ANTI-TRUST REFORM

PHOTOCOPY
PRESERVATION

ANTI-TRUST REFORM

Clinton Presidential Records
Digital Records Marker

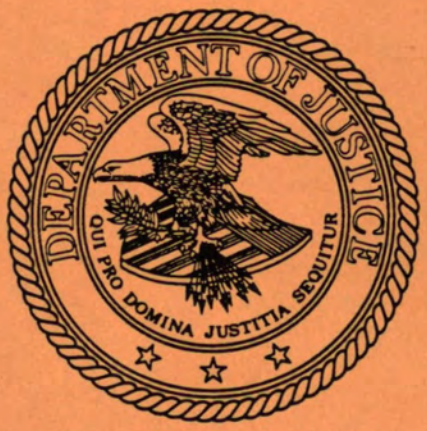
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

five

Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust



Issued by the
U.S. Department of Justice
and the
Federal Trade Commission

September 27, 1994

U.S. DEPARTMENT OF JUSTICE
ANTITRUST DIVISION

(OFFICE OF THE ASSISTANT ATTORNEY GENERAL)
(OFFICE OF THE DEPUTY ASSISTANT ATTORNEY GENERAL)

10th & Constitution Avenue, NW
Washington, DC 20530

FAX TRANSMITTAL SHEET

If you do not receive all the pages, please call (514-2401).

CONFIDENTIAL!!
PLEASE DELIVER IMMEDIATELY!!

DATE: 5/10/94 TIME: _____ am/pm

TO: Melanie Vedder
OFL

Phone: (202) 456-6266

Fax: (202 45- 6244

FROM: Anne K. Bingaman
Assistant Attorney General
Antitrust Division

Phone: (202) 514-2401

Fax: (202) 616-2645

No. of Pages: 9 (*excluding* transmittal page)

COMMENTS: Melanne, I have also submitted this to the regular OMB clearance process. We are coordinating with Chris Jennings also. I am out sick, so please call Neil Roberts or Bob Potter at 514-2512 with any comments. Thanks

STATEMENT OF ANNE K. BINGAMAN
ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION
UNITED STATES DEPARTMENT OF JUSTICE

Submitted to the Committee on Finance
United States Senate
On Competition and Antitrust Issues in Health Care Reform
May 12, 1994

I am pleased to have the opportunity to submit to the Committee the views of the Department of Justice on the role of competition and the antitrust laws as significant reform of our health care system is underway. My statement will also address proposals for antitrust immunities in some of the health care reform bills before the Congress and the antitrust-related provisions of the President's proposed Health Security Act.

The Vital Importance of Competition and the Antitrust Laws

The President's proposed Health Security Act and most of the other major proposals for health care reform rely heavily on the forces of competition to increase the availability and improve the quality of health care services, foster efficiency in the delivery of those services, and control their spiralling costs. For too long, the salutary effects of competition in health care marketplaces have been inhibited. Third party payment mechanisms that do not stimulate cost-effective consumer and provider decisions, limitations on the ability of consumers to choose health care plans on the basis of quality and price, and consumer unawareness of the merits and costs of the choices they do have are examples of inhibitions on competition that need to be addressed.

The Health Security Act promotes competition in many ways. The health care delivery system it will create will stimulate increased competition between and among various types of health plans and between and among institutional and individual health care providers. Plans will compete to be selected by consumers by seeking ways to lower premiums and increase the quality of care through networks of qualified providers. Providers will compete to develop or participate in plans by demonstrating that they can provide high quality care at affordable prices, and by seeking innovative ways to offer that care. Consumers will have information that will make them better able to evaluate and select their health care coverage on the basis of cost and quality, and thus play their important role in stimulating effective competition among plans and providers. In short, the Health Security Act will promote competition to its rightful status as a major determinant in health care reform.

As we reform our health care system to rely heavily on increased competition, it is vital that we remember that promoting and protecting that competition requires effective prohibitions against private conduct that would undercut it. Fortunately, we do not have to invent such prohibitions: They have existed for a century in the form of our antitrust laws. Given the proposals for sweeping immunities from the antitrust laws or serious constraints on their effectiveness in some of the bills before the Congress, however, I fear that this simple connection between increasing competition and preserving the laws that protect it may be overlooked as health care reform is pursued. That is a mistake we must not make.

The antitrust laws of the United States and their enforcement by the Department and the Federal Trade Commission are sound, including as applied in the health care industry.

The antitrust laws have existed for over a century as the principal guarantor of effective competition in free marketplaces. They have proved, time and again, far superior to pervasive government review, regulation, and oversight of individual or collective activities that may have competitive consequences. Indeed, they have been termed the "Magna Carta" of our fundamental national economic system.

In the health care area, as is the case generally, the antitrust laws are enforced so as to take into account not only indications of possible competitive harm, but also the potential for procompetitive increases in efficiency, lowered administrative and other costs, improvements in quality, enhanced innovation, and other factors that are important to the cost-effective delivery of quality health care services. Many types of procompetitive industry activity are well recognized as highly unlikely to raise any significant competitive concern. For example, neither the Department nor the FTC has ever challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical equipment. Only those activities that would harm health care markets and consumers by raising prices, decreasing availability or quality of services, or discouraging innovation face potential antitrust challenge.

Antitrust Guidance to the Health Care Community

Although antitrust principles in the health care area are basically sound, the Department and the FTC have recognized that antitrust uncertainty in the health care community, particularly in these changing times, should be addressed. To that end, we have been working since last summer to provide antitrust guidance to the industry. In September

1993, we issued six Statements of Antitrust Enforcement Policy in the Health Care Area, covering matters that we knew to be of concern to health care providers and others. Our statements cover six areas:

- Hospital mergers
- Hospital equipment joint ventures
- Physicians' provision of information to purchasers
- Hospitals' exchange of price and cost data
- Joint purchasing arrangements among providers, and
- Physician network joint ventures.

Our statements contain "safety zones" describing mergers, joint ventures, and other activities that the agencies have concluded are very unlikely to raise competitive concerns. The statements also make clear, however, that conduct that does not fall within the safety zones is not by implication likely to be challenged by the Department or the FTC. Indeed, much conduct not amenable to coverage by a safety zone because of the significance of the particular circumstances will be recognizably and demonstrably procompetitive in those circumstances. The statements set out the analysis the agencies use in evaluating conduct outside the safety zones so that health care providers may more confidently assess antitrust issues raised by proposed conduct even if the safety zones themselves are not applicable.

Both the safety zones and the agencies' analysis of other conduct are set out in our policy statements in simple, straightforward terms. Our goal is to provide antitrust guidance to health care providers themselves, and not only to the antitrust bar that advises the industry.

While our 1993 policy statements cover a lot of ground and, I believe, have contributed greatly to health care providers' understanding of antitrust issues, I also believe that we can and should do more. When we issued our policy statements last September, we recognized that additional antitrust guidance in the areas they cover as well as in other health care areas may be desirable. We are hard at work on such additional guidance right now, and have pledged to continue this effort. In this regard, I want to express my sincere appreciation for the advice and counsel we have received from representatives of the health care community in our ongoing efforts to develop useful antitrust enforcement policy statements. The legal and practical insights that have been shared with us by the American Hospital Association, the American Medical Association, and a variety of other interested and knowledgeable parties have been invaluable.

We have also instituted an expedited procedure to supplement the general antitrust guidance set forth in the Statements of Antitrust Enforcement Policy in the Health Care Area with more specific guidance on specific proposed conduct. We have committed to respond to requests for Department business reviews of specific health care activities within 90 or 120 days, depending on the nature of the conduct. The Federal Trade Commission has made the same commitment with respect to its advisory opinion procedure. Health care providers are taking advantage of these procedures, and we anticipate that they will result in significant further clarification of antitrust rules and guideposts to the advantage of all.

Proposals for Antitrust Immunities

Several of the bills that have been introduced to bring about health care reform contain

proposals for broad antitrust immunities in the health care area. We strongly believe that such immunities are potentially harmful and unnecessary. They are harmful in that they could seriously undercut an important goal of health care reform -- to bring to bear for the first time truly effective forces of competition in health care markets to improve health care quality and availability and control health care costs. They are unnecessary in that there are no actual antitrust barriers to individual or collective activities among members of the health care community that would foster improved service quality, cost-saving efficiencies, or procompetitive diversity and opportunity in the provision of health care. Antitrust uncertainty, to the extent it exists, can be and is being vigorously addressed by an unprecedented effort among the Department, the FTC, and interested members of the health care community. In short, our antitrust laws are sound as applied to health care: There is no need for special, broad antitrust immunities that could defeat the basic goals of health care reform.

A discussion of all of the specific provisions in all of the bills that contain proposed health care antitrust immunities is beyond the scope of this statement, but I would offer general comments on three types of broad immunities that would be provided by S. 1658 and its companion bill, H.R. 3486. The Department previously has commented extensively on these provisions in response to requests from the Judiciary Committees. I attach a copy of our comments, and I would request that those comments be included in full in the record of this hearing.

S. 1658 and H.R. 3486 provide several types of broad immunities from the operation of the antitrust laws to the health care industry. The bills would provide antitrust immunity

for any health care activity that (i) falls within one of the "safe harbors" described in the bills, (ii) falls within any additional safe harbor established by the Attorney General, after seeking suggestions for further safe harbors through the Federal Register, or (iii) is covered by a "certificate of review" issued by the Attorney General with the concurrence of the Secretary of Health and Human Services. Additionally, the bills provide special antitrust protections in the form of guaranteed "rule of reason" treatment and the "detrebling" of any antitrust damages for a health-care cooperative venture, if notice of the venture is provided to the Attorney General.

The broad new statutory antitrust immunities that would be created across the health care industry by S. 1658 and H.R. 3486 are not needed and could do substantial harm. The certificate-of-review immunity scheme in the bills, covering any activity relating to the provision of health care services, would create pervasive and continuing Federal government regulation of the competitive and other dimensions of an unknown and potentially vast number of health care provider activities. The regulatory tasks it imposes as a substitute for straightforward antitrust enforcement could well overwhelm the Justice Department, seriously impeding its ability to focus on any activities that actually would have anticompetitive effects. Moreover, administering such a program would require a massive and costly new bureaucracy. Attempts to guard against anticompetitive effects through regulation have proved to be no substitute for effective antitrust enforcement, and entrusting the guarding of competition in the nations's largest industry -- an industry desperately needing a competitive transfusion -- to such a scheme would be a tragic mistake.

The notification-based antitrust protections in S. 1658 and H.R. 3486 present comparable concerns. These provisions could undercut sound antitrust legal standards that protect consumers against clearly anticompetitive conduct. They could also undermine antitrust damage remedies that appropriately deter conduct that would raise prices and reduce the availability and quality of health care services. And the "safe harbor" provisions in the bills, based as they would be on hard-to-amend statutory language and legislative history, could have unintended anticompetitive effects, whereas enforcement policy statements based on common-sense, basic competitive principles would not.

For these reasons, the Department strongly opposes antitrust immunities in the health care sector such as those that would be provided by S. 1658 and H.R. 3486.

Antitrust Provisions in the Health Security Act

The Health Security Act contains two antitrust-related provisions. First, section 5501 of the Act repeals the broad antitrust immunity in the McCarran-Ferguson Act for the business of insurance to the extent that such business relates to the provision of health benefits. The current, broad immunity could allow health insurers to act anticompetitively and thereby interfere with the Health Security Act's goal of relying on competition between insurers to control health care costs.

The Health Security Act also provides that, in connection with the establishment by a regional alliance of a fee schedule for use in regional alliance fee-for-service health plans, health care providers may collectively negotiate the fee schedule with the regional alliance (section 1322(c)). This section recognizes that the establishment of such fee schedules by the

alliances is basically a governmental function under the Act, and provides that the actions of the alliances in this regard and their negotiations with providers collectively shall be accorded the antitrust treatment due to government actions and efforts by private parties to influence those actions (section 1322(c)(5)). Such actions and efforts generally are not subject to the antitrust laws, but under section 1322, as is the case generally, there are important limits on what actions providers may take to influence an alliance's fee-for-service schedule decisions. The principal limitation is that providers may not threaten or engage in any boycott to force an alliance to adopt their suggestions or recommendations (section 1322(c)(6)). As used in section 1322, the term "boycott" is intended to include any threat or action through which providers collectively would decline initially to participate, or departicipate, in fee-for-service health care delivery unless fees were set at certain levels.

