U.S. Department of Justice

Antitrust Division

[4843b]

Washington, D.C. 20530

DATE 8/3/94

TO: Jennifer Klein FAX # 456-2878

PHONE # 456-2599

FROM:

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COMMENTS: Per our conversation yesterday.

TOTAL PAGES TRANSMITTED: 5 (EXCLUDING TRANSMITTAL SHEET)

PANAFAX NO. 202-514-9082

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

July 29, 1994

Anne K. Bingaman
Assistant Attorney General
Antitrust Division
United States Department of Justice
Washington, D.C. 20530

Re: Health Care Policy Statements

Dear Ms. Bingaman:

I am writing to urge the Department to update and expand the Statements of Antitrust Enforcement Policy in the Health Care Area that it issued last September jointly with the Federal Trade Commission ("FTC"). As you know, I have been a strong advocate for providing antitrust guidance to the health care community. I was enormously impressed with the policy statements issued by the Antitrust Division and the FTC last September. They dealt with pressing issues that had created antitrust confusion among health care providers and could have chilled new and innovative health care deals among hospitals and other providers. The policy statements were of great benefit to health care providers when they were issued last September, and I believe that updating and expanding them as soon as possible is needed to continue that progress.

Three separate groups have contacted me with their concerns about the policy statements. First, the American Hospital Association (with which I have worked cooperatively since it first raised the issue of antitrust guidance) has indicated that there are four additional areas in which hospitals require antitrust guidance in the near future. They are multi-provider network formation and operation; joint ventures for services and existing equipment; efficiency considerations in mergers and joint ventures; and application of the state action doctrine to deals involving hospitals. I feel confident that the Antitrust Division will be able to provide speedy additional guidance to hospitals in these areas through policy statements.

Second, I have also been contacted by a number of non-physician providers. They have requested that the policy statements be revised to specify that they apply to deals involving nurses, nurse-anesthetists, optometrists and other non-physician providers. This seems to be a request that can be accommodated easily.

Third, I have been contacted by a number of my colleagues

about expanding the policy statements to address the special needs of rural hospitals and other providers. Rural providers have requested that additional illustrative examples be included in the policy statements to deal with the antitrust questions that arise in sparsely populated areas of the country, including small towns. They have also requested that the Antitrust Division and the FTC develop a plan to disseminate more widely the updated policy statements among rural providers. That could be accomplished in a variety of ways, including closer coordination with the Department of Health and Human Service's Office of Rural Health. However, I would appreciate any other recommendations that you might have on ways to get the policy statements into the hands of more rural providers.

Thank you for your assistance with this matter. I look forward to working with you on updated and expanded policy statements for health care providers.

Sincerely,

Howard M. Metzenbaum
Chairman,
Subcommittee on
Antitrust, Monopolies &
Business Rights

CC: George J. Mitchell
Edward M. Kennedy
Patrick J. Leahy
Thomas A. Daschle
Tom Harkin
James M. Jeffords
John H. Chafee

U.S. Department of Justice

Antitrust Division

DRAFT

Office of the Assistant Attorney General *Washington, D.C. 20530*

The Honorable Howard M. Metzenbaum
Chairman
Subcommittee on Antitrust, Monopolies
and Business Rights
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter of July 29, 1994, in which you urge the Department to update and expand the Statements of Antitrust Enforcement Policy in the Health Care Area that it issued jointly with the Federal Trade Commission in September 1993. As your letter reflects, those policy statements dealt with a number of issues that had been identified by the health care community and the agencies as warranting guidance to dispel unwarranted antitrust uncertainty that may be deterring mergers, joint ventures, and other joint conduct that does not present serious competitive problems. Indeed, such activities may significantly further the goals of improving health care quality and access at lower costs, increasing innovation and efficiency, and reducing costs in the health care sector.

We have been informed by representatives of health care providers and other interested groups that our policy statements are serving their intended purpose of reducing antitrust uncertainty and providing greater clarity with respect to the application of the antitrust laws in the health care area. The agencies have not challenged any activity falling within one of the "safe harbors" in those statements, nor are we aware of any private cases challenging such activities.

