DEPARTMENT OF JUSTICE

STATEMENT

OF

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BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

CONCERNING

"EXAMINING COMPETITION IN GROUP HEALTH CARE"

PRESENTED

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Mr. Chairman and Members of the Committee, I am pleased to be here to discuss the Antitrust Division's work to protect competition in the health care marketplace. Every American knows the importance of affordable health care, and for us that means ensuring that health care markets are able to respond to consumer demand without interference from anticompetitive restraints. The Antitrust Division utilizes both enforcement actions and competition advocacy to protect and promote competition in health care markets.

The Health Care Marketplace

Most of us rely on private health insurance to help defray the cost of health care, particularly catastrophic expenses that can arise unexpectedly and for which it is difficult for individual families to plan. Group health plans have developed as a means for employers and other associations to contract for health insurance on behalf of a large group of individuals, so that individuals in the group can better obtain health insurance at more affordable rates.

The group health care plan model involves transactions among a number of parties. Individuals and families receive health care coverage through employment or membership in an association. The employer or association contracts with a group health plan – an insurer – to provide coverage for members of the group. Health care providers – physicians, pharmacists, nurses, hospitals, clinics, equipment suppliers, and others – supply services and products to the insured individuals and families and receive some or all of the payment from the group plan, with any remaining amount generally coming from the individual or family or, in some cases, the employer.

Employers and other associations are attractive to insurers because they bring numerous customers into a group health plan. The group offers its employees or members to the insurer in exchange for the insurer providing better coverage at lower premium costs. Likewise, a group health plan offers its subscribers to providers as potential patients in

exchange for the providers agreeing to care for them at lower rates. With competition at every level, everyone benefits. The insured individuals and families obtain better and more affordable coverage. The health plans obtain health care services and products on behalf of their subscribers at lower cost. Participating health care providers offering good quality and competitive rates are able to increase the number of patients they serve.

At any point in these arrangements, however, an anticompetitive restraint can interfere with efficient access or supply and can drive prices away from competitive levels. If that occurs, consumers are harmed. For example, if competing providers were to conspire with each other to insist on artificially high prices, health plans could be forced to raise premiums, curtail service, or even leave the market, restricting patient access to affordable health care. Similarly, if competing health plans were to conspire with each other to pay artificially low prices, providers could be forced to curtail service or go out of business, also restricting patient access to affordable health care services.

Those are examples of the kinds of anticompetitive restrictions we are on the lookout for as we monitor health care markets. In addition to looking for anticompetitive conduct, the Department also examines proposed mergers among hospitals, health plans, or provider groups that could have the effect of reducing competition, restricting access and consumer choice, and dampening healthy incentives to provide quality care at affordable prices.

Recent Enforcement Activity

Although the Federal Trade Commission and the Antitrust Division have a long-standing process for allocating our shared antitrust enforcement authority between ourselves so as to avoid duplication of enforcement effort, health care is a sector in which both agencies are active, depending on the particular markets involved. While many of the Antitrust Division's recent health-care-related investigations and enforcement actions have

been in the markets for group health plans and health insurance, we have also been active in a variety of other health care markets. Let me turn now to a description of some of our recent activities.

This past April, the United States District Court for the District of Delaware entered its final judgment in favor of the Department in our case against Dentsply, after Dentsply's unsuccessful appeals had run their course. The Department had filed suit to stop the defendant -- Dentsply International, a corporation which provides 70% to 80% of the prefabricated artificial teeth used in the United States -- from enforcing unlawful restrictive dealing agreements and engaging in other unlawful conduct designed to restrict most of the tooth distributors in the United States from selling products made by Dentsply's competitors. The Department alleged that Dentsply's actions both deprived its competitors of the opportunity to distribute their products efficiently and deterred potential new entrants from the market for prefabricated artificial teeth.

This past February, the Division sued a West Virginia hospital, Charleston Area Medical Center, which had made an agreement preventing a nearby competing hospital from developing a cardiac surgery program in the neighboring county, thereby preventing competition between them for cardiac surgery. The case was settled with a consent decree terminating the anticompetitive agreement.

This past December, the Division challenged the merger of UnitedHealth Group and PacifiCare Health Systems, two of the nation's largest health insurers, on the grounds the merger would reduce competition for health insurance in Tucson, Arizona and Boulder, Colorado. We alleged that the merger would lead to inflated premium prices and reduced quality of coverage in Tucson, and would lead to artificial depression of reimbursement rates for physicians in Boulder, resulting in reduced availability and quality of medical care. The case was settled with a consent decree that required divestitures in these

two areas.

