DEPARTMENT OF JUSTICE

The Importance of Vigorous Antitrust Enforcement in Health Care

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I. Introduction

Thank you very much for that kind introduction.

Today's event is a special one for me. These are my first public remarks as Deputy Assistant Attorney General of the Antitrust Division. I am immensely honored to serve in this role and work with the men and women of the Antitrust Division during this exciting time in antitrust enforcement.

I am delighted to be here, in person, to discuss some of the health care-related issues that are "top of mind" at the Antitrust Division.

During my career, I have been fortunate to have the opportunity to work on a wide-range of health care-related antitrust matters, at the FTC, in private practice, and now at the division. Those matters have run the gamut and involved providers, pharmaceutical companies, medical device makers, pharmacy benefit managers or PBMs, health insurers, and health technology companies.

Through that time, I have developed an appreciation for the way health care affects people's lives and the role it plays in our national economy. Health care plays such an important role in our well-being, it provides millions of jobs across the country, and it accounts for almost 20% of our economy. Of course, nothing has made us understand the critical role of health care companies and heroic workers more than the COVID-19 pandemic. Simply put, no industry is more important to our well-being and livelihoods.

That is precisely why we must aggressively enforce the antitrust laws in the health care industry. Vigorous competition in health care means lower costs for drugs and procedures, increased quality of care, additional lifesaving innovations, and more good-paying jobs. Protecting competition in health care is among the highest priorities of the Antitrust Division.

II. Understanding the Realities of Health Care Markets

Assistant Attorney General (AAG) Kanter has underscored that antitrust enforcers need to think carefully about the market realities applicable to particular matters and industries. Our economy has undergone changes we have not seen since the Industrial Revolution, and the health care industry is no exception. As the Supreme Court explained in *General Dynamics* and *Brown Shoe*, "Congress indicated that a merger had to be functionally viewed, in the context of its particular industry."[1] We must therefore understand the context of *today's* health care industry so that we can undertake competition analysis against present market realities.

To that end, the division and the FTC held a public comment period for the merger guidelines that sought input from a diverse set of stakeholders from across the nation. Additionally, we hosted a series of listening forums to hear from those who have experienced firsthand the effects of mergers on the frontlines.

[1] *General Dynamics* 415 U.S. 486, 498 (quoting *Brown Shoe* at 321-22).

One of those forums was focused on health care. The health care forum was held in April. It provided a platform for stakeholders with a variety of roles and experience to provide their views and have their voices heard.

Here, we heard directly from registered nurses, professors, physicians, pharmacists, and patients whose firsthand stories about the harm of consolidation came to life. They raised real and serious concerns. Specifically, they told us that consolidation has resulted in the reduction of research, staffing shortages, and decreased quality of care. The listening forum reminded us about how consolidation has the potential to impact Americans in everyday life across our country.

Working with our enforcement partners at the FTC to host these listening forums has been a great collaborative initiative between the agencies, and we look forward, where appropriate, to including what we have heard in these forums in our work ahead. More broadly, we look forward to continuing to share ideas, knowledge and best practices in the health care space with our friends at the Federal Trade Commission, who as folks know, also have vibrant health care enforcement initiatives and a fantastic bench of legal and economic practitioners.

Internalizing the stories in these listening sessions and reflecting on my experience in the industry, what struck me about the market realities in the health care industry today was the complexity of the commercial relationships that stand between a doctor and a patient. Few experiences are more private, personal or important, than a doctor or nurse in an examination room evaluating a patient.

Yet in the modern health care industry, a wide array of companies can influence that relationship. We are not alone with our doctor in that room. Hospital systems, insurers, PBMs, drug companies, data services providers, technology firms, and a host of other players are there too, influencing every aspect of the relationship. More and more often, a distant private equity owner of the practice group is there too. These players can influence, or in some cases even determine, the tests to be given, the drugs to be prescribed, the procedures to be offered, and the time spent trying to address a medical issue.

At their best, these companies can add value and help. They can equip the patient and doctor to make more informed decisions with lower financial burdens. But at their worst, they can extract value or try to thwart rivals — adding cost, delay, and burden, while reducing quality and impeding innovation which competition brings.

That is why competition enforcement is so very important in this industry, and why the Antitrust Division feels a unique duty to safeguard the competitive process in health care.

III. Civil Antitrust Enforcement in Health Care

With that backdrop, I wanted to highlight a few areas of focus in the health care antitrust enforcement effort. I will focus my remarks on certain aspects of civil enforcement at the division because that is my area of expertise, but I would be remiss if I did not note that my

colleague at the Antitrust Division, Richard Powers, leads a team of prosecutors who are laser-focused on pursuing antitrust crimes in the health care sector as well.

