, better costs, better outcomes, it will be extremely difficult as a practical matter for the Justice Department or the Federal Trade Commission to do anything about it, and that's the way it should be. And I think they'd even tell you in their heart of hearts that's what they believe. They will frequently say, look, we do not run hospitals. We don't know how to do it. They're actually trying to stay out of the way most of the time in getting this work done. And these criteria and the criteria they've set forth in their advisory opinions really give the industry potentially a great deal of flexibility to collaborate, to coordinate, and to move the ball forward.

And other parts of the government are fully lined up behind that. I spent a long time in government working for both parties. You know, they disagree about a lot, but what they all unanimously agree about is that, look, we've got to figure this out, and no one sitting at Connecticut and K Street really knows how to do that. They are looking out to the industry to come up with solutions, and people should not be timid about putting them forward. I do think it's understandable that when you live 2,000 miles away, the last thing you want to do is be seen to be pushing the envelope to Washington, which does have a lot of resources behind it, but I think you will find a receptive audience. So those letters that the commission keeps putting out, and which seem to have a lot of six-point type of requirements in order to have a successful clinical integration program, I think have largely been misread. Yes, they say you can't simply raise prices, but they do leave a great deal of flexibility for providers to do various things. And if you look at the track record again, you are not seeing challenges to programs that they may not think perfectly line up with their way of doing things. Just the opposite: you see zero, and I can tell you there are no investigations going on, at least when I was there, that were really trying to move the needle in terms of further eliminating the type of clinical integration that can happen.

You know, just to prove a point, one would think that if the FTC was being particularly cautious, it would be extremely dubious about any type of clinical integration in concentrated markets. Just the opposite has happened. I'm not aware of any clinical integration program that's been rejected based on the fact that it was in a rural or densely populated area. And if you look at some of the recent actions, particularly the TriState market, that one wasn't just at the 50 percent sort of mark, depending on how you sort of did the math, you were north of 60 and 70 percent, and the Commission said that's OK. Their bias was, let's see if we can figure this out. The only hitch, and I'm not sure it's much of a hitch, is they relied heavily on the fact that it was not exclusive.

So if instead of this sort of arrangement, you had an arrangement where perhaps all these people are going to merge, which I'll talk about in a second, that might have been a harder sell. But at least at the starting point of the analysis, the fact that markets are concentrated is in no way a barrier to clinical integration.

Accountable Care Organizations. are another area where providers have successfully pushed back, and I think are likely to successfully continue to do so in the future, notwithstanding that there are differences in views, obviously, on whether they're effective or not.

The original version of the ACO antitrust trust statement, which the agencies put out in draft, which I worked on, for a certain category of ACOs the trip to certain market share threshold had mandatory review, which would have potentially taken a lot of time. The provider community sensibly pushed back on that. Other parts of the government were very concerned that the Justice Department and the FTC would not intentionally, but inadvertently as a result of that approach act as a real stumbling block to the rapid formation of ACOs. So the mandatory part of the review was removed. It's now entirely discretionary. And what's happened, you know, at least up to the point that I left eight months ago, and I think it's still the case, is no one is submitting these things for review.

So the ACO program is by and large going forward without significant hands-on antitrust review. And on balance that's probably a good thing. I mean, if the program does not work, then obviously people will see those results and it may be revisited. But at the moment antitrust is in no sense an impediment whatsoever to the formation of ACOs.

All right, deal risk. So you can say, look, that's all well and good. I'm glad I could do my clinical integration program; I'm glad I can do my ACO. But what I really want to do is merge. And to pick up a point on the prior speaker, the consolidation is inevitable, regardless of whether you think it's a good thing or not, regardless of whether you think consolidation produces economies of scale, the risk driven by, on the reimbursement side, is going to continue to push significant mergers and acquisitions in the provider sector, both at the hospital level and the physician level. And the only question is really how it's going to come out?

So if you want to stop the FTC's winning streak, here's how I would think about doing it. To date the hospitals, and it's easy to say and hard to do, have not done a good job, at least from the FTC's perspective, in being proactive up front in saying how this is going to be better. To date there has never been a serious block of a deal with robust information showing that consumers would benefit from a transaction. But what also hasn't happened is there haven't been enough presentations by the provider sector as to how that's

going to work. And so I cannot emphasize enough that the way to get deals through is to be as proactive as possible to figure out and explain with contemporaneous business records how consumers will benefit, and then double that level of proactiveness and be ready to go both in front of the agencies and in the court, if the courts are needed.

Health plans are a part of this story. Hospitals and insurance companies are understandably at odds over things all the time. That's natural; that's inevitable. Health insurance plans can be a huge ally in facilitating pro-competitive hospital consolidation. And so it is essential – well, not essential – it is highly important to think about the payer landscape when planning deals and what's going to be their reaction to the deal, and to be proactive in a responsible way about reaching out to them *ex ante*. The FTC cannot bring cases without witnesses. It's hard, or it's certainly much harder to do if the payers oppose a deal; that's a significant advantage for the Commission if they don't; and think it's a good thing, it's a significant problem.

State AGs are critical to the FTC's litigation strategy. All five of those cases I mentioned were brought with state AG support. People need to think aggressively and innovatively about how to explain to local law enforcement officials, including the attorney general's office, that a deal is likely to be good.