* * *

Before concluding, I would like to underscore the one point I think is vital to keep in mind as antitrust issues are considered during health care reform. Among the primary goals of such reform is to bring the forces of competition effectively to bear in health care markets as never before. To accomplish this goal the efficacy of the antitrust laws must be preserved, and we seek the Committee's support in this effort. The Department of Justice must also continue to work with the FTC and the health care community to reduce unwarranted antitrust uncertainty in the health care area, which we have pledged to do.

Thank you again for the opportunity to submit to the Committee the views of the Department of Justice on these important issues.

file DOJ/Anti-trust

Elliot
Health System

Excellence
Caring
Innovation

2 Elliot Way
Manchester, NH 03103-3534
(603) 669-5300
(603) 623-1321

January 26, 1994

Ms. Melanne Verveer
Deputy Assistant to the President, and
Deputy Chief of Staff to The First Lady
The White House
Washington, DC 20500

Dear Ms Verveer:

We were delighted to learn on Monday that the U.S. Department of Justice, following an extensive review, has decided not to oppose the merger of Fidelity Health Alliance and Elliot Health System. This decision by the Federal government now allows us to move forward, consummate the merger and begin integrating and rationalizing our services and capabilities to the benefit of our community.

Last evening's Greater Manchester Chamber of Commerce Annual Meeting was most upbeat in large measure because of the great news from Washington and the overwhelming community support to develop our own local approach to health care reform.

Thank you and the First Lady for your continued interest in our effort. I sincerely appreciate your telephone call yesterday to follow up on the status. Hopefully, you'll soon return to New Hampshire and your schedule permitting, we'd welcome the opportunity to bring you up to date on our progress.

Sincerely,

Philip B. Ryan
President

PBR/dlb:15122

file antitrust

U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General Washington, DC 20530

The Honorable Alex McMillan
U.S. House of Representatives
Washington, D.C. 20515-3309

Dear Congressman McMillan:

Thank you for your letter of September 22, 1993, congratulating the Department on its issuance, in conjunction with the Federal Trade Commission, of six Statements of Antitrust Enforcement Policy in the Health Care Area. We hope that the Statements will be ~~extremely~~ helpful in providing guidance to hospitals and other health care providers regarding the antitrust implications of mergers, joint ventures and information exchanges. The Statements are designed to alleviate antitrust uncertainty perceived by the health care community, and thus facilitate procompetitive cooperative activities that could lower health care costs.

Our recently released Statements of Antitrust Enforcement Policy address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures. The Statements set forth "antitrust safety zones," which describe circumstances under which the Department and the FTC will not challenge conduct under the antitrust laws. In the Statements, the agencies also commit to expedited responses to business review or advisory opinion requests to provide further, more specific antitrust guidance to the health care community.

With your letter, you enclosed a copy of H.R. 2640, the "Health Care Cooperative Antitrust Protection Act of 1993," and requested the Department's responses to three specific questions. Before answering these questions, I believe it would be useful to state our understanding of H.R. 2640.

H.R. 2640 would establish a broad, two-tiered antitrust exemption program covering health care joint ventures based on a comprehensive federal review and approval process. A limited antitrust exemption could be obtained through a notification and pre-clearance process involving the Secretary of Health and Human Services and the Attorney General. The notification would have to include the identities of the parties to the joint venture, the nature, objectives, and planned activities of the joint venture, and assurances that the entities participating in the joint venture would notify the Secretary and the Attorney General of any changes in their activities. This exemption would limit antitrust damage exposure to actual, rather than treble, damages, and provide that any antitrust challenge to an exempted joint venture must be evaluated under the antitrust rule of reason, rather than under any per se-unlawful rule.

SP. (fixed)

Alternatively, a total, 5 year antitrust exemption could be obtained by a health care joint venture if the Secretary, with the concurrence of the Attorney General, determined that a proposed joint venture also promoted each of the following goals:

(1) The enhancement of the quality of health care services provided to individuals residing in the geographic area served by the entities participating in the joint venture;

(2) The preservation of meaningful competition among providers of health care services in such area;

(3) The reduction of the costs of providing health care services in such area, or an increase in the efficiency of the provision of such services;

(4) The improvement of the utilization of health care services in such area; and

(5) The elimination of costly and unnecessary duplication in the delivery of health care services in such area.

The Secretary, with the concurrence of the Attorney General, would be required to approve or disapprove applications for limited antitrust exemptions within 30 days and applications for total antitrust exemptions within 90 days.

With respect to each health care joint venture applying for an antitrust exemption, the Secretary would be required to prepare a written notice that identified the parties involved and described the planned activities of the venture, submit the notice to the parties, and publish the notice in the Federal

Register. Parties to joint ventures receiving total exemptions would be required to file annual reports on their activities, as well as provide any other information required by the Secretary and the Attorney General to ensure that the joint venture meets the bill's criteria. Antitrust exemptions granted under the bill could be revoked if applicable requirements no longer were met.

H.R. 2640 also would establish the "Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care," comprised of the Secretary of Health and Human Services, the Attorney General, the Director of the Office of Management and Budget (or their designees) and a representative of the Federal Trade Commission. The Committee would be tasked to discuss and evaluate competition and antitrust policy and their implications with respect to the performance of health care markets, analyze the effectiveness of health care joint ventures receiving exemptions under the legislation in reducing costs and expanding access to health care, and make recommendations to Congress within 2 years regarding any modifications to the exemption program that would be desirable.

With this understanding of H.R. 2640, I turn now to the specific questions posed in your letter.

1. How would H.R. 2640, if enacted, impact DOJ and your recently announced guidelines?

H.R. 2640 would have a directly and significantly impact on the Department of Justice by requiring it to participate in a new federal program for the granting or denial of antitrust exemptions for health care joint ventures under the regulatory process established by the bill. The Department also would participate in the continuing review and possible revocation of antitrust exemptions that fail to continue to satisfy the bill's requirements. It is difficult to project how many limited or total antitrust exemptions would be sought under the bill, but we believe that number could be ~~very~~ substantial.

H.R. 2640 would not have a directly impact on the recently released Statements of Antitrust Enforcement Policy in the Health Care Area. It could, however, lead to confusion between these Statements (and any further statements of antitrust enforcement policy) and the specific guidelines called for by the bill under which health care joint ventures submit applications for antitrust exemptions, assuming that the bill's provision for the issuance of such guidelines contemplates that they will be substantive in nature. Similar confusion might be engendered by specific decisions granting or denying exemptions under the bill. This is so because total exemptions under the bill may

be granted only if a health care joint venture promotes each of the goals set forth in the bill, whereas antitrust enforcement policy focuses initially only on whether proposed conduct is anticompetitive. If it is not, there is no need to examine the types of potentially procompetitive justifications for joint ventures that the bill sets forth.

In effect, enactment of H.R. 2640 would result in two federal programs to deal with perceived antitrust uncertainty in the health care area: (1) a new system involving the Department of Health and Human Services and the Department of Justice under which limited or total antitrust exemptions for health care joint ventures of an unspecified nature could be obtained, renewed, or revoked through a regulatory process; and (2) the continuation of our existing antitrust enforcement program a key part of which is the provision of antitrust guidance by the Department of Justice and the Federal Trade Commission to the health care community through general statements of enforcement policy and specific business reviews or advisory opinions.

Both programs would have the same purpose--to reduce any unwarranted deterring effect that antitrust uncertainty may have on procompetitive, efficiency enhancing, cooperative activities among health care providers while protecting the public against activities that would actually be anticompetitive and raise the cost of health care. While this goal is indeed a laudable one, it is the Department's view that it is best achieved by reasonable, responsible, and well-explained antitrust enforcement policies, rather than by regulation and antitrust exemption as proposed by H.R. 2640. The DOJ/FTC Statements of Antitrust Enforcement Policy in the Health Care Area and further antitrust guidance by the agencies will accomplish this goal, and do so in a non-regulatory, non-intrusive manner that minimizes both private and governmental costs. Moreover, we believe that the proposed legislation may discourage rather than encourage efficiency-enhancing joint ventures if resort to regulation and exemption is perceived by the health care community, wrongly, as the only way to avoid unreasonable antitrust risk.

2. Would your guidelines affect the ability of private parties to sue hospitals for practices violative of current antitrust laws?

The DOJ/FTC Statements of Antitrust Enforcement Policy in the Health Care Area represent the views of both federal agencies responsible for enforcing the antitrust laws. Based on the agencies' knowledge of the antitrust laws and experience in the health care field, the agencies were able to announce "antitrust safety zones" in six important areas of health care.

The Department firmly believes that, absent extraordinary circumstances, conduct falling within these safety zones is not anticompetitive and does not violate the antitrust laws. As a result, health care providers can have a high degree of confidence that if they tailor their activities to fall within the antitrust safety zones, they would not violate the antitrust laws. Therefore, even though the Statements of Antitrust Enforcement Policy do not legally operate to limit the rights of private parties to sue, we believe it extremely unlikely that private suits challenging conduct falling within the safety zones would be instituted or successful. Activities that fall outside the safety zones but are not anticompetitive under the rule of reason analyses set forth in the Statements should fare similarly. And conduct that is the subject of a favorable expedited business review or advisory opinion, which is provided for in the Statements, also could be engaged in with a high degree of antitrust confidence.

In sum, while the Statements of Antitrust Enforcement Policy in the Health Care Area are not binding on the courts, we believe, that as official statements of both federal agencies' enforcement policies, they will be given great weight in any contemplated private antitrust litigation.

3. Do the "safety zones" envisioned in your guidelines preclude DOJ or FTC from initiating action against a health care provider if their actions are found to be violative of current antitrust law?

As noted above, the DOJ/FTC Statements of Antitrust Enforcement Policy in the Health Care Area represent the views of both federal agencies responsible for enforcing the antitrust laws. The antitrust safety zones in those Statements describe conduct which, absent extraordinary circumstances, the agencies are confident would not violate the antitrust laws. As noted in the Statements:

> The Agencies are confident that conduct falling within the antitrust safety zones contained in these six policy statements is very unlikely to raise competitive concerns. Accordingly, the Agencies anticipate that extraordinary circumstances warranting a challenge to such conduct will be rare.

Statements of Antitrust Enforcement Policy in the Health Care Area, p.4, fn.2 (Sept. 15, 1993).

By necessity, as part of the overall effort to hold health care costs down, the Department has retained the ability to challenge conduct falling within a safety zone in the rare

instance in which the purpose or effect of such conduct clearly is to increase prices to consumers or to decrease quality or efficiency. The Department believes that it would be a disservice to the health care community as well as to consumers nationwide not to reserve the right to prevent such conduct.

This reservation does not in any way undercut the value of the safety zones in resolving antitrust uncertainty. If health care providers perceive unusual anticompetitive potential in specific proposed conduct that appears to fall within a safety zone, they can receive a quick and effective determination as to whether that conduct will be challenged under the expedited business review or advisory opinion procedure described in the Statements of Enforcement Policy in the Health Care Area.

* * *

We very much appreciate the opportunity to respond to your letter. The ~~Department~~ Administration shares your commitment to making affordable health care available to all Americans. We believe that the antitrust laws have an important role to play in ensuring that health care providers as well as consumers do not encounter anticompetitive activities in health care markets. At the same time, we hope that our recently released Statements of Enforcement Policy in the Health Care Area will promote a broader understanding of the reality that the antitrust laws are not a barrier to procompetitive cooperative activities among members of the health care community.

If we can be of further assistance, please do not hesitate to call. => OMB tagline.

Sincerely,

Sheila F. Anthony
Assistant Attorney General

We also believe that the Statements will provide the proper guidance to health care providers as they position themselves for changes in the health care market in response to proposed reform initiatives.