As you know, health care delivery systems and markets continue to evolve, emphasizing the need for careful, continuing attention to antitrust enforcement policy in this crucial sector of the economy. Recognizing this, the agencies have continued to meet with interested members of the health care community to consider possible revisions to our existing policy statements and additional statements covering other health care antitrust issues. We have benefitted greatly from the suggestions of many in the health care community over the last few months in this

Thank you again for your thoughtful letter. The Department believes strongly that sound, reasoned antitrust enforcement is the best way of preserving and promoting competition in this crucial and dynamic sector of the economy. We are committed to and well along the way toward issuing revised and updated health care enforcement policy statements, and we appreciate very much your continuing strong support of our efforts.

Sincerely,

Anne K. Bingaman
Assistant Attorney General

regard. We fully intend to revise and update our policy statements, and are nearing completion of our first effort to do so. I expect that new Department of Justice/Federal Trade Commission health care antitrust enforcement policy statements will be issued very soon.

Our September 1993 statements covered a number of important areas identified to us by health care providers: 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. Notwithstanding the breadth of the 1993 statements, however, we recognized when we released them that additional antitrust guidance might be warranted in the areas they covered, as well as in other evolving health care contexts. The comments and suggestions we have received from the health care community since the issuance of our September 1993 statements have provided valuable input in this regard.

Your letter notes concerns regarding additional policy statements expressed to you by the American Hospital Association. We have been working closely with the AHA as to how best to address the issues that are important to hospitals in particular, and I believe that we have made substantial progress in addressing those issues. Your letter also notes concerns expressed to you by non-physician providers that the policy statements should appropriately be revised to specify that they apply to such providers as well. These same concerns and recommendations have been expressed directly to us, and I believe that they have merit. Finally, your letter notes contacts by your colleagues about expanding the policy statements to address the needs of rural hospitals and other providers. We are acutely aware of rural providers' concerns about the application of antitrust principles in rural settings. Rural providers have requested additional illustrative examples of the policy statements as they apply in sparsely populated areas. Addressing the desire of rural health care providers for additional antitrust guidance through illustrative examples is but one example of our current efforts to update and expand our health care antitrust enforcement policy statements. We agree with you that widespread dissemination of our policy statements in rural areas is vital and will work to accomplish that goal.

I would also note that we have met with representatives of other members of the health care community, including the American Medical Association, regarding their suggestions for revisions or supplements to our policy statements. I believe that a number of the suggestions that we received also can be accommodated by our current effort to update and expand these statements.

U.S. Department of Justice

Antitrust Division

Washington, D.C. 20530

[4843b]

DATE 8/2

TO: Jennifer Klein FAX # 456-2878

PHONE #

FROM:

___ NEIL ROBERTS (202-514-2512)
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___ LINDIA KELLY (202-514-2497)

COMMENTS: Per conv.

TOTAL PAGES TRANSMITTED: 9 (EXCLUDING TRANSMITTAL SHEET)

PANAFAX NO. 202-514-9082

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agreed to

19

Amendment to H.R. 3600

Offered by Mr. Canady

Page 980, after line 16, insert the following (and make such technical and conforming changes as may be appropriate):

Subtitle G—Application of the Antitrust Laws to Health Care Services

SEC. 5601. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws if—

(1) the activity is within one of the categories of safe harbors described in subsection (b); or

(2) the activity is within an additional safe harbor designated by the Attorney General under subsection (c).

(b) SAFE HARBORS.—The following activities are safe harbors for purposes of subsection (a)(1):

(1) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(A) IN GENERAL.—Subject to subparagraph (B), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care provided to patients.

(B) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under this paragraph if the activity is conducted for purposes of financial gain; or #(i)

(ii) interferes with the provision of health care services by any provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

(2) PARTICIPATION IN SURVEYS.—The participation of a provider of health care services in a written survey of the prices of services, reimbursement levels, or the compensation and benefits of employees and personnel, but only if—

(A) the survey is conducted by a third party, such as a purchaser of health care services, governmental entity, institution of higher education, or trade association;

(B) the information provided by participants in the survey is based on prices charged, reimbursements received, or compensation and benefits paid prior to the third month preceding

the month in which the information is provided; and

(C) if the results of the survey are disseminated, the results are aggregated in a manner that ensures that no recipient of the results may identify the prices charged, reimbursement received, or compensation and benefits paid by any particular provider.

