DEPARTMENT OF JUSTICE

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I am pleased to have this opportunity to tell you about some of the Antitrust Division's recent initiatives and enforcement actions in the health care industry. I thank Chairman Muris and the Federal Trade Commission for their sponsorship of this Workshop and for inviting our participation.

Strong antitrust enforcement plays a significant role in encouraging and facilitating competition in the health care industry. In the few minutes I have, I will give you a brief overview of what we are currently doing, identify some areas that concern and interest us, and tell you where I think our efforts will be directed in the future.

I first want to address a matter that has perhaps been the subject of misunderstanding among some observers -- the absorption of the responsibilities and most of the resources of the Health Care Task Force by the newly created Litigation I Section earlier this year. That action did not signal, and has not resulted in, the Division's exit from a significant enforcement role in the health care sector. Rather, it was part of a congressionally-approved, Division-wide modernization effort undertaken to concentrate industry expertise within six civil sections of roughly equal size, each having broad merger and nonmerger responsibility in assigned industries and sufficient staff to perform those responsibilities efficiently and effectively. In the case of the Health Care Task Force, the core of its staff and their health care expertise were not dissipated by the reorganization; they were merely transferred to the newly formed Litigation I Section. Led by Mark Botti and John Read, Chief and Assistant Chief, respectively, of Litigation I, the former Health Care Task Force staff members continue to investigate health care matters within the context of a full-fledged section. In accordance with the philosophy underlying the modernization, we expect the Section to engage in "community policing" in this

significant industry.

One area of primary concern for Litigation I will be the evaluation of mergers of, and unilateral or coordinated conduct by, health insurers. For consumers to benefit from competition in health care markets, sufficient competition must be maintained not only among providers but also among the health plans that purchase the providers' services on behalf of their plan members. Our competitive interest in this regard has been heightened by the generally increased level of consolidation of health insurance markets in the past few years. Given these ongoing market changes, we will pay close attention to whether any particular merger would give the merged insurer sufficient market power to increase prices or reduce quality in the sale of managed care plans in specific geographic areas or to acquire monopsony power over providers. The Division will make close scrutiny of health insurance plan mergers a priority.

Likewise, we will continue to focus on collective or unilateral activity by health insurers that may raise competitive concerns, depending on the insurer's market power and other relevant market conditions. To cite some examples, we recently scrutinized the health insurance market in a major metropolitan area for possible evidence of coordination or collusion among managed care plans operating there. In addition, in the past several months, we have investigated a complaint by providers in the Philadelphia metropolitan area that a form of "all-products clause" instituted by an insurer with substantial market share -- a clause that gave providers more favorable reimbursement rates if they agreed to participate in all of the insurer's plan offerings -- was anticompetitive.

Furthermore, we continue to receive and evaluate complaints about managed care plans'

use of most-favored-nations ("MFN") clauses to determine if they merit more complete investigation and, ultimately, any enforcement action. These types of clauses generally operate to protect insurers against other plans getting better reimbursement rates from providers and generally create disincentives for providers to lower reimbursement rates. In this regard, we have, for example, investigated the use of an MFN clause by a Blue Cross Plan in Alabama, which we closed upon confirming through document production and other investigation that the plan had abandoned its MFN policy. Similarly, in Western Pennsylvania, Highmark, an insurer with significant market share, recently proposed to the Pennsylvania Department of Insurance the inclusion of an MFN clause in Highmark's contracts with hospitals. During the mid-1990s, the Division had advised the Insurance Department that Highmark's proposal then to institute an MFN policy raised serious competitive concerns. While we were evaluating Highmark's latest MFN proposal, Highmark abandoned it.

Another area of the health care sector that we are currently focusing on and that has absorbed an increasing amount of our resources is the rather broad category of what can best be described as "ancillary health care products and services." The *Dentsply* case is a recent example. That lawsuit, filed in federal district court in Delaware, challenges the use by Dentsply, the dominant manufacturer of artificial teeth in the United States, of restrictive dealing arrangements with dental laboratory distributors. The trial of that case lasted more than three weeks last Spring; the post-trial filings have been completed; and closing argument is scheduled for September 20, 2002.

In *Dentsply*, we are challenging two exclusive dealing practices by Dentsply, which has

an 80% share of the artificial tooth market in the United States and sells all of its teeth to dealers. Under Dentsply's "Dealer Criterion No. 6," if a dealer selling Dentsply teeth begins selling a competitive brand, Dentsply pulls its teeth from that dealer (no pun intended). In addition, Dentsply has a practice of requiring new dealers to drop some or all competitive brands in order to get the Dentsply tooth business in the first instance.

There are several important legal issues presented by this case, and I will highlight two. One issue is whether exclusive dealing agreements that are, as a technical matter, terminable at will can nevertheless cause anticompetitive effects in the market. Dentsply sells its teeth to dealers on a purchase order basis, and there is no express duration to the agreements. Yet, as a practical matter, those agreements have been perpetual in length because no dealer has been willing to give up its substantial Dentsply tooth business to add a rival tooth brand. Dentsply's policy presents an "all or nothing" choice to dealers: if a dealer adds any competitive brands, it loses all of its Dentsply business. Given Dentsply's 80% market share, that choice has been an easy one for dealers to make over the past 15 years. During that time, even though several dealers have expressed an interest in adding a rival tooth line, none has done so.