The O-M-B- advises that, from the standpoint of the Administration's program, there is no objection to the submission of this report.

file Antitrust

Congress of the United States

Washington, DC

November 3, 1993

Mrs. Hillary Rodham Clinton
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

We are writing to ask your assistance in deleting those sections of the Health Security Act that provide an antitrust exemption for physicians and other providers, before it is introduced in the Congress. Specifically, Title I Subtitle D of that Act now includes an explicit antitrust exemption for collective provider negotiations with Health Alliances over fee schedules for fee-for-service health plans. Such negotiations would already be accorded antitrust immunity under the state action and Noerr-Pennington doctrines -- provided that the conditions of the doctrines are met.

States meet these conditions every day in insulating from antitrust challenge a wide host of various state-run or state-supervised entities or franchisees, which provide everything from electrical power and water service to trash collection. No pro-consumer purpose is served, however, by the Federal government simply declaring the conditions to be automatically met even before health alliances are in operation.

As you may be aware, yesterday our staffs met with representatives from the White House and the Department of Justice's Antitrust Division to discuss in detail our serious concerns about the proposed exemption. Therefore, we will not reiterate all of those concerns in this letter.

However, it is clear to us that this antitrust exemption will benefit primarily physicians represented by the American Medical Association. The AMA has stated in its own publication and in other news accounts, which are attached, that it has been seeking an antitrust exemption for group negotiations to protect its members' fees. It has even gone so far as to suggest that the AMA should act as the bargaining agent for such collective negotiations for all physicians groups.

The fact is that the proposed antitrust exemption for physicians could undermine the cost containment goals of health care reform and force consumers to pay higher prices or receive less care. Moreover, we believe that higher prices and less care would almost certainly result from enacting this exemption if the Administration's current plan is altered in any substantial manner during the legislative process.

We are also seriously concerned that the proposed antitrust exemption will incite an outpouring of demands by physicians and other provider groups for broader exemptions. Resisting those demands would be made more difficult by the fact that the AMA would be perceived as having won an exemption for itself in the Health Security Act. As you know, we were both delighted with the Administration's decision, announced publicly on September 15, 1993, that a series of antitrust guidelines would be promulgated by the Antitrust Division to help promote pro-competitive collective behavior by healthcare providers rather than resorting to unjustified exemptions from the antitrust laws.

We continue to believe that it would be in the best interest of consumers for the Administration to delete the sections of the Health Security Act that would provide antitrust exemptions for physicians and other providers.

Sincerely,

JACK BROOKS
Chairman
House Judiciary Committee

HOWARD M. METZENBAUM
Chairman
Senate Subcommittee on Antitrust,
Monopolies and Business Rights

cc: The Honorable Anne Bingaman
Mr. Ira Magaziner

Enclosures

to cap annual increases in health insurance premiums. Stark ... citing new data that shows ... tails for President Clinton's health

AMA turns up the heat to get break on antitrust

By Brian McCormick
AMNEWS STAFF

CHICAGO — In a detailed and sometimes stinging analysis, the AMA is trying a new tack in seeking antitrust relief for physicians under a reformed health system.

The review of federal antitrust enforcement in health care says such relief is mandatory to maintain market competition — a watchword of the White House reform plan.

The 21-page critique was sent to the Justice Dept. and Federal Trade Commission and presented separately to White House health reformers. It proposes several enforcement policy changes to help physicians feel more comfortable about collaborative activity in the current market.

Most of the changes would broaden the "safety zones" the two agencies announced last month to protect physicians or hospitals engaging in certain joint ventures.

But the letter, signed by AMA general counsel Kirk Johnson, also includes a proposal to deal with market conditions anticipated under health reform. If large, highly regulated regional purchasing alliances are set up as the de facto single payers for health services in a market, then providers should be allowed to band together under a single entity to negotiate clinical and payment issues, Johnson argues. And that, he says, should be organized medicine.

It's not the AMA's first pitch for medicine to have leave to negotiate collectively. The Association made

See *ANTITRUST, page 34*

New antitrust reform plea

The AMA has revised its pitch for antitrust relief for physicians. It is proposing changes in the White House reform plan as well as a broadening of recently released health care antitrust 'safety zones.'

Clinton plan should allow:

- Negotiated rule-making to let medicine bargain directly with government on payment and clinical issues.

'Safety zones' should:

- Protect physician ventures including more than 20% of market's doctors.
- Liberalize classification of specialists considered competitors in ventures.
- Expand definition of 'risk sharing' to include doctors who hold equity in fee-for-service IPAs or PPOs.
- Protect 'price-related information' provided by doctors to purchasers.

NEWS
515 North State
Chicago IL 60610

#DXNBBNP**********F
#00157598408#9344 F1 01-

HON. HOWARD M METZENBAUM
SENATE OFFICE BUILDING
WASHINGTON, DC 20510

Antitrust

Continued from page 1

such a proposal last year as part of a multipart bid for antitrust relief. Justice and FTC officials never formally answered, but they have been quoted as rejecting any special treatment for medicine.

Agency officials declined comment on the latest proposal until they could prepare a formal response.

There also was no immediate White House response. But AMA leaders who have met with White House officials several times since the release of President Clinton's draft reform plan have repeatedly described them as "sympathetic" to medicine's antitrust concerns and willing to listen to AMA proposals.

Antitrust experts outside the AMA gave varied responses to the proposal. Some saw merit in the concerns expressed in the letter. Others believed that granting the AMA's requests would give doctors license to engage in anticompetitive activity.

Seller beware

"The president's plan does not call for a true competitive market," Johnson wrote. "It calls for competition on the seller side of the market, but would have virtually no competition on the buyer side. Instead, it would create a highly regulated health care system in which entities called 'health alliances' exercise monopsony power."

Under such a system, Johnson argued, doctors should be free to collaboratively negotiate with the alliance as a single entity, rather than through an array of competing health plans. As a model, the AMA suggests using the Negotiated Rulemaking Act of 1990, a law that outlines a preregulation negotiations process between federal agencies and the subjects of regulation.

Negotiations with doctors would would bring the United States more in line with other industrialized countries in which government exercises a high degree of control over health care, Johnson said. "These countries have a better record of cost control than does our market-based system."

But Johnson was quick to add that the AMA would still prefer a pure market solution to one built on regulation and negotiation.

"The Clinton plan would more closely approximate the operation of a competitive market if it required more than one alliance to operate in a given market, and if its provisions for employer opt outs were expanded," he said. If competition among buyers was assured, he said there would be no need for collective negotiation among providers.

Quality, access could suffer

Robert Bloch, a Washington, D.C., antitrust lawyer and former Justice Dept. official, agrees in part with Johnson.

"I agree that we should have multiple alliances and more opportunities for corporate alliances to form," he said. "If there is only one alliance in a market, there is a risk of monopsony [a buyer's monopoly] power that can have an anticompetitive effect."

Bloch warned of the risk in a special health reform issue of the *National Law Journal* published this month. He cautioned that an alliance with market power could drive prices down to such an extent that quality, innovation and access could suffer.

Conversely, he added, the monopsony power could backfire by forcing most providers out of the market and leaving the alliance at the mercy of a remaining health plan or network.

But Bloch stopped short of supporting physician involvement in regulatory systems that exist whether they like them or not.

Safety zones criticized

The negotiated rulemaking proposal is the most controversial aspect of the AMA letter. But the analysis also criticizes the federal safety zones created to encourage collaboration in health care and address the uncertainty that breeds antitrust fears among physicians contemplating such activity.

One of the six safety zones announced last month dealt with physician joint ventures such as PPOs and IPAs. The guideline said such ventures posed no antitrust risk if they included fewer than 20% of a market's physicians in a given specialty and if the venture featured adequate financial risk sharing — such as capitated payment or substantial fee withholds.

The AMA noted several concerns with this safety zone. First, the 20% threshold is more conservative than the government itself was using only a few years ago. It also fails to distinguish between exclusive arrangements and nonexclusive ventures, where doctors can deal independently or through other networks with purchasers.

The AMA letter proposes a two-tiered alternative to the 20% limit. For nonexclusive ventures, it says, up to half a market's doctors should be allowed to collaborate without fear of antitrust scrutiny. Ventures that tie physicians into full-time, exclusive contracts should have a 35% threshold — which, the letter contends, was fed-

See ANTITRUST, facing page

Antitrust

Continued from facing page

eral enforcement policy in the Reagan years.

Former Justice Dept. antitrust official Charles Rule is not sure a two-tiered safety zone could work. "A 50% threshold for nonexclusive ventures makes sense, but when you get into the issue of whether a venture is a *de facto* exclusive, the lines become blurred."

But he agreed on raising the threshold to 35%. "The concern is whether the physicians in a venture are in a position to exercise market power," said Rule, now a lawyer in private practice in Washington, D.C.

"If 65% or more of the market's physicians are not in the venture, there is very little likelihood that the 35% can inflict harm," he said.

Concerns about defining risk

The letter also reiterates AMA concerns about the government's narrow definition of risk-sharing within physician joint ventures.

In civil actions in recent years, the FTC and Justice have labeled PPOs or IPAs as anticompetitive "shams" if they did not incorporate capitation or fee withholds. But the AMA has repeatedly argued that holding a substantial equity stake in the venture should be viewed as risk sharing.

"Since the savings achieved by physician joint venture networks are ultimately derived from improvements in the clinical management of patients — not from the mode of compensation — we recommend that the statement place greater emphasis on creating efficiencies and less on the manner of compensation," the AMA letter says.

AMA associate general counsel Edward Hirshfeld added that the restrictive safety zone flies in the face of free market doctrine. "The stock market — and corporate America, for that matter — operates on the idea of pooling capital and risking loss. To exclude that activity and to say that the only way to pool risk is via a reimbursement mode is overly narrow."

Hirshfeld also called the safety zone on provision of information from physicians to buyers overly narrow. The guideline specifically excludes price-related information sharing.

The AMA argues that some courts have recognized the provision of such information, as long as it does not cross the line to become price-fixing or a boycott threat.

And Hirshfeld argues that the agencies added insult to injury in another safety zone by allowing hospitals to participate in the very activity that was proscribed for physicians.

But Boch, who during his Justice Dept. tenure prosecuted four Arizona dentists for providing price-related information to buyers, sees a clear distinction between the hospital and physician safety zones.

"The hospital guideline deals with historical price information that is aggregated by an objective third party," he says. "What is contemplated for physicians is the ability to communicate on future prices they will accept, which is far more dangerous."

Health plan sweetened for doctors

Boston Globe 10/30/93

Late change offers antitrust exemption

By Richard A. Knox
GLOBE STAFF

WASHINGTON – After months of internal debate, the Clinton administration decided this week, apparently at the 11th hour, to modify its health reform proposal to give doctors broad immunity from antitrust laws.

The changes allow physicians to exchange information on fees and to bargain collectively with regional health insurance purchasing groups on how much they would be paid for each service.

As news of the proposed antitrust exemption spread yesterday, officials at the American Medical Association and other leading physician groups were guardedly pleased, while consumer advocates and antitrust specialists expressed dismay about what they called the provision's anticonsumer implications.

"This is movement in the right direction," said Dr. Robert McAfee, a Maine surgeon who is president-elect of the 294,000 member AMA. "It might make us feel a bit warmer toward the proposal. I'm not sure whether it will translate to support."

"It sounds like it may have been a major concession to AMA," said Dr. Denman Scott of the American College of Physicians. A spokesman for the American Society of Internal Medicine called the provision "a significant loosening of the antitrust law" and "a surprising and positive development."

But Mark Silbergeld of Consumers Union, which publishes Consumer Reports magazine, warned that the change, if allowed to stand by Congress, would result in higher doctors' fees:

"If all of the doctors get together and discuss what fees they're going to ask for and present a united front, they're obviously going to aim as high as possible and not set prices at a competitive level," he said. "Letting doctors collude and bargain a single fee schedule is not consistent with cost control."

"This is essentially creating a loophole in the antitrust laws that physicians can drive a truck through," said a congressional aide, who asked not to be identified.

Under federal antitrust law, doctors are prohibited from colluding to fix prices. New guidelines issued in September loosened those restrictions to permit doctors to bargain [illegible] but only if no more than 20 percent of physicians in any market area take part.