(3) JOINT VENTURES FOR HIGH TECHNOLOGY AND COSTLY EQUIPMENT AND SERVICES.—Any activity of a health care cooperative venture relating to the purchase, operation, or marketing of high technology or other expensive medical equipment, or the provision of high cost or complex services, but only if the number of participants in the venture does not exceed the lowest number needed to support the venture together with any other providers for whom the participation in the venture is the only means of obtaining or operating such equipment or providing such services.

(4) HOSPITAL MERGERS.—Activities relating to a merger of 2 hospitals if, during the 3-year period preceding the merger, one of the hospitals had an average of 100 or fewer staffed beds and an average

daily inpatient census of less than 50 percent of such beds.

(5) JOINT PURCHASING ARRANGEMENTS.—Any joint purchasing arrangement among health care providers if—

(A) the purchases under the arrangement represent less than 35 percent of the total sales of the product purchased in the relevant market area; and

(B) the amounts paid under the arrangement represent less than 20 percent of the total revenues of the supplier of the product purchased.

(6) PHYSICIAN NETWORK JOINT VENTURES.—Any activity of a physician network joint venture comprised of 20 percent or less of the physicians in each physician specialty who practice in the relevant geographic market and share substantial financial risk.

(7) NEGOTIATIONS.—Activities consisting of good faith negotiations to carry out any activity—

(A) described in this subsection; or

(B) within an additional safe harbor designated by the Attorney General under subsection (c).

General (in consultation with the Chair of the Federal Trade Commission) shall publish in the Federal Register proposed additional safe harbors for purposes of subsection (a)(2) for providers of health care services. Not later than 180 days after publishing such proposed safe harbors in the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(2) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under paragraph (1), the Attorney General shall take into account the following:

(A) The extent to which a competitive or collaborative activity will accomplish any of the following:

(i) An increase in access to health care services.

(ii) The enhancement of the quality of health care services.

(iii) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(iv) An increase in the ability of health care facilities to provide services in

United States Department of Justice

Antitrust Division
Main Justice Building
10th & Constitution, NW
Washington, DC 20530

Office of Assistant Attorney General

FACSIMILE TRANSMISSION COVER SHEET

DATE: 8/2/94

TO: Jennifer Klein

OF: White House

FAX NUMBER: 202-456-2878

FROM: Robert A. Potter

PHONE: 202/616-0964 FAX: 202/514-9082

Number of pages (including this page): 23

Message:

F:\JH\HR3600\BROOKS.008

Amendment to H.R. 3600

Offered by Mr. Brooks

0

Page 835, in the table of contents of title V, strike the item relating to section 5501 insert the following:

Sec. 5501. Short title.
Sec. 5502. Rules of construction.
Sec. 5503. Amendments.
Sec. 5504. Publication and availability of historical underwriting capacity risk pool notifications.
Sec. 5505. Business review.
Sec. 5506. Study and report.
Sec. 5507. Effective dates.

Beginning on page 979, strike line 21 and all that follows through line 16 on page 980, and insert the following:

SEC. 5501. SHORT TITLE.

This subtitle may be cited as the "Insurance Competitive Pricing Act of 1994".

SEC. 5502. RULES OF CONSTRUCTION.

The amendments made by this subtitle preserve—

(1) the provisions relating to State taxing and regulatory authority in section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act;

(2) the availability, to persons engaged in the business of insurance, of the defense of State action in the same manner and to the same extent as such defense is available to other persons;

(3) the availability, to persons engaged in the business of insurance, of any antitrust immunity or defense that may be applicable under law other than the McCarran-Ferguson Act;

(4) the legal standards applicable under the McCarran-Ferguson Act, as in effect before such Act is amended by this subtitle, to all conduct described in the safe harbors found in subparagraphs (B), (C), (D), and (E) of section 2(b)(1) of the McCarran-Ferguson Act, as amended by this subtitle; and

(5) the provisions relating to boycott, coercion, or intimidation in section 3(b) of the McCarran-Ferguson Act.

SEC. 5503. AMENDMENTS.

Section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act, is amended—

(1) in subsection (b)—

(A) by striking ": *Provided*," and all that follows through "law." and inserting the following:

"except as follows:

"(1)(A) The antitrust laws shall be applicable to the business of insurance except as provided in subparagraphs (B), (C), (D), and (E).

