Antitrust Compliance in Healthcare Consolidations: Addressing Tension Between Antitrust and ACA Requirements

Lessons From Recent Decisions on Market Definition and Efficiency Claims

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Antitrust Compliance in Healthcare Consolidations: Addressing Tension Between Antitrust and ACA Requirements

Strafford Live CLE Webinar
April 30, 2015

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Presentation overview

• Framework for assessing acquisitions, mergers and integrations (“collaborations”)
• Recent developments
  – 9th Circuit ruling in St. Luke’s
  – 6th Circuit ruling in ProMedica Health System
  – Mass. Superior Court rejection of Partners Healthcare’s planned acquisitions
  – Other developments: FTC/DOJ Healthcare Workshop
• Practical guidance for addressing antitrust in healthcare transactions
Framework for assessing collaborations
Key antitrust questions

1. Will the collaboration involve agreements regarding 
   competitively-sensitive issues?

2. Is there sufficient “efficiency-enhancing integration”
   to avoid per se analysis?

3. Are any restraints reasonably necessary
   ("ancillary") to the legitimate goals of the
   collaboration?

4. Under the rule of reason or merger analysis, do
   anticompetitive effects outweigh the procompetitive
   benefits?
1. Are competitively-sensitive issues involved?

- Collaborations that do not involve agreements regarding competitively-sensitive issues are not likely to raise antitrust concerns.
- Competitively-sensitive issues include:
  - Prices or rates, including discounts and negotiation strategies
  - What services to furnish to which customers (i.e., which markets to serve)
  - Competitive strategies generally
2. Is there an “efficiency-enhancing integration?”

- A “naked” agreement among competitors regarding the prices they charge or the markets they serve may be considered *per se illegal* price-fixing or market allocation.
  - Plaintiff need only prove:
    - Competitors entered into agreement
    - Agreement involved prices or rates
  - Would cover joint negotiations among competing providers

- Does not matter if:
  - Providers have only a small share of the market
  - Health plan is dominant or has large market share
  - Goal is to obtain reasonable reimbursement rates or to negotiate contracts that would allow for higher quality

- Prosecutions have involved unintegrated physician networks (e.g. messenger models that seek to negotiate fees).

- Hospital networks/JVs also have been investigated or challenged.
Exception to *per se* rule

- FTC/DOJ: Agreements that could be *per se* illegal are evaluated under the **Rule of Reason** if they are:
  - reasonably related to, and reasonably necessary "ancillary", to
  - achieve the procompetitive benefits from an "efficiency-enhancing integration of economic activity"

- **Rule of Reason analysis**
  - Relevant market definition (product/geographic)
  - Evaluation of anticompetitive effects
    - Entry arguments
    - Could power buyers defeat price increase?
  - Evaluation of procompetitive efficiencies
What constitutes “an efficiency-enhancing integration?”

- Revised 1996 FTC/DOJ *Statements of Antitrust Policy in Health Care*:
  - Rule of reason treatment should be applied to *physician* networks that are
    - Financially integrated through
      - Substantial financial withhold
      - Capitated arrangements
      - And perhaps other mechanisms . . .
    
    or
  - Clinically integrated
    - Are the parties achieving through their collaboration cost and quality efficiencies that they would not likely be able to achieve on their own?
    - An MSSP ACO is viewed as being clinically-integrated

- Merger or employment also constitutes full economic integration
  - And also would be immune from Sherman Act §1 scrutiny under *Copperweld*
3. Are joint negotiations (or other agreements) ancillary to achieving the benefits of that integration?

- Joint negotiations must be “ancillary” to the integration
  - FTC asks: why can’t the providers do all of their value-enhancing initiatives without joint negotiations?
    - According to FTC: “Without joint negotiations, providers wouldn’t engage in initiatives” is not a good answer
    - FTC accepts that the need for the network to be assured that all of its members will participate in all network contracts is a reasonable basis for joint negotiations

- Agreements must be related to the economic integration
  - A joint venture to produce PET scans will not justify joint pricing for surgical services
4. Under the **Rule of Reason or merger analysis**, is transaction anticompetitive?