The AMA, which is angling for the right for itself or its state and county affiliates to be bargaining agents for doctors, has argued for months that the law puts them at an unfair disadvantage confronting the anticipated clout of the health plans or "health alliances," the regional purchasing groups that the Clinton plan would set up.

The language of the 1,846-page Clinton health reform proposal permits national, state or county medical societies or specialty associations to negotiate on behalf of all their members in setting fee schedules.

If physicians are not happy with the outcome of negotiations, however, the Clinton proposal bars them from boycotting – withholding their services – or threatening to boycott.

To the AMA's disappointment, however, the Clinton proposal stops short of allowing doctors to bargain over other types of payment. For instance, there is no antitrust exemption allowing them to negotiate contracts with managed-care plans, such as health maintenance organizations or HMOs, that would pay them per subscriber rather than per service.

The AMA's general counsel, Kirk Johnson, last night called the provision "a quarter of a loaf" and said the physician group would lobby hard in Congress for broader antitrust exemptions. He pointed out that other nations, such as Germany and Canada, permit doctors to bargain collectively over payments within the framework of national health insurance.

Johnson, in a telephone interview, said the AMA has had White House assurances that President and Hillary Rodham Clinton support even broader immunity so physicians can bargain with health plans over all forms of payment, not just over fee schedules.

However, the AMA lawyer said, administration officials said they did not want to put more sweeping antitrust language in the proposal because of fierce opposition from House and Senate judiciary committees as well as strong internal resis-

The White House referred inquiries to the Justice Department, where an official, who asked not to be named, emphasized that the proposal limits doctors' antitrust exemption to bargaining on fee schedules, not other forms of payment. In answer to critics' concerns that this might "spill over" to other forms of collusion, the official said: "We believe we would be able to uncover and challenge spillover effects where they happen to exist."

The AMA also wants some remedy short of boycott in case doctors and health alliances or health plans reach an impasse.

Dr. Robert Graham, executive director of the American Academy of Family Physicians, said it is important for the Clinton proposal to permit collective bargaining for fee-for-service plans.

Much of the nation is too thinly populated to support competing managed care plans, Graham noted, so fee-for-service plans will dominate. In addition, the Clinton plan opens the door more widely than anticipated to multiple fee-for-service plans in each region; and it requires all HMOs to offer plans that allow subscribers to seek fee-for-service care.

But Graham said family practitioners have strong reservations about allowing the AMA to be their bargaining agent because its affiliates are often dominated by surgeons and other procedure-oriented specialists. "If you get in with a medical society group, you spend all the time negotiating fees for CAT scans and other procedures, and nobody wants to talk about the fee for an office visit," he said.

~~CONFIDENTIAL~~

DRAFT 8/23/93

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION
ANTITRUST ENFORCEMENT POLICY STATEMENTS
IN THE HEALTH CARE AREA

The Department of Justice and the Federal Trade Commission (the "Agencies") set forth below six statements of their antitrust enforcement policies regarding mergers and various joint activities in the health care area. The six policy statements address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment and services; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.

These policy statements are designed to provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers or joint ventures that would lower health care costs. Sound antitrust enforcement will continue to protect consumers against truly anticompetitive activities.

Antitrust analysis is inherently fact-intensive. The following policy statements give health care providers guidance, in the form of "antitrust safety zones," which describe the circumstances under which the Agencies will not

challenge conduct as violative of the antitrust laws as a matter of prosecutorial discretion. The statements also set forth an outline of the analysis the Agencies will use to review conduct which falls outside the "antitrust safety zones." 1/

The policy statements also set forth the Department's expedited business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions. The policy statements, for the first time, commit the Agencies to responding to requests for business reviews from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except hospital mergers outside the "antitrust safety zones." The Agencies make this commitment to swift and certain expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental and far-reaching change.

1/ These policy statements are intended to describe the Agencies' analysis of conduct falling outside the antitrust safety zones in understandable terms, not to restate or deviate from applicable law or policy statements.

1. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MERGERS AMONG HOSPITALS

Introduction

Most hospital mergers do not present competitive concerns, either because the merging hospitals are not significant competitors of each other, or because the merger allows the hospitals to realize significant cost savings. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers based on the Agencies' extensive experience analyzing hospital mergers and the developing empirical literature in this area. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. Antitrust Safety Zone: Mergers Of Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of

fewer than 40 patients averaged over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients may be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

B. The Agencies' Analysis Of Hospital Mergers That Fall Outside The Antitrust Safety Zone

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice-Federal Trade Commission 1992 Horizontal Merger Guidelines.

Applying the analytical framework of the Merger Guidelines to particular facts of specific hospital mergers, the Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects. Such situations include transactions where the Agencies found that: (1) the merger would not increase the likelihood of the exercise of market power either because of the existence post-merger of strong competitors or because the merging hospitals were sufficiently differentiated; (2) the merger would allow the hospitals to realize significant cost savings that could not otherwise be realized; or (3) the merger would eliminate a hospital that likely would fail with its assets exiting the market.

Antitrust challenges to hospital mergers are relatively rare. Of the more than 250 hospital mergers in the United States since 1987, the Agencies have challenged only six, and in most cases sought relief only as to part of the transaction. Most reviews of hospital mergers conducted by the Agencies are concluded within one month.

***

If hospitals are considering mergers that fall within the "antitrust safety zone" and believe they need additional certainty regarding the legality of their conduct under the antitrust laws, they can take advantage of the Department's business review procedure (28 C.F.R. § 50.6 (1992)) or the

Federal Trade Commission's advisory opinion procedure (16 C.F.R. §§ 1.1-1.4 (1993)). The Agencies will respond to business review requests on behalf of hospitals considering mergers that fall within the "antitrust safety zone" within 90 days after all necessary information is submitted.

2. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES TO PURCHASE, OPERATE AND MARKET HIGH-TECHNOLOGY MEDICAL EQUIPMENT AND SERVICES

Introduction

Most hospital joint ventures to purchase, operate and market high-technology or other expensive equipment do not create antitrust problems. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers. These efficiencies include the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase costs without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers. The Agencies have never challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical equipment.

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology (or other expensive) equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes the Agencies' antitrust analysis of hospital high-technology joint ventures that fall outside the antitrust safety zone. Finally, this statement includes examples of its application to hospital high-technology joint ventures.

A. Antitrust Safety Zone: Hospital High-Technology Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge under the antitrust laws any joint venture among hospitals to purchase, operate and market the services of high-technology (or other expensive) medical equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment, absent extraordinary circumstances. 2/ A joint venture that includes additional hospitals also will not be challenged if the additional hospitals could not support the equipment on their own or through the formation of a competing joint venture, absent extraordinary circumstances.

For example, if two hospitals are each unlikely to be able to recover the cost of individually purchasing, operating and marketing the services of a magnetic resonance imager (MRI) over its useful life, their joint venture with respect to the MRI would not be challenged by the Agencies. On the other hand, if the same two hospitals entered into a joint venture with a third hospital that independently could have purchased, operated, and marketed an MRI in a financially viable manner, the joint venture would not be in this antitrust safety zone.

2/ A hospital or group of hospitals will be considered able to support high-technology equipment for purposes of this antitrust safety zone if it could recover the acquiring, operating, and marketing costs of the equipment over its useful life.

If, however, none of the three hospitals could have supported an MRI by itself, the Agencies would not challenge the joint venture. 3/

Information necessary to determine whether the costs of a piece of high-technology medical equipment could be recovered over its useful life is normally available to any hospital or group of hospitals considering such a purchase. This information may include the cost of the equipment, its expected useful life, the minimum number of procedures that must be done to meet a machine's financial breakeven point, the expected number of procedures the equipment will be used for given the population served by the joint venture and the expected price to be charged for the use of the equipment. Expected prices and costs should be confirmed by objective evidence, such as experiences in similar markets for similar technologies.

B. The Agencies' Analysis of Hospital High-Technology Joint Ventures That Fall Outside the Antitrust Safety Zone

The Agencies recognize that joint ventures that fall outside the antitrust safety zone do not necessarily raise significant antitrust concerns. The Agencies will apply a "rule of reason" analysis in their antitrust review of such

---

3/ The antitrust safety zone described in this statement applies only to the joint venture and agreements reasonably necessary to the venture. It would not apply to or protect, for example, agreements made by participants in a joint venture that are related to a service not provided by the venture.

joint ventures. 4/ The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the services involved and of the hospital industry generally, and the reason for, and purposes of, the venture. It also allows for consideration of efficiencies that will result from the venture. The steps involved in a rule of reason analysis are set forth below. 5/

Step one: Define the relevant market. The rule of reason analysis first identifies the service that is produced through the joint venture. The relevant product and geographic markets that include the service are then properly defined. This process seeks to identify any other provider that could offer a service that patients or physicians generally would consider a

---

4/ This statement assumes that the joint venture is not likely merely to restrict competition and decrease output. For example, two hospitals that independently operate profitable MRI services could not avoid charges of price fixing by labelling as a joint venture their plan to obtain higher prices through joint marketing of their existing MRI services.

5/ For many joint ventures, it will be clear initially that the likelihood of competitive harm is small or that the venture will provide substantial efficiencies. In such cases, it will not be necessary to complete all steps in the analysis to conclude that the joint venture should not be challenged.

good substitute to that provided by the joint venture. Thus, if a joint venture were to purchase and jointly operate and market the services of an MRI, the relevant market would include all other MRIs in the area that could feasibly serve the same patients, but would not include providers with only traditional X-ray equipment.

Step two: Evaluate the competitive effects of the venture. This step begins with an analysis of the structure of the relevant market. If there are many providers that would compete with the joint venture, it is unlikely that competitive harm would result from the joint venture in the relevant market and the analysis would continue with step four described below.

If the structural analysis of the relevant market determined that the joint venture would eliminate an existing or potentially viable competing provider of a service and that there were few other competing providers of that service, it then would be necessary to assess the extent of the potential anticompetitive effects of the joint venture. In addition to the number of competing providers, other factors that could restrain the ability of the joint venture to raise prices either unilaterally or through collusive agreements with other providers would include: (1) regulatory restraints on price; (2) characteristics of the market that make anticompetitive agreements unlikely; and (3) the likelihood that new providers would enter the market and start providing the service.

The extent to which the joint venture restricts competition among or between the hospitals participating in the venture is evaluated during this step. In some cases, a joint venture to purchase high-technology equipment may not substantially eliminate competition between the hospitals in providing the service made possible by the equipment. For example, two hospitals might purchase a mobile MRI jointly, but operate and market MRI services separately. In such instances, the potential impact on competition of the joint venture would be substantially reduced. 6/

Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. In the case of high-technology medical equipment or services, efficiencies can be substantial because of the need to spread the cost of expensive equipment over a large number of patients and the potential for improvements in quality to occur as providers gain experience and skill from performing a larger number of procedures.

Step four: Evaluate ancillary agreements. This step determines whether the joint venture includes ancillary

---

6/ If steps one and two reveal no competitive concerns with the joint venture, step three is unnecessary, and the analysis continues with step four described below.

agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. For example, if the participants in a joint venture formed to purchase a mobile lithotripter also were to agree on the daily room rate to be charged lithotripsy patients who required overnight hospitalization, this ancillary agreement as to room rates would be unnecessary to achieve the benefits of the lithotripter joint venture. Although the joint venture itself would be legal, the ancillary agreement on hospital room rates would not be legal and would be challenged.

C. Examples of Hospital High-Technology Joint Ventures

The following are examples of hospital joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate the venture.

1. New Service That Can Be Offered Only By A Joint Venture

All the hospitals in a relevant market agree that they jointly will purchase, operate and market a helicopter to provide emergency transportation for patients. The need for helicopter services is not great enough to justify having more than one helicopter operating in the area and studies of similarly sized communities indicate that a second helicopter service could not be supported.

This joint venture falls within the antitrust safety zone. It would make available a service that would not otherwise be available, and for which duplication would be inefficient.