Another issue relates to the importance of the traditional proxies used by courts in assessing exclusive dealing agreements. Traditionally, courts have examined factors such as the duration of the agreements and the percentage of the market foreclosed to competitors, and in *Dentsply*, we believe we have strong evidence to show that these factors support a violation. But we also have direct evidence, from a variety of sources, of the anticompetitive effects of Dentsply's exclusionary practices -- that is, evidence that the practices have substantially

reduced competition and consumer choice, deterred entry, and increased prices. That evidence should be enough, we are arguing, for the court to find that Dentsply's conduct has caused adverse effects. We are optimistic that the evidence we presented will result in a finding of liability, enabling restoration of competition in the artificial tooth market nationwide for the benefit of consumers.

Our significant attention to the areas of health insurance and health care products should not be taken as an indication that the Division will ignore issues in provider markets. While we believe our focus on health insurance is complementary to the FTC's increased commitment to enforcement in provider markets, we will continue to use our expertise regarding providers to open investigations and take action where appropriate. Currently, the Department is pursuing a number of health care matters focused on provider conduct, including a number that we have opened in recent months. Litigation I has and will continue to focus particularly on horizontal activity. For example, in *United States v. Federation of Physicians and Dentists*, we are in the process of securing entry of a stringent consent decree that would put an end to illegal collective action undertaken by orthopedic surgeons in private practice through their membership in a professional union operating nationwide. In that case, we alleged that the Federation of Physicians and Dentists had recruited nearly all of the private practice orthopedic surgeons in Delaware as members, who then agreed to designate the Federation's executive director as their agent to negotiate the fee levels they would accept from Blue Cross & Blue Shield of Delaware. When Blue Cross declined to negotiate with the doctors through the Federation, the Federation and others persuaded the doctors to deal with Blue Cross only through the Federation, and ultimately organized nearly all of its member orthopedists to terminate their contracts with Blue

Cross in the belief that such action would force Blue Cross to accede to their fee demands. The proposed consent decree is nationwide in scope and prohibits the Federation from participating in, encouraging, or facilitating any agreement or understanding between competing physicians or from negotiating, collectively or individually, on behalf of competing physicians about any payer contract or contract term -- activities that if undertaken would force health plans to pay increased fees.

And we continue to investigate other allegations that professionals in various markets are using seemingly legitimate joint conduct as a pretext for collusion. Over the past several months, we have been conducting an investigation into a physician-owned joint venture that provides a multi-practice network of physicians to health care payers in a substantial urban area. The network began operating in 1995, and now has several hundred physician members, representing over 90 percent of the physicians practicing in this market. We have also opened an inquiry into a hospital network, and have recently initiated a review in one market of a hospital joint operating agreement and a review in another market of physician collective bargaining.

It must be recognized that if, in our scrutiny of horizontal conduct, we discover health care businesses crossing the line to engage in explicit collusive arrangements regarding fees or market allocation, we will consider prosecuting criminally. In this regard, we have recently strengthened our liaison relationship with the FTC, so that FTC staff who uncover evidence of such explicit agreements in the course of their investigations can quickly bring the evidence to the attention of our National Criminal Enforcement Section staff.

I would like to say a few words on the procedural front and highlight our merger review

process. Assistant Attorney General Charles James has made it a top priority to make our merger review process more efficient and manageable for the Division and for all parties in all industries, including the health care sector. That effort began with his announcement of the Division's Merger Review Process Initiative, which established a number of methods for making the initial 15-or 30-day waiting period more productive, as well as streamlining both the Second Requests that are issued and the staff's assembling and analysis of information post-Second Request. The procedures outlined in the Merger Review Process Initiative are designed to encourage Division staff and the merging parties to more quickly identify critical legal, factual, and economic issues regarding proposed mergers, facilitate more efficient and more focused investigative discovery, and provide for an effective process for the evaluation of evidence. A key component of the process is that staff are authorized and encouraged to actively tailor investigative plans and strategies according to each proposed transaction, in lieu of reliance on standardized procedures or models. While the dearth in merger activity has led to only limited experimentation with this Initiative, the early feedback, both from staff and parties, has been quite positive. We hope that parties will continue to work cooperatively with us.

As an important follow-on initiative to improve our merger review procedures, the Division is now in the process of disseminating to its staff suggestions about investigative techniques that have proven to be particularly effective in past merger investigations. We believe that this initiative will enable staff in future merger investigations to draw upon the collective experience of the Division, adopt the best investigative techniques, and continue to improve upon them.

In closing, I want to emphasize that the Division intends to continue closely monitoring

and, where appropriate, take enforcement action in the vitally important health care sector of the economy. In doing so, we expect to give greater attention than we have traditionally given to the area of health care insurance. At the same time, of course, we will maintain flexibility to enable us to adapt our enforcement focus to any significant anticompetitive activities that arise in the health care industry. Using our strong expertise in this industry, and in partnership with the FTC, we intend to work to ensure a competitive health care marketplace for consumers.