- Identify potential competitive concerns
- Define the relevant market (product/geographic)
- Calculate market shares and change in market concentration
- Analyze anticompetitive effects
- Assess likelihood of entry
- Consider procompetitive efficiencies
- Consider “failing firm” defense/ “flailing firm” argument
Defining the relevant market

- Key question: To whom else could customers turn in response to a price increase?
  - Who is the customer?
    - Patients
    - Health plans
    - Employers
  - Product dimension
    - With physicians, starting point is physician specialties
    - But in some cases, product could be more narrow than a single specialty, or encompass multiple specialties
    - Hospital services may be grouped together as a “cluster,” but various service lines also could be analyzed separately (e.g. OB)
  - Geographic dimension
    - How far will patients go for certain types of care?
    - Will vary by service
Consider market shares and competitive dynamics

• What share levels raise concerns?
  – DOJ/FTC: Presumption that merger will enhance market power if it increases HHI by >200 points and results in market HHI >2500
  – Another possible rule of thumb: If merged entity will have <30% share, unlikely to raise antitrust issues
  – With hospitals, scrutiny is typically on 4-to-3, 3-to-2 or 2-to-1 deals
  – Degree of concern will grow as share size increases, in clearly defined market with high barriers to entry

• History of competition between the parties
  – Are they each other’s closest competitors?
  – Have health plans leveraged one of them against the other?
Entry

- DOJ/FTC Merger Guidelines: Agencies consider the “timeliness, likelihood and sufficiency” of entry

- In physician markets, consider
  - Regulatory barriers to entry
  - Whether new physicians will be able to obtain referrals
  - Whether hospitals or health plans might sponsor entry

- With hospital markets, regulatory and capital requirements may pose significant barriers

- Recent history of entry – whether successful or not successful – can be very probative
Efficiencies

- DOJ/FTC will only “credit” efficiencies that are:
  - “Merger-specific” – i.e. likely to be accomplished with the merger and unlikely to be accomplished through another means
  - Verifiable – can you point to past experience?
  - Cognizable – i.e. are not caused by an anticompetitive reduction in output or service
- Efficiency claims are unlikely to “trump” very substantial adverse competitive effects
Failing firm defense

• Very narrow defense—must show that firm would likely exit the market
  – Can’t meet financial obligations and can’t reorganize under bankruptcy
  – No other buyers who would raise fewer competitive concerns

• But also relevant is whether target is “flailing”
  – Poor financial condition goes to future competitiveness
FTC v. St. Luke’s

- **St. Luke’s is a Boise, ID-based health care system with:**
  - 8 hospitals, including 400-bed hospital in Boise and 137-bed hospital in Meridian
  - >100 clinics throughout Idaho and eastern Oregon
  - 500 employed physicians, including the Mercy Group in Nampa with 7 adult PCPs
- **Saltzer Medical Group**
  - 41 physician - multi-specialty group with principal office in Nampa, ID
  - Includes 16 adult PCPs and 11 pediatricians
  - More than ¾ of its patients come from Nampa
- **St. Alphonsus Health System is a subsidiary of Trinity Health, including:**
  - 381-bed hospital in Boise
  - 152-bed hospital in Nampa
  - 200 employed physicians, including 14 PCPs in Nampa and 20 in Canyon County
  - Treasure Valley Hospital – JV for 9-bed short-term care hospital with ASC in Nampa opened 2012
FTC v. St. Luke’s: competitive effects

• Horizontal case
  – St. Luke’s/Saltzer would account for 80% share of PCPs in Nampa, giving St. Luke’s increased negotiating leverage
  – St. Luke’s/Saltzer will move ancillary services to hospital-based rates and higher-priced St. Luke’s facilities

• Vertical case
  – Reduced competition for inpatient and outpatient services because of foreclosure of critical source of physician referrals to rival hospital
  – Court did not address vertical theory
Examples of “bad documents” from St. Luke’s

111. The Acquisition adds to St. Luke’s market power and weakens BCI’s ability to negotiate with St. Luke’s. As BCI’s Jeff Crouch explained, St. Luke’s is already the dominant provider in a number of markets, and the transaction extends their reach to the Nampa market. Trial Tr. at 311, 433 (J. Crouch).

112. BCI’s concerns are supported by an e-mail written by Christopher Roth (St. Luke’s Regional Medical Center CEO) to St. Luke’s COO and COO. See Exhibit

improvement. The e-mailed plan called for (1) reducing expenses, (2) increasing volume, and (3) a “Price Increase ($ Unknown).” Id. Under that heading of “Price Increase” was a bullet point stating: “Pressure Payors for new/directed agreements.”

pressurer payors for more reimbursement but rather could pressure them to direct more patients to St. Luke’s high quality and low cost clinics. Trial Tr. at 2339 (Roth). That explanation is not credible, however, given that the “pressure” language quoted above was contained under a heading entitled “Price Increase” and was part of a discussion of how to increase income. The point being made in the e-mail was that St. Luke’s should use its bargaining leverage to increase reimbursements from health plans.