2. Joint Venture to Purchase Expensive Equipment

All five hospitals in a relevant market jointly agree to purchase a mobile lithotripter. Each will share equally in the cost of maintaining the equipment, and the equipment will travel from one hospital to another and be available one day each week at each hospital. The hospitals' agreement contains no provisions for joint marketing of, and protects against exchanges of competitively sensitive information regarding, lithotripsy services. 7/ There are also no limitations on the prices that each hospital will charge for lithotripsy services, on the number of procedures that each hospital can perform, or on each hospital's ability to purchase a lithotripter of its own. Although any combination of two of the hospitals could afford to purchase the equipment and recover their costs within the equipment's useful life, patient volume from all five hospitals is required to maximize the efficient use of the machine and lead to significant cost savings. In addition, patient demand would be satisfied by provision of the equipment one day each week at each hospital. The joint venture would

---

7/ Examples of such information include prices and marketing plans.

result in higher use of the equipment, thus lowering the cost per patient and potentially improving quality.

This joint venture does not fall within the antitrust safety zone because smaller groups of hospitals could afford to purchase and operate lithotripters and recover their costs. Therefore, the joint venture would be analyzed under the rule of reason. The relevant service would be lithotripsy services, and the five hospitals all potentially compete against each other for patients requiring this service. Although there are other procedures, such as surgery, that can be used to treat some patients, this example assumes that these procedures are not included in the relevant market because patients who receive lithotripsy services are unlikely to switch to other treatments in response to a price increase in lithotripsy services.

Because the joint venture is likely to reduce the number of lithotripters in the market, there is a potential restraint on competition. The restraint would not be substantial, however, for several reasons. First, the joint venture is limited to the purchase of the equipment and would not eliminate competition among the hospitals in the provision of lithotripsy services. Each hospital will market its services independently, and will not exchange competitively sensitive information. In addition, the venture does not preclude a hospital from purchasing another unit should the demand for these services increase. Because the joint venture raises some

competitive concerns, however, it is necessary to examine the potential efficiencies created by the venture. The joint venture would produce substantial efficiencies while providing access to high quality care. Thus, this joint venture would on balance benefit consumers since it would not lessen competition substantially, and it would allow the hospitals to provide a service in a more efficient manner. On these facts, the joint venture would not be challenged by the Agencies.

***

Hospitals that are considering high-technology or other expensive equipment joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a hospital high-technology joint venture within 90 days after all necessary information is submitted.

3. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PHYSICIANS' PROVISION OF INFORMATION TO PURCHASERS OF HEALTH CARE SERVICES

Introduction

The collective provision of information by competing physicians to a purchaser in an effort to influence the terms upon which the purchaser deals with the physicians does not necessarily raise antitrust concerns. Generally, physicians' collective provision of information other than fee-related information to a purchaser is likely either to provide procompetitive benefits or to raise little risk of anticompetitive effects.

This statement sets forth an antitrust safety zone that describes collective physician provision of information that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. 8/ It also describes conduct that is expressly excluded from the antitrust safety zone.

8/ This statement is limited to physicians' collective activities. Physicians acting individually may provide any information to any purchaser without incurring liability under federal antitrust law. Moreover, this statement is limited to the collective provision of information outside the scope of a joint venture. The exchange of information that necessarily occurs among physicians involved in joint venture activities generally does not raise antitrust concerns.

A. Antitrust Safety Zone: Physicians' Collective Provision Of Information That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

Physicians' collective provision of underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment is unlikely to raise any significant antitrust concern and will not be challenged by the Agencies, absent extraordinary circumstances. Thus, the Agencies will not challenge, absent extraordinary circumstances, a medical society's collection of outcome data from its members about a particular procedure that they believe should be covered by a purchaser and the provision of such information to the purchaser. The Agencies also will not challenge, absent extraordinary circumstances, physicians' development of suggested practice parameters--standards for patient management developed to assist physicians in clinical decisionmaking--which also may provide useful information to patients, physicians, and purchasers. Because physicians' collective provision of such information poses little risk of restraining competition and may help in the development of protocols that increase quality and efficiency, the Agencies will not challenge such activity, absent extraordinary circumstances.

Excluded from the antitrust safety zone is any attempt by physicians to coerce a purchaser's decisionmaking by implying or threatening a boycott of any plan that does not follow the physicians' joint recommendation. Physicians who collectively

threaten to or actually refuse to deal with a purchaser because they object to the purchaser's administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk. For example, physicians' collective refusal to provide X-rays to a purchaser that seeks them before covering a particular treatment regimen would present an antitrust violation. Similarly, physicians' collective attempt to force purchasers to adopt recommended practice parameters by threatening to or actually boycotting purchasers that refuse to accept their joint recommendation also would risk antitrust challenge.

Also excluded from the antitrust safety zone is physicians' collective provision of fee-related information to purchasers. Such conduct raises particular antitrust concerns because--unlike recommendations that may improve quality or efficiency--its most apparent value is to signal physicians' collective price demands. Competing physicians who agree on the fees that they would like to be paid and seek to negotiate those fees with a purchaser run a substantial antitrust risk, and an even greater risk if they threaten to or actually boycott a purchaser that does not accept their "suggested" fees. Antitrust liability may attach even without an express agreement to boycott a purchaser because physicians' collective provision of fees or fee schedules may result in an agreement on fees.

* * *

Competing physicians who are considering jointly providing information to a purchaser and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of physicians who are considering jointly providing information within 90 days after all necessary information is submitted.

4. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION

Introduction

Participation by competing hospitals in surveys of prices for hospital services, or surveys of salaries, wages or benefits of hospital personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Hospitals can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers also can use price survey information to make more informed decisions when buying hospital services. Without appropriate safeguards, however, information exchanges among competing hospitals may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of hospital services. A collusive restriction on the compensation paid to hospital employees, for example, could create personnel shortages that would adversely affect the availability of health care services.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among hospitals that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also

briefly describes the Agencies' method of analysis of information exchanges that fall outside the antitrust safety zone.

A. Antitrust Safety Zone: Exchanges of Price and Cost Information Among Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, by the Agencies

The Agencies will not challenge, absent extraordinary circumstances, hospital participation in written surveys of (a) prices for hospital services, 9/ or (b) wages, salaries or benefits of hospital personnel, if the following conditions are satisfied:

(1) the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);

(2) the information provided by survey participants is based on data more than 6 months old; and

(3) there are at least five hospitals reporting data upon which each disseminated statistic is based, no individual hospital's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular hospital.

The conditions that must be met for an information exchange among hospitals to fall within the antitrust safety zone are

---

9/ The "prices" at which hospitals offer their services to purchasers can take many forms, including billed charges for individual services, discounts-off billed charges, or per diem, capitated, or diagnosis related group rates.

intended to ensure that an exchange of price or cost data is not used by competing hospitals for discussion or coordination of hospital prices or costs. They represent a careful balancing between a hospital's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing hospitals to communicate with each other regarding a mutually acceptable level of prices for hospital services or compensation for employees.

B. The Agencies' Analysis of Hospital Exchanges of Information That Fall Outside The Antitrust Safety Zone

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Exchanges of future prices for hospital services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing hospitals of price or cost information results in an agreement among competitors as to the prices for hospital services or the wages to be paid to hospital employees, that agreement will be considered unlawful per se.

***

Competing hospitals that are considering participating in a survey of price or cost data and are unsure of the legality of

their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of hospitals who are considering exchanging information within 90 days after all necessary information is submitted.

5. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON JOINT PURCHASING ARRANGEMENTS AMONG HEALTH CARE PROVIDERS

Introduction

Most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns. Such collaborative activities typically allow the participants to achieve efficiencies that will benefit consumers. Joint purchasing arrangements usually involve the purchase of a product or service used in providing the ultimate package of health care services or products sold by the participants. Examples include the purchase of laundry or food services by hospitals, the purchase of computer or data processing services by hospitals or other groups of providers, and the purchase of prescription drugs and other pharmaceutical products. Through such joint purchasing arrangements, the participants frequently can obtain volume discounts, reduce transaction costs, and have access to consulting advice that may not be available to each participant on its own.

Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchases of a product or service that it can effectively exercise market power 10/ in the purchase of

---

10/ In the case of a purchaser, this is the power to drive down the price of goods or services being purchased below competitive levels.

the product or service, or (2) the products or services being purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns. 11/

This statement sets forth an antitrust safety zone that describes joint purchasing arrangments among health care providers that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes factors that mitigate any competitive concerns with joint purchasing arrangements that fall outside the antitrust safety zone. 12/

11/ An agreement among purchasers that simply fixes the price that each purchaser will pay or offer to pay for a product or service is not a legitimate joint purchasing arrangement and is a per se antitrust violation. Legitimate joint purchasing arrangements provide some integration of purchasing functions to achieve efficiencies.

12/ This statement applies to purchasing arrangements through which the participants acquire products or services for their own use, not arrangements in which the participants are jointly investing in equipment or providing a service. Joint ventures involving investment in equipment and the common provision of services are discussed in a separate policy statement.

A. Antitrust Safety Zone: Joint Purchasing Arrangements Among Health Care Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.

The first condition compares the purchases accounted for by a joint purchasing arrangement to the total purchases of the purchased product or service in the relevant market. Its purpose is to determine whether the joint purchasing arrangement might be able to drive down the price of the product or service being purchased below competitive levels. For example, a joint purchasing arrangement may account for all or most of the purchases of laundry services by hospitals in a particular market, but represent less than 35 percent of the purchases of all commercial laundry services in that market. Unless there are special costs that cannot be easily recovered associated with providing laundry services to hospitals, such a purchasing arrangement is not likely to force prices below competitive levels. The same principle applies to joint purchasing arrangements for food services, data processing, and many other products and services.

The second condition addresses any possibility that a joint purchasing arrangement might result in standardized costs, thus facilitating price fixing or otherwise having anticompetitive effects. This condition applies only where some or all of the participants are direct competitors. For example, if a nationwide purchasing cooperative limits its membership to one hospital in each geographic area, there is not likely to be any concern about reduction of competition among its members. Even where a purchasing arrangement's membership includes hospitals or other health care providers that compete with one another, the arrangement is not likely to facilitate collusion if the goods and services being purchased jointly account for a small fraction of the final price of the services provided by the participants. In the health care field, it may be difficult to determine the specific final service in which the jointly purchased products are used, as well as the price at which that final service is sold. 13/ Therefore, the Agencies will examine whether the cost of the products or services being purchased jointly accounts, in the aggregate, for less than 20 percent of the total revenues from all health care services of each competing participant.

13/ This especially is true because some large payers negotiate prices with hospitals and other providers that encompass a group of services, while others pay separately for each service.

B. Factors Mitigating Competitive Concerns With Joint Purchasing Arrangements That Fall Outside The Antitrust Safety Zone

Joint purchasing arrangements among hospitals or other health care providers that fall outside the antitrust safety zone do not necessarily raise antitrust concerns. There are several safeguards that joint purchasing arrangements can adopt to mitigate concerns that might otherwise arise. First, antitrust concern is lessened if members are not required to use the arrangement for all their purchases of a particular product or service. Members can, however, be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount or other favorable contract can be negotiated. Second, where negotiations are conducted on behalf of the joint purchasing arrangement by an independent employee or agent who is not also an employee of a participant, antitrust risk is lowered. Third, the likelihood of anticompetitive communications is lessened where communications between the purchasing group and each individual participant are kept confidential, and not discussed with, or disseminated to, other participants.

These safeguards will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health

care services offered by the participants. 14/ The adoption of these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose. Where there appear to be significant efficiencies from a joint purchasing arrangement, the Agencies will not challenge the arrangement absent substantial risk of anticompetitive effects.

The existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups currently are not great. Thus, in most circumstances at present, it is not necessary to open a joint purchasing arrangement to all competitors in the market. The exclusion from the arrangement of some competitors will raise antitrust concerns only if those who are excluded are put at a significant competitive disadvantage in competing with the participants.

* * *

Hospitals or other health care providers that are considering joint purchasing arrangements and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business

---

14/ Obviously, if the members of a legitimate purchasing group engage in price fixing or other collusive anticompetitive conduct as to services sold by the participants, whether through the arrangement or independently, they remain fully subject to antitrust challenge.

review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a health care provider joint purchasing arrangement within 90 days after all necessary information is submitted.

6. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES

Introduction

In recent years, many independent physicians and physician groups have organized individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and similar physician network joint ventures to market their services to health insurance plans and other purchasers. 15/ Typically, such ventures contract to provide physician services to plan subscribers at reduced prices, and commit to utilization review and other limits on the provision of unnecessary care. Because of their potential for providing quality services at reduced costs, IPAs, PPOs, and similar physician network joint ventures promise significant procompetitive benefits for consumers of health care services. 16/

15/ An IPA or PPO typically provides medical services to the subscribers of health insurance plans, but it does not act as the insurer of the subscribers. In addition, an IPA or PPO does not require complete integration of the medical practices of its member physicians. Such physicians typically continue to compete for patients who are enrolled in health insurance plans not served by the IPA or PPO.

16/ As used in this policy statement, a physician network joint venture is a physician-controlled venture that jointly markets the services of its member physicians.

This statement of enforcement policy sets forth an antitrust safety zone that describes physician network joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. 17/ It also describes the Agencies' antitrust analysis of physician network joint ventures that fall outside the antitrust safety zone. Finally, this statement presents examples of its application to physician network joint ventures.

A. Antitrust Safety Zone: Physician Network Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, a physician network joint venture comprised of 20 percent or less of the physicians in each physician specialty with active hospital admitting privileges who practice in the relevant geographic market 18/ and share substantial financial risk. In relevant markets with less than five physicians in a particular specialty, a physician network joint venture otherwise qualifying for the antitrust safety

---

17/ Although this statement refers to IPAs and PPOs as examples of physician network joint ventures, the Agencies' competitive analysis focuses on the substance of such arrangements, not on their formal title. This policy statement applies, therefore, to all entities that are substantively equivalent to a physician network joint venture.

18/ Generally, relevant geographic markets for the delivery of physician services are localized.

zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 20 percent of the physicians in that specialty. 19/

To qualify for the antitrust safety zone, physicians participating in a physician network joint venture must share substantial financial risk. The following are examples of situations in which substantial financial risks are shared by members of a physician network joint venture:

(a) when there is agreement to provide services to a health insurance plan at a "capitated" (or per subscriber) rate;

(b) provision by a physician network joint venture of financial incentives for its members to achieve cost-containment goals, such as withholding a substantial amount of the compensation due to its members, with distribution of that amount to members only if cost-containment goals are met; or

(c) the holding by members of a physician network joint venture of substantial ownership or equity interests in the health insurance plan with which the venture contracts.

The antitrust safety zone applies equally to "exclusive" and "non-exclusive" physician network joint ventures. An "exclusive" venture significantly restricts the ability of its members to affiliate with other physician network joint ventures and to contract individually with health insurance

---

19/ For purposes of this antitrust safety zone, in calculating the number of physicians in a relevant market and the number participating in a physician network joint venture, each physician ordinarily will be counted individually, whether the physician practices in a group or solo practice.

plans. A "non-exclusive" venture, on the other hand, does not impose any significant explicit or implicit restriction on the ability of its members to affiliate or contract with such other organizations.

B. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zone

Physician network joint ventures that fall outside the antitrust safety zone do not necessarily raise substantial antitrust concerns. Physician network joint ventures will be reviewed under a rule of reason analysis and not viewed as per se illegal 20/ either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies. A rule of reason analysis determines whether the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture. The rule of reason analysis is flexible, and takes into account all characteristics of the particular physician network joint venture that bear on its likely effect on competition. The

---

20/ This statement assumes that the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians that simply fixes the price that each purchaser will pay.

steps involved in a rule of reason analysis of physician network joint ventures are set forth below.

Step one: Define the relevant market. The rule of reason analysis first identifies the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty ordinarily will be considered a separate relevant service market, there may be instances in which significant overlap of services provided by different specialties of physicians justifies including physicians from more than one specialty in the same market. For each relevant service market, the relevant geographic market will include all physicians whom health insurance plans and their subscribers consider to be good substitutes for physicians participating in the joint venture.

Step two: Evaluate the competitive effects of the physician joint venture. The structure and activities of the physician network joint venture and the nature of competition in the relevant market are examined to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health insurance plans above competitive levels or prevent the formation of other physician network joint ventures that would compete with it.

If in the relevant market there are many other physician network joint ventures or many physicians who would be

available to form competing physician network joint ventures or be available to contract directly with health insurance plans, it is unlikely that the joint venture would raise any competitive concerns. In assessing the availability of physicians in the relevant market for forming competing physician network joint ventures, it will be necessary to analyze both the number of physicians in each relevant service market and the competitive significance of the exclusive or non-exclusive nature of the physician network joint venture. If a physician network joint venture is non-exclusive, the anticompetitive risks posed by such a venture may be substantially less than if the participating physicians had formed an exclusive physician network joint venture. 21/

Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. The potential of physician network joint ventures to generate efficiencies by lowering the costs of health care to consumers can vary substantially. Efficiencies that the Agencies are most likely to recognize include any cost savings associated with the assumption of

---

21/ If steps one and two reveal no competitive concerns with the physician network joint venture, step three is unnecessary, and the analysis continues with step four below.

financial risk by the participating physicians. The Agencies will also consider other possible efficiencies, such as reduced administrative costs and improved utilization review.

Step four: Evaluation of ancillary agreements. This step determines whether the physician network joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the physician network joint venture. For example, if the physicians participating in a joint venture agree on the prices they will charge patients who are not covered by the health insurance plans with which their joint venture contracts, such an agreement plainly is unnecessary to the success of the joint venture and is an antitrust violation. 22/

C. Examples of Physician Network Joint Ventures That The Agencies Would Not Challenge

The following are examples of physician network joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate such ventures under this policy statement.

22/ This analysis of ancillary agreements also applies to physician network joint ventures that fall within the antitrust safety zone.

1. Physician Network Joint Venture Comprising More Than 20 Percent Of Physicians with Active Admitting Privileges At a Hospital

County Seat is a relatively isolated, medium-sized community of about 350,000 residents. The closest town is 50 miles away. County Seat has five general acute care hospitals, which offer a mix of basic primary, secondary, and tertiary care services.

A total of 500 physicians have medical practices based in County Seat, and all maintain active admitting privileges at one or more of County Seat's hospitals. No physician from outside County Seat has any type of admitting privileges at a County Seat hospital. The physicians represent 10 different specialties and are distributed evenly among the specialties, with 50 doctors practicing each specialty.

One hundred physicians (also distributed evenly among specialties) maintain active admitting privileges at County Seat Medical Center. County Seat's other 400 physicians maintain active admitting privileges at other County Seat hospitals.

Half of County Seat Medical Center's 100 active admitting physicians propose to form an IPA to market their services to purchasers of health care services. The physicians are divided evenly among the specialties. Under the proposed arrangement, the physicians participating in the joint venture would agree to implement utilization review, quality assurance, and other measures designed to reduce the provision of unnecessary care

to the plan's subscribers, and a substantial amount of the compensation due to member physicians would be withheld and distributed only if these measures are successfully met. This physician network joint venture would be exclusive in that participating physicians would not be free to contract individually with health insurance plans or to join other physician joint ventures.

A number of health insurance plans that contract selectively with hospitals and physicians already operate in County Seat. These plans as well as local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active admitting physicians and the inpatient services provided at County Seat Medical Center. Physicians with medical practices based outside County Seat, however, are not good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

A key issue is whether a physician network joint venture, such as this IPA, comprised of 50 percent of the physicians in each practice specialty with active privileges at one of five comparable hospitals in County Seat would fall within the antitrust safety zone. The physicians within the joint venture represent less than 20 percent of all the physicians in each specialty in County Seat.

County Seat is the relevant geographic market for purposes of analyzing the competitive effects of this proposed physician joint venture. Within each specialty, physicians with admitting privileges at area hospitals are good substitutes for one another. However, physicians with practices based elsewhere are not considered good substitutes.

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have admitting privileges, to be relatively interchangeable. Thus, in this example, any attempt by the joint venture's participants collectively to increase the price of physician services above competitive levels would likely lead third-party payers to recruit nonparticipating physicians at County Seat Medical Center or other area hospitals.

Because physician network joint venture participants comprise less than 20 percent of each group of specialists in County Seat and because the physicians agreed to share substantial financial risk, this proposed joint venture would fall within the antitrust safety zone.

2. Physician Network Joint Venture With A Large Market Share In A Relatively Small Community

Smalltown has a population of 25,000, a single hospital, and 50 physicians, most of whom are family practitioners. All the physicians practice exclusively in Smalltown and have

active admitting privileges at the Smalltown hospital. The closest urban area, Big City, is located some 35 miles away and has a population of 500,000. A little more than half of Smalltown's working adults commute to work in Big City. Some of the health insurance plans used by employers in Big City are interested in extending their network of providers to Smalltown to provide coverage for subscribers who live in Smalltown, but commute to work in Big City (coverage is to include the families of commuting subscribers). However, the number of commuting Smalltown subscribers is a small fraction of the Big City employers' total workforce.

Responding to these employers' needs, a few health insurance plans have asked physicians in Smalltown to organize a nonexclusive IPA large enough to provide a reasonable choice to subscribers who reside in Smalltown, but commute to work in Big City. Because of the relatively small number of potential enrollees in Smalltown, the plans prefer to contract with such a physician network joint venture, rather than engage in what may prove to be a time-consuming series of negotiations with individual Smalltown physicians to establish a panel of physician providers there.

A number of Smalltown physicians have agreed to form a physician network joint venture. The joint venture will contract with health insurance plans to provide physician services to subscribers of the plans in exchange for a monthly capitation fee paid for each of the plans' subscribers. The

physicians forming this joint venture would constitute about half of the total number of physicians in Smalltown. They would represent about 35 percent of the town's family practitioners, but higher percentages of the town's general surgeons (50 percent), pediatricians (50 percent), and obstetricians (67 percent). The health insurance plans that serve Big City employers say that the IPA must have a large percentage of Smalltown physicians to provide adequate coverage for employees and their families in Smalltown and in a few scattered rural communities in the immediate area and to allow the doctors to provide coverage for each other.

In this example, other health insurance plans already have entered Smalltown, and contracted with individual physicians. They have made substantial inroads with Smalltown employers, signing up a large number of enrollees. None of these plans has had any difficulty contracting with individual physicians, including many who would participate in the proposed joint venture.

Finally, the evidence indicates that Smalltown is the relevant geographic market for all physician services. Physicians in Big City are not good substitutes for a significant number of smalltown residents.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would be comprised of over 20 percent of the physicians in a number of

relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health insurance plans to contract individually with area physicians or with other physician network joint ventures. In addition, the joint venture is likely to result in cost savings because the physicians have agreed to accept capitated fees. Under a capitated reimbursement system physicians have incentives to provide quality care in a cost-effective manner.

That health insurance plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to be a low-cost method for plans to enter an area without investing in costly negotiations to identify and contract with individual physicians.

Moreover, in small markets such as Smalltown, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollees. For instance, if there were only three obstetricians in Smalltown, it would not be possible for a physician network joint venture offering obstetrical services to have less than 33 percent of the obstetricians in the relevant area. Furthermore, it may be impractical to have less than 67 percent in the plan, because two obstetricians may be needed in the venture to provide coverage for each other.

Despite the joint venture's relatively large market share of some specialists, it appears unlikely to have anticompetitive effects because of three factors: the demonstrated ability of health insurance plans to contract with physicians individually, if they so desire; the possibility that other physician network joint ventures could be formed; and the benefits that health insurance plans perceive in obtaining the coverage provided by this physician network joint venture. Therefore, the Agencies would not challenge this physician network joint venture.

* * *

Physicians who are considering forming joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchange programs announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a physician network joint venture within 90 days after all necessary information is submitted.

SUGGESTED REVISION OF 8/6/93 DRAFT
(Pages 177-178)

ANTITRUST

The antitrust laws serve an important function in the new health care system, enforcing rules of competition critical to the efficient operation of the new system.