In 2005, the Division investigated a territorial market allocation arrangement among the twelve Medicare-approved home health agencies in Vermont. Under this agreement, the agencies did not compete, leaving Medicare and Medicaid beneficiaries in Vermont without any competition in home health services. While our investigation was underway, the State of Vermont enacted legislation mandating separate territories for the home health agencies as part of an overall regulatory scheme, and we subsequently closed our investigation.

In 2005, the Division brought an action against two hospitals in southern West Virginia, Bluefield Regional Medical Center and Princeton Community Hospital Association. The hospitals had entered into an illegal market allocation agreement under which Princeton would provide cancer services (but not cardiac surgery services) and Bluefield would provide cardiac surgery services (but not cancer services), eliminating competition between them in these areas. The case was settled with a consent decree requiring the hospitals to abandon their agreement and requiring that they obtain our approval before entering into any new agreement regarding cancer services or cardiac surgery.

In 2005, we sued the Federation of Physicians and Dentists, which had orchestrated a boycott of health plans by competing OB/GYNs in Cincinnati. Our motion for summary judgment is pending, and the case has been referred for mediation.

In 2004, we conducted extensive investigations into two mergers among group health insurers – UnitedHealth Group with Oxford Health Plans, and Anthem Inc. with WellPoint Health Networks – to determine whether the merger might give the combined firm market power either in the provision of health insurance services, or on the buyer side, as payors for health care services. As explained in the closing statements we issued, we ultimately concluded that neither competitive problem was likely and closed the investigations.

In 2003, we challenged the G.E./Instrumentarium merger regarding its likely harm to competition for critical care monitors and for mobile C-arm x-ray machines used in surgery. The case was settled with a consent decree requiring G.E. to divest Instrumentarium's critical care monitor and mobile C-arm x-ray operations before the two firms could merge.

In 2002, we sued Mountain Health Care, a North Carolina physician organization with over 1000 members, for restraining competition by adopting joint fee schedules for its members and negotiating with health plans on their behalf, which had resulted in patients paying inflated prices for medical care. That case was settled by a consent decree requiring Mountain Health Care to cease operations.

Joint Hearings on Health Care Antitrust Issues

In 2003, the Division and the FTC hosted a series of hearings on a full range of health care competition law and policy issues, to increase our knowledge about health care antitrust issues, and to educate policymakers and the public about antitrust issues and enforcement in this area. In 2004, the Division and the FTC issued an extensive joint report on those hearings.[1] The Report covers a variety of issues, including issues relating to physicians, hospitals, pharmaceuticals, and insurance.

Among its recommendations, the Report encourages payors and providers to continue innovating to increase incentives for providers to lower costs and enhance quality, and to improve incentives for consumers to seek these improvements. The report also counsels against relying on community commitments for resolving competitive concerns with hospital mergers, or looking to "countervailing power" for an effective response to disparities

[1] The report, "Improving Health Care: A Dose of Competition," can be found at www.usdoj.gov/atr/public/health_care/204694.htm.

in bargaining power between payors and providers, specifically recommending against legislation to immunize collective bargaining among competing physicians.

The report also urges that the role of subsidies and mandates be re-examined for distorting effects on competitive efficiency, and that unnecessary regulatory barriers to entry into provider markets be reduced. The health care marketplace is extensively regulated – not only in terms of rules imposed by government as a large third-party payor, but also in terms of the variety of mandates and restrictions enacted to protect patients and subscribers. Some of these regulations can create their own anti-competitive inefficiencies and barriers to entry, and we have been examining some of these regulations in our competition advocacy role.

One such barrier to entry is the certificate of need, under which providers need state regulatory authority before they can enter a market -- for example, by building a new facility. The restrictive effect of certificates of need was a factor in our investigations into the Vermont home health care agencies and into the market allocation agreement between the Bluefield and Princeton hospitals.

We believe this Report will continue to be a useful resource for the health care community and the antitrust bar on these issues, and it will inform our antitrust investigations and enforcement actions into the future.

Conclusion

Mr. Chairman, the Antitrust Division fully recognizes the critical importance of a competitive health care marketplace to all Americans. We are committed to preserving competition in this marketplace through appropriate antitrust enforcement, and we will continue to monitor this marketplace closely.

Thank you for the opportunity to testify. I would be happy to answer questions.