First, merger and acquisition enforcement will remain a top priority, as will Section 2 enforcement.

The division's Healthcare and Consumer Products Section (HCP), led by Eric Welsh, along with our first-rate team of economists in the Economic Analysis Group (EAG), are the leading group of health care antitrust practitioners in the world. In my previous job, I saw their work and talents from the other side of the table and today it is a pleasure to be working alongside them.

HCP and our economic team are empowered to vigorously scrutinize transactions and conduct that may violate the antitrust laws and, when they do, challenge them in court. Our lawyers and economists are battled-tested and have been very successful in recent health care merger litigation.

They remain busy on several matters, including of course the ongoing litigation to block UnitedHealth's proposed acquisition of Change, the leading independent supplier of technologies used by health care providers to submit health insurance claims, and by health insurers to evaluate and pay these claims. The division has several competitive concerns, including the loss of head-to-head competition, exploitation of competitively sensitive information, and reduced innovation. The case is in the midst of discovery and is currently scheduled to go to trial on August 1.

In addition to mergers, Section 2 enforcement is new a top priority. AAG Kanter has been clear about a desire to reinvigorate Section 2 enforcement when appropriate. For the reasons I mentioned above, unlawful unilateral conduct in the health care space can have a significant and personal impact on people and businesses and is another reason the division's world-class lawyers and economists are following the health care sector closely.

Second, as AAG Kanter recently remarked, we are thinking a lot about enhancing antitrust enforcement around a variety of issues surrounding private equity.

This is highly relevant to the health care sector.

Private equity has been increasingly active in acquisitions in recent years, with health care being a significant focus. According to Refinitiv data, last year private equity groups announced a record 14,730 deals globally worth $1.2 trillion… that is trillion with a T. This nearly doubles the previous high set in 2007. According to Pitchbook data, in 2020 the second leading sector for private equity investments was health care, equaling 18 percent of the all funding.

I want to be clear: Private equity can play an important role in our economy. But certain private equity transactions and conduct suggest an undue focus on short-term profits and aggressive cost-cutting. Thus, private equity firms can be fundamentally different than other

market participants. It is also for these reasons that the division often looks more favorably on a market participant as a buyer of assets than a private equity firm.

To the extent that private equity transactions and conduct are focused on short-term gains and aggressive cost-cutting in the health care space, they can lead to disastrous patient outcomes and, depending on the facts, may create competition concerns.

As I mentioned earlier, during the recent listening forum on health care jointly hosted by the FTC and DOJ, we heard from folks throughout the health care industry who described their firsthand experiences about the effect of consolidation and acquisitions by private equity groups. They described fewer caregivers, degradation of care, commoditization of health care services, and increased prices. This group of speakers from across the industry raised important topics that we are considering today. We are also aware of, and are analyzing, recent competition studies that have suggested the negative impact of certain private equity acquisitions and conduct in important health care products and services, including home health care, inpatient services, outpatient services, and pharmaceuticals.

Although not exhaustive, here are few specific areas of enforcement we are thinking more about:

- First, we are focused on potential antitrust enforcement on private equity "roll-ups," namely whether in particular circumstances a series of often smaller transactions can cumulatively or otherwise lead to a substantial lessening of competition or tendency to create a monopoly. Similarly, we will analyze whether private equity companies may violate the antitrust laws with investments creating or enhancing power across a "stack" of technology or other products/services.

- Second, we are focused on whether certain private equity investments may chill fierce competition on the merits. Specifically, whether certain private equity investments may either blunt the incentive of the target company to act as a maverick or a disruptor in health care markets or otherwise cause the target company to focus solely on short-term financial gains and not on advancing innovation or quality.

- Third, we are very focused on potential Section 8 enforcement. To the extent that private equity investments in competitors leads to board interlocks in violation of Section 8, the division is committed to taking aggressive action.

- Fourth, we have recently become aware of what appears to be some HSR filing deficiencies in the private equity space. This has us asking ourselves whether private equity companies may not be taking seriously enough their obligations under the HSR Act. We are evaluating our next steps on that front.

In sum, there is a lot going on in the division's thinking about the intersection between antitrust, health care, and private equity.

Third, data, entanglements, and labor issues will continue to be a big focus.

As you all know, data analysis and partnerships play a massive role in health care. Health care data and partnerships, depending on the specific facts and circumstances, can play a positive role in the health care industry.