While the vigorous enforcement of the antitrust laws is important, in several areas legitimate concerns exist about the need for greater clarity concerning enforcement policy and the ability of some health care providers to be sure their conduct comports with sound antitrust rules.

HOSPITAL MERGERS

Hospitals smaller than a certain size, as measured, for example, by number of beds or patient census, require certainty that they will not be challenged by the federal government if they attempt to merge. Such hospitals often are sole community providers that do not compete with other hospitals.

The Department of Justice and the Federal Trade Commission publish guidelines that provide safety zones for such mergers and an expedited business review or advisory opinion procedure through which the parties to such mergers can obtain timely (i.e., within 90 days) additional assurance that their merger will not be challenged. Guidelines also will provide the analysis the agencies use to evaluate mergers among larger hospitals.

HOSPITAL JOINT VENTURES AND PURCHASING ARRANGMENTS

Hospitals may enter into joint ventures involving high technology or expensive equipment and ancillary services, as well as joint purchasing arrangements involving the goods and services they need.

The Department of Justice and the Federal Trade Commission publish guidelines that provide safety zones for such joint ventures and arrangements, examples of ventures that would not be challenged by the agencies, and an expedited business review or advisory opinion procedure through which the parties to joint ventures can obtain timely (i.e., within 90 days) advice and assurance as to whether ventures that do not fall with the safety zones will be challenged.

PHYSICIAN NETWORK JOINT VENTURES

Physicians require additional guidance regarding the application of the antitrust laws to their formation of physician networks that would negotiate effectively with health plans.

The Department of Justice and the Federal Trade Commission publish guidelines that provide safety zones for physician network joint ventures that do not possess market power (below 20 percent) and that share financial risk, examples of networks that would not be challenged by the agencies, and an expedited business review or advisory opinion procedure through which the parties to networks that do not fall within the safety zones can obtain timely (i.e., within 90 days) advice and assurance as to whether their network will be challenged.

STATE ACTION IMMUNITY

(No change from 8/6/93 draft)

McCARRAN-FERGUSON

(No change from 8/6/93 draft)

SUGGESTED REVISION OF 8/6/93 DRAFT
(Page 55)

STATE REGULATION OF PLANS

States qualify health plans to participate in alliances. Each state establishes a mechanism to assess the quality of health plans, their financial stability and capacity to deliver the comprehensive benefit package to the proper geograhic market of each plan. States will disclose the criteria that each health plan must satisfy to become qualified. Health plans which satisfy those criteria shall be qualified. Only plans qualified by the state may offer health coverage through alliances.

American Medical Association
Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

August 12, 1993

The Honorable Anne K. Bingaman
Assistant Attorney General
Antitrust Division
Department of Justice
10th and Constitution Avenue, NW
Room 3101
Washington, DC 20503

Dear Anne:

We appreciated the opportunity to meet with you on August 2 to discuss the application of antitrust policy in the health care sector. We commend your interest in clarifying the antitrust rules for physicians and hospitals. In her speech to the AMA's House of Delegates in June, Mrs. Clinton offered the medical profession a new bargain in which physicians would more aggressively manage their peers in return for freedom from insurance company interference in the physician patient relationship. Ira Magaziner has also promised antitrust relief for physicians in the President's health care reform plan. We are pleased that you will play a critical role in developing antitrust policy that takes account of the importance of competition in advancing the health system reform agenda of the Clinton administration.

Antitrust policy with regard to physicians should reflect five important aspects of the health care delivery system: 1) Physicians act as both providers of medical services and advocates for their patients regarding insurance company decisions on coverage, medical necessity and payment policies; 2) The health care market is undergoing radical transformation. Large entities increasingly dominate health care insurance and delivery and they are contracting with large employers to control huge patient bases; 3) Physicians, who predominantly practice in small groups and have comparatively few capital and management resources, are greatly disadvantaged in this market; 4) Large buyers and alliances of buyers of health care also are forming and exercising substantial leverage in the marketplace; 5) The threat of antitrust litigation continues to impede the ability of the profession to regulate itself.

We would ask that in formulating antitrust policy as applied to physicians, you expressly reaffirm at least four important principles:

1. Absent a boycott, the antitrust laws do not prevent physicians from collectively advising payers on coverage, medical policy, and payment matters. Enforcing the antitrust laws to stifle the collective presentation of views would undermine the role of physicians as advocates for good medical care. It would thereby impede the Administration's goal of maintaining the quality while reducing the costs of health care. In United States v. Alston, 974 Fed. 2d 1206, 1214 (9th Cir. 1992), the Ninth Circuit Court of Appeals found that in light of the collective power of large insurance plans "individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans..."

2. The antitrust laws do not prevent physicians from engaging in good faith peer review of medical practices and fee levels that may harm or exploit patients. On the contrary, such peer review promotes competition by encouraging physicians to provide quality care at market prices. It also helps assure that patients will not receive inadequate care and will not pay more than they should in a competitive market. We continue to wait for the Federal Trade Commission to grant us even the simple authority to discipline known fee gougers. We are attaching under separate cover the provisions of Congressman Archer's bill which deal in general terms with the problem.

3. The antitrust laws do not prevent physicians from jointly marketing their services at specified prices as long as payers are free to reject their proposals and to deal with physicians individually. In these circumstances, joint marketing efforts -- even in the absence of risk sharing — simply inject an additional competitive alternative into the market. This alternative is important in efficiently making available to managed care plans networks of physicians that will be needed to meet the medical needs of enrollees. As Charles Rule stated as Assistant Attorney General for the Antitrust Division in 1988:

> "While the competitive benefits of HMOs and PPOs are generally recognized, some have at times been far too hostile, in my opinion, to provider-controlled organizations that do not entail a very high degree of integration. For example, it has been suggested that in order to form a legitimate PPO, the providers must contribute capital and share a substantial degree of the risk of adverse financial results. The Department believes that PPOs can achieve substantial procompetitive benefits through integration that falls far short of financial participation and sharing of risks." (March 11, 1988, Conn. State Bar Assn).

4. The antitrust laws are as concerned with monopsonization as they are with monopolization. For this reason, the Division should carefully monitor the actions of payers with significant market power to determine whether they are driving price or quality below competitive levels. Moreover, the Division should permit physicians to level the playing field by negotiating collectively with powerful payers in defined circumstances.

In light of these four principles, the AMA urges you to take the following actions:

-- Issue a clear statement that physicians may lawfully join together to advise payers on coverage, policy, and payment issues as long as the physicians do not threaten or engage in a boycott.

-- Support legislation that would (a) establish physician review committees within managed care plans to provide clinical judgments on medical policies, quality assurance efforts, grievance mechanisms, and certain administrative and financial matters and (b) permit physicians to serve on such committees without fear of antitrust liability if they do not threaten or engage in a boycott.

-- Issue a clear statement that physicians may jointly market their services at an agreed-upon fee level even with no risk sharing -- as long as the physicians lack market power and the purchasers are free to deal with each physician individually.

-- Take aggressive action against monopsonization, and support legislation that would permit physicians to form negotiating groups to bargain collectively with purchasers who control 35% or more of the market as long as any group does not represent more than 20% of the physicians in the community or any specialty.

-- Where the purchaser or purchasing pool amounts to a single payer, as in Medicare, support negotiated rulemaking with the profession as a whole.

We submit that these actions would be in accord with the antitrust laws and are critical to the successful implementation of health system reform as envisioned by the White House Task Force. We have previously forwarded to you our detailed specifications.

We look forward to continuing our discussions about antitrust policy in the health care sector to establish new, clearer guidelines. We would be happy to arrange within the next few weeks a working session in which other health care antitrust experts sat down with you and us to objectively work on guidelines.

Finally, let us reiterate the willingness of the AMA to suggest medical forums in which you could outline antitrust policy to physicians.

Sincerely,

James S. Todd MD

James S. Todd, MD
Executive Vice President

Kirk B. Johnson, JD
Senior Vice President and General Counsel

ANTITRUST REFORM

Competition plays an important role in making health care affordable to all consumers. In many circumstances, competition can be promoted by mergers, joint ventures, and other cooperative activities among hospitals and other health care providers.

The Justice Department and the Federal Trade Commission, which enforces antitrust laws, are working to reduce uncertainty regarding the application of antitrust laws to these activities. This will make it easier for the health care community to collaborate and undertake cooperative cost saving initiatives. For example, lower health care costs could be achieved through mergers of small, inefficient hospitals or joint purchases by hospitals of expensive equipment such as MRI machines.

Sound antitrust enforcement will continue to protect consumers against truly anti competitive activities that lead to higher prices.

Clarifies Antitrust Policy

- For the first time, the Justice Department and the Federal Trade Commission have issued antitrust enforcement policy statements for a specific industry.

- The six policy statements will help alleviate uncertainty within the industry by helping hospitals and health care providers know whether they can enter into mergers and joint ventures without violating antitrust laws. This will make it easier for mergers and joint ventures to take place, resulting in lower health care costs.

Defines Safety Zone

- The policy statements provide antitrust "safety zones" which describe circumstances under which the Justice Department and the FTC will not challenge:

  -- Hospital mergers;

  -- Hospital joint ventures involving high-technology or other expensive medical equipment;

-- Physicians' provision of information to purchasers of health care services;

-- Hospital participation in exchanges of price and cost information;

-- Joint purchasing arrangements among health care providers; and

-- Physician network joint ventures.

Expedites Businesses' Reviews

- The Department of Justice and the Federal Trade Commission have committed to an expedited business review procedure.

- The agencies will provide responses within 90 days, after all necessary information is received, to companies seeking guidance on health care joint ventures and information exchanges.

October 8, 1993

U.S. DEPARTMENT OF JUSTICE
ANTITRUST DIVISION
(OFFICE OF THE ASSISTANT ATTORNEY GENERAL)
(OFFICE OF THE DEPUTY ASSISTANT ATTORNEY GENERAL)
10th & Constitution Avenue, NW
Washington, DC 20530

FAX TRANSMITTAL SHEET/PLEASE DELIVER IMMEDIATELY
If you do not receive all the pages, please call (514-2401).

DATE: 10/14 **TIME:** _____ am/pm

TO: Melanne Verveer

Phone: 456-6266

Fax: 456-6244

FROM: ANNE K. BINGAMAN

Assistant Attorney General

Antitrust Division

Phone: (202) 514-2401

Fax: (202) 616-2645

No. of Pages: 5 (*excluding* transmittal page)

COMMENTS:

ANNE K. BINGAMAN

October 14, 1993

Spr. TAB
DOJ

VIA FAX

Melanne Verveer
Office of the First Lady
The White House
Washington, DC 20500

Dear Melanne:

I have looked closely at the language which you and Greg Lawlor suggested on Tuesday afternoon when I was out of town. We have redrafted your language in a manner which is preferable on Exhibit A, hereto. My thoughts are as follows:

I have been in several hours of meetings with Dr. Todd and Kirk Johnson, General Counsel of the AMA, and they have made the point repeatedly that the fee for service doctors do not want to boycott, or threaten to boycott, but simply want the ability to present their views collectively on fees. Indeed, I don't think they could credibly make an argument that they want to be able to boycott.

Accordingly, we have included language which contains a proviso, that nothing in this bill should be construed to permit a boycott. This is an important point to include, and there should be no difficulty with the AMA on this matter. It will also go very far toward assuring Senator Metzenbaum and the FTC, who will have incredible concerns if the proviso exempting boycotts is not included.

Also, in Exhibit A, hereto, I have changed the "negotiate" language to "make presentations to" and "discuss with" regional alliances the fee schedules. I have done this because the very word "negotiate" implies the process of offer and acceptance, bargaining, and mutual agreement. If the alliances are analogized to a state regulatory agency which sets prices, then the "negotiate" language is not applicable and makes no sense. What the word "negotiate" implies very strongly as a legal matter is if that agreement cannot, for some reason, be reached--i.e., if the doctors don't explicitly

accept the rate being proposed by the alliances--then there is no rate until all sides have agreed. I don't think this is what the Administration wants, and I don't think it is what the doctors have asked for, certainly never to me in my several meetings with them.