113. Saltzer’s documents likewise confirm that the Acquisition will enhance its negotiating leverage. In an internal exchange, Nancy Powell (who at the time was Saltzer’s Chief Financial Officer) informed Dr. Page (Saltzer’s Chairman of the

Findings of Fact & Conclusions of Law – page 21
Examples of “bad documents” from St. Luke’s

Contracting Committee) that BCI’s changed policy on reimbursements for consults would cost Saltzer $22,000. See Exhibit 1361. Dr. Page responded that “this is a pretty big blow,” and he speculated that “[i]f our negotiations w/luke’s go to fruition, this will be something we could try to get back, i.e. consult codes, as there would be the clout of the entire network.” Id. (emphasis added).

...cull from these surveys the main benefits and barriers to large group practices as cited by these medical provider participants. What they found was this: “Gaining negotiating leverage with health insurance plans was the most frequently cited benefit; it was cited 8 times more often than improving quality.” Trial Tr. at 2671 (Dr. Enthoven)

116. St. Luke’s itself confirmed the importance of gaining negotiating leverage with health insurance plans. In a 2009 presentation to the Board of Directors discussing a plan to integrate physician practices with the hospital, St. Luke’s officials wrote that “St. Luke’s Treasure Valley recognizes that market share in primary care is a key...
Examples of “bad documents” from St. Luke’s

116. St. Luke’s itself confirmed the importance of gaining negotiating leverage with health insurance plans. In a 2009 presentation to the Board of Directors discussing a plan to integrate physician practices with the hospital, St. Luke’s officials wrote that “St. Luke’s Treasure Valley recognizes that market share in primary care is a key success factor, critical to sustaining a strong position relative to payer contracting . . . .” See Exhibit 1461 at SLHS000039821.

Anticompetitive Effects – Twin Falls Example

117. In the Twin Falls Idaho market, the dominant provider of primary care services was the Physician Center, managed by St. Luke’s. Trial Tr. at 241 (J. Crouch).

118. Between 2002 and 2009, BCI did not contract with this St Luke’s group, believing that there remained sufficient coverage with about 20 primary care providers within 15 miles and almost 50 primary care providers within 30 miles, including the Burley area. Trial Tr. at 244-45 (J. Crouch).
FTC v. St. Luke’s: key decision points

• Market definition was narrow
  – Geographic market for PCP services did not include Boise (20-miles away)

• Efficiencies were not merger-specific
  – Integrated care requires a “committed team” and a committed team can be assembled without employing physicians
  – St. Luke’s is extending EMR to both employed and independent physicians, so not merger-specific

• Entry/expansion attempts had been unsuccessful
  – St. Al’s had been unable to recruit new internists, family practice physicians, or pediatricians in past 2 years
FTC v. St. Luke’s: 9th Cir. Opinion

• Competitive Effects
  – PCP market shares met the presumption of harm
  – St. Luke’s and Saltzer had been each other’s closest competitors
  – Documents evidenced increased bargaining power of a combined St. Luke’s/Saltzer
  – Rejected findings related to increased prices in ancillary services

• Efficiencies
  – Efficiencies have to go to rebutting the presumption of a reduction in competition, i.e. improving patient care isn’t enough
  – Upheld district court finding that efficiencies weren’t merger-specific
  – Even if they were merger-specific, they didn’t offset the harm to competition
FTC v. ProMedica Health System
FTC v. ProMedica: case history

- FTC and Ohio AG challenged ProMedica’s acquisition of St. Luke’s Hospital in Toledo, OH
- District Court granted Preliminary Injunction
- Full trial before the FTC ALJ
- Full Commission affirmed
- 6th Circuit affirmed FTC
- Petition for Writ of Certiorari is pending at the Supreme Court
FTC v. ProMedica: key points

- ProMedica/St. Luke’s allegedly accounted for:
  - 60% of general acute-care inpatient hospital services
  - 80% of inpatient OB services
- Transaction would consolidate market from 4 to 3
  - St. Luke’s was the third largest hospital in Lucas County; ProMedica and Mercy were #1 and #2
  - Payors leveraged St. Luke’s against ProMedica in negotiations
- Parties anticipated St. Luke’s could raise its prices
- St. Luke’s struggled financially but had been working to turn around its finances—positive operating margin in August 2010
- Bad documents were prominently featured in FTC’s case
“An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout.”