"(B) The antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct—

"(i)(I) to collect, compile, classify, or disseminate historical data;

"(II) to develop procedures to collect, compile, classify, or disseminate historical data; or

"(III) to verify that historical data is accurate and complete;

"(ii) to determine, using standard actuarial techniques, or disseminate, a loss development factor or developed losses;

"(iii) to develop or disseminate a standard insurance policy form (including a standard addendum to an insurance policy form and standard terminology in an insurance policy form) if such agreement or joint conduct does not include an agreement to adhere to such standard form, or to require adherence to such standard form, except that the fact that 2 or more per-

sons engaged in the business of insurance use such standard form—

"(I) shall not be sufficient in itself to support a finding that an agreement to adhere, or to require adherence, to such standard form exists; and

"(II) may be used only for the purpose of supplementing or explaining direct evidence of the existence of an agreement to adhere, or to require adherence, to such standard form;

"(iv) to develop or disseminate, for use in providing insurance in a State, a manual that is filed, before dissemination, with the State entity that regulates the business of insurance under State law, if such manual includes only—

"(I) information and conduct described in clauses (i), (ii), and (iii), including relativity factors;

"(II) during the transition period, a trend factor or information to which a trend factor has been applied, to the extent permitted under subparagraph (C); and

"(III) explanations and instructions for using the manual (or any of the infor-

mation contained in the manual), if such agreement or joint conduct does not include an agreement among competitors to adhere, or to require adherence, to any of such explanations or instructions;

"(v) to provide insurance pursuant to a public necessity market mechanism;

"(vi) to provide insurance as a historical underwriting capacity risk pool;

"(vii) to administer a public necessity market mechanism in a State, pursuant to the authorization of and under the supervision of such State, if all persons who provide insurance in such State pursuant to such mechanism, and all persons seeking to obtain insurance through such mechanism, have a reasonable opportunity to appeal determinations affecting them to a governmental entity;

"(viii) to develop or participate in a program to inspect commercial buildings and fire protection facilities, and evaluate government building code requirements and enforcement of such requirements, to determine the likelihood and potential extent of loss due to fire, wind, hail, earthquake, flood, or tidal wave, pursuant

to a State law that provides procedures for making such a determination and provides a reasonable opportunity for an affected person to appeal such a determination to a governmental entity; or

"(ix) to develop or participate in a program, pursuant to a workers' compensation insurance plan filed with the State entity that regulates the business of insurance under State law, to measure an employer's experience with respect to occupational accidents and illnesses for which such employer is liable, against the comparable experience of other employers, and to make a modification for an individual employer based on such comparisons, if an affected employer has a reasonable opportunity to appeal a determination under such program to a governmental entity,

to the extent that such conduct is regulated by State law.

"(C) During the transition period, the antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct to determine or disseminate a trend factor, to

the extent that such conduct is regulated by State law.

"(D) The antitrust laws shall not be applicable to conduct by a director, officer, or employee of a national trade association representing insurance agents, or of a State trade association representing insurance agents that is affiliated with such national trade association, acting within the scope of the authority vested in such director, officer, or employee by the trade association involved, that consists of preparing, disseminating, or discussing a report or comment (including describing, evaluating, and suggesting possible responses for members of the association whose directors, officers, or employees prepared such report or such comment to consider) with respect to any insurer practice affecting the relationship between insurers and insurance agents, if—

"(i) such report or such comment includes a conspicuous statement that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws;

"(ii) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of such responses;

"(II) initiating any communication (including a mailing, association publication, or association meeting) with any member of any such association with respect to such report or such comment (including any of such responses), other than by a means designed to reach all members, or all directors and officers, of such association;

"(III) referring to any of such responses in any discussion unless the discussion emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws; or

"(IV) the formal endorsement of such report or such comment (including any of such responses) by any part of the membership of any such association, other than a statement that dissemination of such report or such comment has been approved by the directors or officers of the association whose directors, officers, or employees prepared such report or such comment; and

"(iii) the number of directors and officers of any such association who are involved in preparing, disseminating, or discussing such report or such comment (including any of such responses) does not substantially exceed the number of directors and officers of such association serving on April 30, 1994;

and if the business of insurance is regulated by State law.