However, as data creates, or gets held by those with, market or monopoly power, a host of potential antitrust considerations arise. First, concentrated data overall can create entry or expansion barriers for new, potentially disruptive entrants or expanders that could lead to lower costs or higher quality or more innovation. Second, firms with powerful data reservoirs may have the incentive and ability to engage in anticompetitive conduct around access to data, which in turn could entrench positions or obstruct rivals. Third, depending on the specific facts and circumstances, data can reveal competitively sensitive information about rivals leading to a host of potential issues. Finally, and similar to the entry barrier point, data acquisition and concentration can create situations implicating "feedback loops" that ultimately lead to enhanced market power or even market tipping.

More broadly than data-specific issues, we are also considering the nature of rivalry and entanglements in the health care space, whether that involves providers, pharmaceutical manufacturers, technology companies, insurers, or others.

Although some of these entanglements may not create antitrust issues, there also can be the real potential for such relationships to diminish bare-knuckled competition. When companies that otherwise should be aggressively competing with one another for products or services have a commercial relationship, it can chill competition. Put another way, if companies are concerned about how their independent competitive decisions may be viewed by partners and change their behavior because of those concerns, that can be a problem. For example, companies may be less likely to challenge a "Frenemy" with disruptive pricing or new product innovations or expansions. We are on the lookout for whether any entanglements between competitors create benefits or if they blunt fierce competition on the merits.

An extreme example of this in the provider context was the *Geisinger/Evangelical* case. This case also had a labor competition angle, which as I will discuss more later is another critical priority of the division.

In that case, the division sued to block Geisinger's partial acquisition of Evangelical. This was a Section 1 and 7 case, where the division alleged that the collaboration agreement between Geisinger and Evangelical would align two close competitors. The agreement created significant entanglements between the two companies, which provided Geisinger with opportunities to influence Evangelical.

Specifically, Geisinger received a 30 percent ownership interest in Evangelical -- in exchange Geisinger agreed to pay $100 million to Evangelical. In addition, Geisinger received rights over investment projects, intellectual property licensing, change of control, oversight of certain funds, access to certain information including competitively sensitive information, and board and consultation rights.

The arrangement would have fundamentally altered their relationship as competitors, curtailing their incentives to compete fiercely and independently. As the Evangelical CEO put it, the arrangement would allow the parties to engage in "coopetition."

In addition to these entanglements, the division alleged no poach activity as evidence of past coordination between Geisinger and Evangelical. We alleged that senior executives of the parties entered into a no-poach agreement not to recruit each other's employees.

The parties ultimately entered into a consent decree.

The division's steadfast approach to labor competition enforcement in the health care space also recently surfaced in another example. In February, the division filed a Statement of Interest in a case involving non-competes for anesthesiologists in Reno, Nevada. In that filing, we outlined in detail the division's current views on employee non-competes and the potential antitrust violations associated with them.[2] These types of issues will continue to be a major focus of the division in whatever way is appropriate based on the specific facts and circumstances.

Finally, any potential remedies in the health care sector and, frankly, all other industries are going to have an extremely high bar.

I will not spend a lot of time on this because AAG Kanter has been very clear about his views on remedies in some of his recent speeches.

In general, AAG Kanter is skeptical of remedies that create <u>any</u> potential risk for not fully addressing the likely competitive harm the division sees. Put another way, the division's view is that it should be incumbent upon companies to eliminate risks associated with remedies rather than have the division assume and monitor those risks.

Thus, it will be a steep hill to climb for structural remedies because of risks such as determining the appropriate scope of the assets, whether those assets can thrive in other hands, ongoing entanglements, and buyer capabilities. It will be an even tougher hill to climb for behavioral remedies like firewalls, etc., that carry yet more risk of effectiveness and impose an even greater monitoring burden on the division.

The desire for this "hard-line" on remedies is particularly evident in industries like health care. A failed remedy in the health care sector can lead to deeply personal harm in people's everyday lives and pocketbooks. The current division leadership simply is not going to agree to remedies that carry a real risk of that occurring.

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To wrap up, the division understands the critically important role that health care companies and workers play in our everyday life and economy. For this reason, the division plans to enhance an already aggressive enforcement agenda in health care. AAG Kanter, and the

[2] Statement of Interest of the United States at 6, *Beck. v. Pickert Medical Group*, CV21-02092 (Nev. 2d J. D. Feb. 25, 2022).

entire division Front Office, believes there is no greater enforcement priority than safeguarding competition in the health care sector.

Thank you for your time and attention.