“ProMedica or Mercy affiliation could still stick it to employers, that is, to continue forcing high rates on employers and insurance companies.”
"ProMedica had a significant leverage on negotiations with some of the [health plans].”

And, an affiliation with ProMedica could, “[h]arm the community by forcing higher hospital rates on them.”

Part of St. Luke’s rationale for transaction: “incredible access to outstanding pricing on managed care agreements”.

St. Luke’s then admitted: this “may not be the best thing for the community in the long run” but that it “sure would make life much easier right now though.”
MA Attorney-General’s Challenge to Partners’ Planned Acquisitions
MA AG challenge to Partners’ expansion

- Partners announced several planned transactions
  - South Shore Health – including hospital and 400 physicians
  - Hallmark Hospital – including hospitals in Medford and Melrose
- Review by MA Health Policy Commission, DOJ and MA AG
- Proposed settlement with MA AG Coakley (6/24/2014)
- Proposed settlement prompted voluminous comments from 174 entities, many skeptical, including negative assessment by HPC:
  - would increase medical spending by $38.5-$49 million
  - give Partners more leverage in future contract negotiations
  - not necessarily result in efficiencies or better access that could not have been otherwise achieved
MA AG/Partners Proposed Consent

• Price caps for 6.5 years on commercial business and on Total Medical Expenditures where Partners bears risk (i.e. not PPOs)
• Component contracting for 7-10 years
• No joint contracting on behalf of unaffiliated physicians
• Growth limits
  – For 7 years, additional hospital acquisitions would require MA approval
  – For 5 years, limit on adding physicians using 1/1/2012 baseline
• Monitor to oversee implementation, but subject to interpretation, exceptions, and recourse to the court
Court rejects Proposed Consent Judgment

• New MA AG Healey expresses little enthusiasm for the settlement
• At request of the parties, court did not conduct an evidentiary hearing and issued no factual findings
• Concluded settlement not in public interest (1/29/15)
  – “Would cement Partners’ already strong position in the healthcare market” and give it ability to raise prices to insurers
  – Would not reasonably and adequately address likely harm
    • Remedies are temporary and limited in scope
    • “Like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off”
• Serious concerns about enforceability
  – Requires ongoing court involvement – doubtful that the court has the necessary technical competence or resources
Other developments: FTC/DOJ Healthcare Workshop
FTC/DOJ Examining Health Care Competition Workshop Series

• February 24 & 25, 2015
  – Early observations regarding accountable care organizations
  – Alternatives to traditional fee-for-service payment models
  – Trends in provider consolidation
  – Trends in provider network and benefit design strategies
  – Early observations regarding health insurance exchanges

• More info on the workshop, including presentations and videos, is available at https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition
FTC/DOJ Workshop: Key enforcers’ remarks

• Bill Baer, DOJ, Asst. Atty. General for Antitrust
  – The agencies are aware of “a wave of vertical integration as hospitals acquire physician practices” as well as the “sometimes conflicting views regarding these transactions.” . . . Opponents express concern “that these transactions result in conglomerates with the market power and bargaining leverage to adversely affect competition.”

• Chairwoman Ramirez, FTC
  – “We appreciate that health care providers throughout the country are scrambling to adapt to a changing market and regulatory environment.” “Their awareness of antitrust law is often in the background.”
  – FTC is growing increasingly concerned with new types of mergers that have emerged recently: urban hospitals buying suburban ones or hospitals buying different types of providers such as imaging companies or diagnostic centers and what effects they can have on competition.
FTC/DOJ Workshop: Provider consolidation

• Workshop focused on what’s next in health care consolidations:
  – Hospital acquisitions of physician groups
  – Hospital system acquisitions of out-of-market or cross-market hospitals and other providers
  – Health system expansion into health plan business or health plan acquisitions of providers

• On “traditional” hospital consolidations, sentiment seemed to be that analysis is now straightforward
  – FTC has successfully challenged hospital mergers in consolidations of 4 to 3 (or fewer) hospitals where geographic market is clearly defined
FTC/DOJ Workshop: Acquisitions of physician groups

• **What is driving consolidation?**
  – Desire for greater physician engagement
  – Enhanced coordination of care
  – Access to capital & technology
  – Medicare payment rules

• **Skepticism** as to whether employment of physicians will lead to more engagement/coordination
  – Lawton Robert Burns: studies show few consistent positive effects of integration
  – Ken Kizer: “achieving clinical integration is dependent on key organizational functionalities, not a particular structure”
FTC/DOJ Workshop: Cross-market consolidations