"(E) The antitrust laws shall not be applicable to conduct of an insurance agent that is a member of an association referred to in subparagraph (D) that consists of independently initiating a communication, in an issue of a regularly scheduled association publication or at a regularly scheduled asso-

ciation meeting, to members of a local trade association representing insurance agents of which such agent is a member, that describes or summarizes all or part of the contents of a report or comment described in such subparagraph provided to such agent by such association described in such subsection and that is made only by a means designed to reach all such members, if—

"(i) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of the possible responses contained in such report or such comment;

"(II) referring to any of such responses unless the references emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to an insurance practice discussed in such report or such comment are illegal under the antitrust laws; or

"(III) the formal endorsement of such report or such comment (including any of such responses); and

"(ii) the primary purpose of such meeting, or of such issue of such publication, is not the discussion of such report or such comment (including any of such responses);

and if the business of insurance is regulated by State law.

"(2) Subsequent to the transition period, the independent purchase of a trend factor by a person engaged in the business of insurance from a person not engaged in providing insurance (and not affiliated with a person engaged in providing insurance) shall be presumed not to violate the antitrust laws.

"(3) The Federal Trade Commission Act shall be applicable to the business of insurance to the extent that such business is not regulated by State law, except that, with respect to enforcement of the antitrust laws, section 5505 of such Act shall be applicable to the business of insurance to the same extent as the other antitrust laws.", and

(2) by adding at the end the following:

"(c) For purposes of subsection (b)—

"(1) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term also includes the Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 13 et seq.), commonly known as the Robinson Patman Act, and section 5 of the Federal Trade Commission Act (15 U.S.C. 45) as such section 5 applies to conduct that constitutes a violation of the Sherman Act or the Clayton Act;

"(2) the term 'developed losses' means aggregate paid losses and aggregate reserves held for received claims, as adjusted by a loss development factor;

"(3) the term 'historical underwriting capacity risk pool' means an underwriting capacity risk pool established prior to April 30, 1994—

"(A) the purpose of which is to provide insurance for a commercial risk relating to—

"(i) an airport, aviation, or aerospace activity;

"(ii) a large commercial or industrial property (including machinery, boilers, and pressure vessels);

"(iii) a grain elevator or feed mill;

"(iv) an oil, gas, or chemical peril;

"(v) the construction or operation of a nuclear energy facility;

"(vi) an inland marine peril or an ocean marine enterprise;

"(vii) a natural disaster;

"(viii) an occupational accident or illness;

"(ix) transportation of currency, mail, securities, bullion, or other valuables by a person with fiduciary responsibility for their safe transport;

"(x) foreign commercial activities undertaken in cooperation with the United States Export-Import Bank; or

"(xi) a war, rebellion, riot, or similar civil commotion;

"(B) whose conduct has not materially changed from the conduct described in accordance with subparagraph (C)(ii) in which such pool—

"(i) was authorized to engage under its charter, bylaws, or other documents of organization or governance filed in accordance with subparagraph (C)(iii); and

"(ii) did engage as so authorized;

prior to April 30, 1994; and

"(C) that, before the effective date of the Insurance Competitive Pricing Act of 1994, filed with the Attorney General of the United States, in accordance with such rules as the Attorney General may have issued, a notification—

"(i) disclosing the identities of the members of such pool on April 30, 1994;

"(ii) describing the nature and scope of the activities of such pool, and the lines of insurance in which such pool was engaged, prior to April 30, 1994; and

"(iii) containing the charter, bylaws, and other documents of organization or governance of such pool in effect on or before April 30, 1994;

"(4) the term 'historical data' means information respecting—

"(A) losses paid by, claims received by, reserves for such claims set aside by, or units of exposure to loss in insurance policies sold by any person engaged in the business of insurance; or

"(B) insurance premiums received by any person engaged in the business of insurance, if such information is not disseminated in a form from which information respecting premiums received by any separately identifiable person engaged in the business of insurance may be derived;

"(5) the term 'insurance agent' means a person that is—

"(A) engaged as an independent contractor in the business of selling insurance;

"(B) licensed under the law of a State as an insurance agent or insurance broker; and

"(C) neither an insurer in any State in which such person is so engaged, nor an employee of an insurer;

"(6) the term 'insurance policy' means a contract under which insurance is sold to an insured;

"(7) the term 'insurer' means a person that is—

"(A) engaged in the business of providing insurance; and

"(B) obligated to pay losses under the insurance policies under which it provides insurance;