The federal government, not surprisingly, regardless of one's politics, really doesn't have a unanimous position on what's going on in the health care sector and how to make things better, even within the same parties. So when I was working on the ACO regs, it was pretty clear to me that a number of people in CMS and HHS thought is this head-to-head brutal Silicon Valley competition really the way through, or, you know, as Don Berwick seemed to favor, in fact by defragmenting the market and producing less sort of dispersion of provider resources and creating more integration, will that move things along in a way that's more likely to be effective and animus to competition? I would continue to reach out to CMS and HHS because their views matter, particularly on deals that affect the Medicare Advantage market, and they can potentially be quite helpful.

So just one quick theme and then I'll stop. Antitrust has long since passed the world of "more is better" and that you need 10 competitors or 100 competitors. And particularly in the health care sector, if it works, it works. And so arguments or positions and structures which make consumers better off will be extremely effective for the antitrust agencies – will be extremely difficult for the antitrust agencies to challenge.

With that let me stop and take a few questions.

Man 2 One of the things you said at the very beginning of your presentation was about the very narrow market definition, which allowed for sort of a nice run of success, if you will, from the FTC perspective. Do you have a point of view – it appears that health care is actually becoming more of a national market phenomenon as you see employers contracting with centers of excellence: Wal-Mart, Lowe’s, etc. And you see larger health care systems across broader geographies. Do you think – is there, do you have a point of view about whether that trend is going to shift the perspective of the FTC in any meaningful way, or whether they’re starting to rethink the market definition?

Soven I think it could, but not without a significant struggle. The enforcement program is predicated on the narrow markets. There is some data that supports that. The payers will occasionally lend support to that. So it may well be an effective argument, but it needs to be more than just a top line narrative description. It needs to be backed up with data. Facts that show that employers are encouraging their employees to travel significant distances for cheaper procedures, particularly tertiary care procedures, those may well alter the landscape, but providers will need to be quite assertive and aggressive in gathering information needed to demonstrate that changing dynamic.

Man 3 Can you take a minute to comment about payer market power?

Soven Yeah, payer market power I view as a puzzle, and some of you have heard me say this before. There shouldn’t be a problem in the health insurance markets. There’s no IP that blocks entry into that market. There’s a lot of capital available to do this. Everybody wants this product. There’s five or six national companies that are extremely good are running health insurance companies. The primary challenge to the health insurance markets – and it’s an extremely hard problem to solve and it’s related to a number of factors – is the potential disparity, and at times the actual disparity, in cost structures of payers.

That hospitals, for very understandable reasons particularly given the much lower Medicaid and Medicare reimbursement rates, charge different prices to different payers, and that disparity in cost structure affects the ability of certain payers to compete in certain markets. So a real open question with regard to the exchanges is whether those exchanges will simply be reflections of some markets on the payer side, which are highly concentrated, or will government, you know, hard or soft pressure, if not make equivalent, reduce the gap in reimbursement rates in hospital charges to certain payers, and then you get a more level playing field. I think that the concentration problem or potential concentration problem in the insurance sector is a much easier thing to solve than the cost structure on the provider level.

- Man 4 Your first point about documenting community benefits has been part of the game for a long time. But as we all know, all the documentation of how much cost we have saved almost never pans out. Why doesn't the FTC require certain performance levels in terms of costs and community benefit as a condition of approval?
- Soven Yeah, that's a great question. Attorney Generals will be very sympathetic to that potentially. The Commission, notwithstanding the fact that they're often referred to as an antitrust regulator, they want to be as far away from anything sounding like regulation as possible. To go back to my earlier point, they correctly realize that they don't know how to run a hospital, and the last thing they want to be doing is monitoring the performance of a market, and whether certain benefits are delivered over a number of years. They feel much better, given their expertise and resources, in simply requiring a structural remedy or a structural outcome, and don't want to get into that. Other government agencies will be much more receptive to it, and I think it's an important tool in the tool kit going forward.
- Man 5 Totally open-ended question: any additional comments regarding IPAs and, you know, the level of integration, or the effect of activities it can be involved in, etc. that we ought to know about?
- Soven Again, I think by and large if you look at the advisory opinions and the policy statements, they've pretty much said what they're going to say. And all they're saying at the end of the day, notwithstanding the length, is if you're going to jointly price, there needs to be a plausible set of facts which suggests that that joint pricing is related to good outcomes for consumers. To go back to my "if it works, it works" framework, and while I know it would be easier if someone had the playbook to say this is really how you do it, where everything's going to be fine, the good and the bad – and I do think there's a lot of good to this – is it will be up to providers and hospitals and physicians to come up with these solutions. And if those solutions are plausible I think the likelihood of antitrust enforcement is low.
- Man 6 What I'm hearing you say is something to the effect of getting together in something like an IPA, aka Grand Junction, Colorado, to increase your revenues is not going to get hit as long as your quality and your cost to patients doesn't increase?
- Soven Correct, but there needs to be support for that second, for the latter half of the argument.
- Man 6 So Grand Junction has quality data coming out their ear lobes.
- Soven I don't recall the specific facts of it, but data which shows that consumers are better off, that should do it.

Thanks very much, and with sincere apologies I've got to run to the airport, but anyone should feel free to contact me, you know, completely on an informal basis and I'd be happy to chat further.