- Cross-market mergers defined as combinations that span different geographic or product markets
- Studies on price effects following cross-market mergers
  - Dafny, Ho, Lee (2015) paper: shows price effects (5-10%) related to acquisitions of hospital in adjacent geographic area
  - Lewis & Plum (2014) study: found evidence of higher prices (10-18%) from hospital system combination with hospital out of area
- What might be causing price increases?
  - Improved quality
  - Difference in negotiation skills
  - Greater ability to walk away, bear risk for being out of network
  - “Common customer”
  - “Common insurer”
FTC/DOJ Workshop: Health plan/ provider integrations

- **Long history of attempts at hospital-sponsored plans and provider/plan integration**
- **According to Burns:** Provider-sponsored plans have not necessarily achieved purported benefits
  - Cost of care – evidence shows “IDNs with more revenue at risk were 20% more expensive”
  - Clinical quality – no meaningful difference in readmissions, infection rates, complication rates
  - Patient satisfaction – no meaningful difference
- **Success of plan-led integration with providers is TBD**
  - Strategy is to control the front-end of care—PCPs—to manage risks
  - Positioning to take risk for greater Med Adv and Medicaid enrollment
  - Address care management of super-utilizers
  - Protect against provider consolidation and movement into health plan business
FTC/DOJ Workshop: Observations

- Workshop itself reflects FTC and DOJ’s priorities and engagement
- ACA may be increasing health plan competition – more competitors and lower barriers to entry
- Increasing importance of narrow/tiered networks
  - Scrutiny over contracting practices that impede their use
  - Perhaps can address concerns over some provider consolidations
- Agencies don’t believe there is a tension between ACA and competition
  - But panelists acknowledged that consolidation may be occurring in reaction to ACA
- Presumption of many panelists: provider consolidation is occurring, and is associated with higher prices
Observations, cont’d

• ACOs are not a primary concern
  – Rather, issue is the extent to which an ACO reflects more consolidated market or tie-up of competitors
  – Physician-driven ACOs raise fewer concerns
• Value-based non-FFS payment may not be panacea if there is a lack of competition
• “Cross-market” transactions are coming under scrutiny – at least by academics
  • Distinguish hospital/hospital in adjacent or distant markets
  • Hospital/physicians in same geographic market
  • But Agencies are still in the very early stages of considering implications of cross-market consolidations
Observations, cont’d

- Providers entering into health plan business and plans moving into the provider space may impact competitive dynamics in each respective market.
- Continued lack of enthusiasm for regulatory consents
  - But in some situations, there may not be good alternatives.
- What CMS does matters to competition
  - Payment policies
  - Insurance exchange rules
  - Metrics/information
- Agencies and CMS are working more closely with each other than ever before.
- Health care markets are in a transition phase.
Practical guidance for addressing antitrust in healthcare transactions
What increases likelihood of investigation or challenge?

- Hospital **consolidation with PSA overlap** with 0-3 remaining competitors
- Hospital **acquisition of physician group** where hospital’s employed physicians compete with target group:
  - Post-transaction market share >50%
  - Potential to foreclose entry/expansion of rivals who rely on physicians for referrals or for ACOs and other integrated arrangements
- **Potential new cross-market theory**: Hospital systems or providers in adjacent PSAs that have common payers and other common customers
  - Each hospital has >30% share in its respective PSA
  - <3 large systems remaining post-transaction
- **Increasing rates to payers** through:
  - Actual price increases – especially with no arguable increase in quality
  - Moving acquired hospital/physicians to existing contracts with higher negotiated rates
  - Moving ancillary services to higher hospital-based rates
What increases likelihood of investigation or challenge, cont’d?

• Evidence of a dominant provider
  – Preventing efforts by payers to steer patients
  – Tying sales of one product to another – e.g. insisting on “all-or-nothing” contracts
  – Contracting with providers on exclusive basis
  – Restricting payers from making cost, quality, efficiency & other info available
  – High rates or history of increasing rates after prior acquisitions

• Complaints from:
  – Health plans
  – Large employers or business groups
  – Competing hospitals or physician practices
  – Disgruntled physicians

• Bad documents
What mitigates risk of investigation or challenge?