All that Dr. Todd and Kirk Johnson say that they want is the ability to make their case to the state alliances on a collective basis. If the state alliances are state agencies, this would be protected by the Noerr-Pennington doctrine, because any party can petition a government agency, as a matter of the First Amendment. Therefore, this is a completely defensible exercise of the fee for service doctors' First Amendment rights to petition a government body, and is completely acceptable on antitrust grounds.

If the word "negotiate" is used, however, it implies strongly--indeed, in effect says--that no rate can be set unless the doctors agree to it. I think this will cause tremendous problems with Senator Metzenbaum and the FTC, because the word "negotiate" is freighted with meaning in antitrust law. We have taken out some of the sting by adding the proviso about boycott, which is critically important, but my best political advice to the President and The First Lady is that the revised language we have added on Exhibit A, which is couched in terms of presentations to the alliances and collective discussions with the alliances, is infinitely more saleable as a matter of political reality on the Hill and with the FTC, and has absolutely no difference in meaning.

In short, the word "negotiate" is a serious problem, and if you are giving the doctors the ability to boycott as part of that, that is even a more serious problem.

I wanted to give you these revisions because I know how important and urgent this is. It is my best advice to the President to go with the draft on Exhibit A, for both legal and political reasons.

From all I have been told by the AMA, the language in Exhibit A gives them precisely what they seek, which is the right to make collective presentations and collectively discuss the fees that they should obtain, but without the right to boycott.

ANNE K. BINGAMAN

I cannot believe that Dr. Todd and Kirk Johnson will look you in the eye and tell you they want the right to boycott.

I have also enclosed, as Exhibit B, language containing the word "negotiate" but also includes the boycott proviso. I want to emphasize that the language on Exhibit A is my best advice, but at the very least the changes reflected in Exhibit B are necessary.

Please feel free to call me at the office or home to talk about this if you want to. I am available anytime. I know how hectic things are and I want to get this word to you immediately.

I am meeting Greg Lawlor at 4:00 p.m. today to tell him the same thing.

My office number is 514-2401; the home number is 202-363-8493.

Thanks a million. We are your loyal supporters here, and are doing our best to give you our best advice, and we know the incredible stress you are operating under. You are doing a terrific job.

Very best.

Sincerely,

Anne

Anne K. Bingaman

EXHIBIT A

° Suggested substitute for paragraph (2), page I.D.-23, 10/6-Revised Draft:

(2) PRESENTATION BY AND DISCUSSION WITH PROVIDERS. -- The fee schedule under paragraph (1) shall be established after presentations by and discussions with providers, and, subject to paragraph (5), providers may collectively make presentations regarding the fee schedule to and discuss the fee schedule with the regional alliance.

° Suggested substitute for paragraph (5), page I.D. 24, 10/6-Revised Draft:

(5) ACTIVITIES TREATED AS STATE ACTION. -- The establishment of a fee schedule under this subsection by a regional alliance of a state shall be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and actively supervised by the State, and conduct by providers respecting the establishment of the fee schedule, including collective presentations to and discussions with the regional alliance pursuant to paragraph (2), shall be considered as efforts intended to influence governmental action; provided, that nothing in this subsection shall be construed to permit providers to threaten or engage in any boycott.

* * *

We understand that the PROVIDER COLLABORATION and PROVIDER FEE SCHEDULE NEGOTIATION paragraphs in the ANTITRUST REFORM section of the Plan (9/7 draft) are being deleted. We suggest the following one-paragraph substitute for the STATE ACTION IMMUNITY paragraphs in the 9/7 draft:

STATE ACTION IMMUNITY

Guidelines interpreting the "state action doctrine" where a state seeks to grant antitrust immunity to hospitals and other institutional health care providers will be published.

* * *

We also suggest that the ANTITRUST REFORM section in the Plan be entitled simply "ANTITRUST."

EXHIBIT B

° Suggested addition to paragraph (2), page I.D.-23, 10/6-Revised Draft (addtional language underlined):

(2) NEGOTIATION WITH PROVIDERS. -- The fee schedule under paragraph (1) shall be established after negotiations with providers, and, subject to paragraph (5), providers may collectively negotiate the fee schedule with the regional alliance.

° Suggested substitute for paragraph (5), page I.D. 24, 10/6-Revised Draft:

(5) ACTIVITIES TREATED AS STATE ACTION. -- The establishment of a fee schedule under this subsection by a regional alliance of a state shall be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and actively supervised by the State, and conduct by providers respecting the establishment of the fee schedule, including collective negotiations by providers with the regional alliance pursuant to paragraph (2), shall be considered as efforts intended to influence governmental action; provided, that nothing in this subsection shall be construed to permit providers to threaten or engage in any boycott.

* * *

We understand that the PROVIDER COLLABORATION and PROVIDER FEE SCHEDULE NEGOTIATION paragraphs in the ANTITRUST REFORM section of the Plan (9/7 draft) are being deleted. We suggest the following one-paragraph substitute for the STATE ACTION IMMUNITY paragraphs in the 9/7 draft:

STATE ACTION IMMUNITY

Guidelines interpreting the "state action doctrine" where a state seeks to grant antitrust immunity to hospitals and other institutional health care providers will be published.

* * *

We also suggest that the ANTITRUST REFORM section in the Plan be entitled simply "ANTITRUST."

We all know that change in our health care system is underway. Hospitals and other providers see it every day.

The economic and competitive pressures are intense. And those pressures will continue.

Reform of our health care system will not eliminate those pressures; it will direct them so that the current system of high quality care will be maintained in an environment where the incentive is to reduce the cost of health care.

I have heard repeatedly from hospitals around the country how their efforts to become more competitive have been frustrated. One of the frustrations has been the threat of antitrust prosecution.

Time and again, expensive opinions from law firms couldn't guarantee no antitrust prosecution when hospitals wanted to merge, share high technology equipment, or form a purchasing cooperative.

Time and again, I have heard that hospitals were frustrated because they couldn't get a quick and reliable answer from the antitrust agencies.

Those frustrations have been heard. We need to provide certainty and reduce the barriers to competition and efficiency.

The Justice Department, under the able leadership of Anne Bingaman, the new head of the Antitrust Division, is in the process of developing and publishing clear and comprehensive guidelines for mergers, networks, joint ventures, purchasing cooperatives and information exchanges.

In addition, they will soon have in place an expedited review process for antitrust opinions. Within 90 days of submitting a request, a hospital would know whether its deal would pass muster. And, if not, why not.

We are committed to making our health care system work better -- for consumers, for hospitals, for everyone. It is not an easy road ahead of us, but we can make these kind of changes if we share a common goal and understanding of the need for change.

From Metzenbaum

SUGGESTED ADDITION TO
MRS. CLINTON'S SPEECH TO AHA, AUGUST 9, 1993

ANTITRUST REFORM

HEALTH CARE REFORM IS TOO IMPORTANT TO THE AMERICAN PEOPLE TO LET ANY KIND OF UNCERTAINTY SLOW IT DOWN. SO, WE LISTENED INTENTLY WHEN YOU TOLD US THAT UNCERTAINTY SURROUNDING ENFORCEMENT OF THE ANTITRUST LAWS WAS A PROBLEM FOR AMERICA'S HOSPITALS.

YOU TOLD US THAT PROCOMPETITIVE DEALS AMONG HOSPITALS WERE BEING CHILLED BY FEAR OF ANTITRUST PROSECUTION. HOSPITALS HAD COME TO BELIEVE THAT EXPENSIVE LEGAL OPINIONS WOULD BE REQUIRED ANY TIME THEY WANTED TO MERGE, SHARE HIGH TECHNOLOGY EQUIPMENT OR FORM A PURCHASING COOPERATIVE. YOU ALSO TOLD US THAT HOSPITALS WERE FRUSTRATED BECAUSE THEY COULDN'T GET QUICK AND RELIABLE ADVICE FROM THE ANTITRUST AGENCIES.

THE ADMINISTRATION HEARD YOU LOUD AND CLEAR. AND, SO DID SENATOR HOWARD METZENBAUM, WHO CHAIRS THE SENATE JUDICIARY COMMITTEE'S ANTITRUST SUBCOMMITTEE. HIS ANTITRUST HEARINGS AND THOSE OF SENATOR ROCKEFELLER, AS WELL AS THE WORK OF THE TASK FORCE, MADE IT CLEAR THAT WE HAD TO DO SOMETHING TO DISPEL MISPERCEPTIONS THAT WERE DISCOURAGING COOPERATION AMONG HOSPITALS.

THIS ADMINISTRATION IS COMMITTED TO REMOVING OBSTACLES TO HEALTH CARE REFORM. SO TODAY I AM PLEASED TO ANNOUNCE THAT AT THE URGING OF SENATOR METZENBAUM, THE ADMINISTRATION AND THE AHA HAVE AGREED TO MOVE AHEAD AND REMOVE ANTITRUST UNCERTAINTY AS A ROADBLOCK TO HEALTH CARE REFORM.

I HAVE DIRECTED OUR NEW, AND EXTRAORDINARILY CAPABLE ANTITRUST CHIEF, ANNE BINGAMAN, TO DEVELOP AND TO PUBLISH CLEAR AND COMPREHENSIBLE GUIDELINES FOR MERGERS, NETWORKS, JOINT VENTURES, PURCHASING COOPERATIVES AND INFORMATION EXCHANGES.

IN ADDITION, I HAVE ASKED MS. BINGAMAN TO INITIATE AN EXPEDITED REVIEW PROCESS FOR ANTITRUST OPINIONS ON HOSPITAL DEALS. WITHIN 90 DAYS OF SUBMITTING A REQUEST FOR AN ANTITRUST OPINION, A HOSPITAL WOULD KNOW WHETHER ITS DEAL WOULD PASS MUSTER AND, IF NOT, WHY NOT.

I AM ALSO COMMITTED TO JOINING THE FEDERAL TRADE COMMISSION IN THIS EFFORT. THERE SHOULD BE A SINGLE SET OF CLARIFYING GUIDELINES FOR HOSPITALS DEALS AND A 90-DAY TURN AROUND FOR OPINION LETTERS REGARDLESS OF WHICH ENFORCEMENT AGENCY REVIEWS IT.

WITH THESE GUIDELINES, YOU WILL HAVE A CLEAR ROAD MAP FOR PERMISSIBLE DEALS. WITH EXPEDITED REVIEW, YOU WILL GET TIMELY ANSWERS WHEN YOU REMAIN IN DOUBT ABOUT A PARTICULAR DEAL

FOR: Melanie Vernon

EYES ONLY

HIGHLY CONFIDENTIAL

DRAFT VERSION

OF

DOJ ANTITRUST

HEALTH CARE ENFORCEMENT

POLICY STATEMENTS

PLEASE DO NOT COPY

OR DISTRIBUTE TO ANYONE

ANNE K. BINGAMAN

Friday 8-6-93
4:15 pm

Hi Melanne —

Here is a short summary of the Antitrust Health Care Guidelines. The 2-page version could be inserted in Hillary's ~~AG~~ speech for Monday, if desired. The 6-page version gives an idea of the substance and is easier to read than the

ANNE K. BINGAMAN

longer version I sent yesterday.

We work for the President and First Lady, so use as you see fit!

Talk to you soon —

Very best,

Anne

FOR: Melanie Vernon

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: Rick DATE: 04/29/13
2013-0534-S

EYES ONLY

~~HIGHLY CONFIDENTIAL~~

DRAFT VERSION

OF

DOJ ANTITRUST

HEALTH CARE ENFORCEMENT

POLICY STATEMENTS

PLEASE DO NOT COPY

OR DISTRIBUTE TO ANYONE

ANNE K. BINGAMAN

Friday 8-6-93
4:15 pm

Hi Melanne —

Here is a short summary of the Antitrust Health Care Guidelines. The 2-page version could be inserted in Hillary's ~~AAG~~ speech for Monday, if desired. The 6-page version gives an idea of the substance and is easier to read than the

ANNE K. BINGAMAN

Longer version I sent yesterday.

We work for the President and First Lady, so use as you see fit!

Talk to you soon —

Very best,

Anne