- Presence of strong competitors – even if market is concentrated
- Evidence of entry and expansion from competing groups
- Supportive or neutral payers and other third-parties
- Clear, pro-competitive and well-documented rationale for acquisition
  - Evidence that transaction will enable cost savings or quality improvements that would be hard to achieve without the transaction
  - Past success in achieving efficiencies from prior transactions
- Financial jeopardy of target entity makes it less of a competitive constraint
What is the future of efficiencies claims?

- District court in *St. Luke’s* concluded proposed efficiencies were not “merger-specific” because they could be achieved through means other than employment model.
- Ninth Circuit held that even if they were merger specific, they would not overcome anticompetitive harm from transaction.
- Agencies will continue to be receptive to efficiencies claims that are:
  - Merger-specific
  - Verifiable
  - Cognizable
- But difficult to use efficiencies defense in court if Agencies mount a challenge.
What about payer reactions?

- Antitrust enforcers rely heavily on health plan input
  - Health plan reaction is important to determining whether transaction will have anticompetitive effects
  - If purchasers don’t have sufficient alternatives, that will be used as evidence that combined entity will have market power

- Easier to justify a price increase if health plans acknowledge that quality and/or utilization have improved

- Develop a strategy for communicating with payers
How much weight is given to complaints from rivals?

- Often discounted in horizontal merger analysis
- More viable economic theory in vertical challenge
- Likely to see more vertical challenges in the future – from private plaintiffs and government
Consider antitrust issues from the beginning

• Will vary considerably
  – In some situations antitrust issues will not be significant
  – In others, they could be key in determining whether the deal can be done or how extensive antitrust review might be

• Crucial that all parties understand from the outset how the proposed arrangement will work and can benefit them
  – If goal is just to gain market clout without changes in clinical practice and efficiencies, then venture will either fail, or prompt tough antitrust scrutiny

• Antitrust issues can be dealt with
  – Informed advice prevents an entity from being overly conservative or blindsided by the risks
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Bob Leibenluft’s practice is devoted entirely to health and antitrust matters, including counseling and litigation regarding antitrust issues in the health, medical device, and pharmaceutical industries.

Upon completing law school, Bob worked as an attorney advisor in the Federal Trade Commission (FTC)’s Office of Policy Planning, concentrating on health and antitrust matters. In 1981, he joined Hogan & Hartson and became a partner in the firm in 1989. He practiced health law at Hogan & Hartson until January 1996 when he rejoined the FTC as Assistant Director for Health Care in the FTC’s Bureau of Competition. As head of the Health Care Division, Bob supervised a 25-30 person staff engaged in the review of mergers, acquisitions, and joint ventures involving hospitals, physicians, and other healthcare providers, as well as conduct in the healthcare and pharmaceutical industries. While at the FTC, Bob supervised the 1996 revisions of the FTC and DOJ Statements of Antitrust Enforcement Policy in Health Care in which the Agencies first addressed clinical integration. He rejoined Hogan & Hartson in September 1998.

Bob is an inaugural fellow of the American Health Lawyers Association, where he previously served as a Vice-President and member of the Board of Directors. He is a former chair of the ABA Antitrust Section’s Health and Pharmaceuticals Committee, Joint Conduct Committee, and State Enforcement Committee. Bob is Chair of the Board of Directors of HCI3, the parent company of Prometheus Payment Inc. and Bridges to Excellence.

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Awards/Rankings
- Chambers USA, Health Care, 2006-2014; Health Care: Regulatory & Litigation, 2008-2014; Antitrust, 2014
- The Best Lawyers in America, Antitrust Law, 2008-2014

Published Works
- “FTC Director Addresses Enforcement Efforts in the Healthcare Sector” (7.17.14)
- “The Antitrust Challenge to the St. Luke’s/Saltzer Medical Group Transaction: Implications for Hospital/Physician Consolidations” (3.6.14)
- “NY Hospital Settlement Could be Model for Future Mergers” Law360)2.12.14)
- New York Attorney General Forces New Ground in Scrutiny of Pharmaceutical Agreements with First-filer Exclusivity No-Challenge Settlement (2.21.14)
Leigh L. Oliver practices antitrust law, with a focus on counseling, government investigations and litigation on a wide range of competition and policy issues. She has extensive experience representing and counseling clients on mergers and acquisitions, joint ventures, sales and distribution practices, Sherman Act, Clayton Act, and FTC Act issues. Leigh has successfully represented clients facing government investigations and challenges of prospective and post-consummated mergers and acquisitions, as well as responding to non-merger government investigations. She has advocated for clients across a variety of industries, but has deep experience working on behalf of clients in the healthcare and life sciences industries.

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