"(8) the term 'loss' means an amount paid or to be paid by a person engaged in the business of insurance to (or for the benefit of) a claimant to satisfy a claim on an insurance policy, and includes any attorney, investigatory, or litigation expenses that are separately incurred, identified, and allocated by such person with respect to that particular claim;

"(9) the term 'loss development factor' means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid;

"(10) the term 'loss incurred' means a loss for which the event has occurred that ultimately gives rise to liability on a claim on an insurance policy, without regard to whether a claim based on such event has been received;

"(11) the term 'public necessity market mechanism' means a plan established by State law or by the State entity that regulates the business of insurance under State law—

"(A) for providing a type of insurance in a State;

"(B) in which the persons providing such type of insurance pursuant to such mechanism represent a substantial number of the persons engaged in the business of providing such type of insurance in such State and are either required by State law, or formally requested or ordered by such State entity to participate;

"(C) the purpose of which is to make such type of insurance available to persons who would not otherwise be able to obtain such type of insurance at affordable cost; and

"(D) in which the rate for such type of insurance is subject to the approval or disapproval of such State;

"(12) the term 'relativity factor' means a ratio comparing one classification of historical data to another such classification, or comparing developed losses in one such classification to developed losses in another such classification;

"(13) the term 'transition period' means the 2-year period beginning on the effective date of the Insurance Competitive Pricing Act of 1994;

"(14) the term 'trend factor' means an adjustment to be made to developed losses in order to ac-

count for any change that is anticipated to affect losses; and

"(15) The term 'underwriting capacity risk pool' means a business arrangement or association—

"(A) whose members consist of 2 or more persons engaged in the business of insurance; and

"(B) that operates for the purpose of providing insurance under which the liability for paying losses is spread among such members.".

SEC. 8504. PUBLICATION AND AVAILABILITY OF HISTORICAL UNDERWRITING CAPACITY RISK POOL NOTIFICATIONS.

The Attorney General shall, not later than 30 days after receiving a notification filed in accordance with section 2(c)(8)(C) of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act—

(1) publish in the Federal Register—

(A) a summary of such notification; and

(B) notice that such notification is available to the public; and

(2) make such notification available to the public.

SEC. 8505. BUSINESS REVIEW.

If a person engaged in the business of insurance submits a written request to the Attorney General in accordance with section 50.6 of title 28 of the Code of Federal Regulations (July 1, 1992), as amended from time to time, for a business review letter with respect to the application of the antitrust laws to specified activities of an underwriting capacity risk pool (as defined in section 2(a)(15) of the Act of March 9, 1945, commonly known as the McCarran-Ferguson Act) of which such person is, or intends to become, a member, then the Attorney General shall issue such letter in accordance with such section.

SEC. 8506. STUDY AND REPORT.

(a) STUDY.—During the 5-year period beginning on the effective date of this Act, the Attorney General shall conduct a study to determine the effect of this subtitle, and the amendments made by this subtitle, on the business of insurance.

(b) REPORT.—Not later than 1 year after the expiration of the 5-year period referred to in subsection (a), the Attorney General shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report summarizing the results of the study required by subsection (a).

SEC. 5507. EFFECTIVE DATES.

(a) GENERAL EFFECTIVE DATE.—Except as provided in subsection (b), this subtitle shall take effect 1 year after the date of the enactment of this Act.

(b) EFFECTIVE DATE OF SECTIONS 5504 AND 5505.—Sections 5504 and 5505 shall take effect on the date of the enactment of this Act.

(4)

#2

Amendment To H.R. 3600

Offered By Mr. Fish

Page 376, line 20, insert the following after the period: "Nothing in this subsection may be construed to prohibit any transaction otherwise lawful under any of the antitrust laws.".

Page 376, insert after line 21 the following (and redesignate the succeeding provisions accordingly):

"(1) ANTITRUST LAWS.—The term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section 5 applies to unfair methods of competition.

(3)

Amendment to H.R. 3600

Offered by Mr. Brooks

Page 135, strike lines 3 through 7, and insert the following:

(2) COMMENTS FROM PROVIDERS.—The fee schedule under paragraph (1) shall be established after considering comments received from providers.

Beginning on page 135, strike line 19 and all that follows through line 25 on page 136.

Page 137, beginning on line 10, strike "negotiate with health providers annually to" and insert "annually".

Page 137, lines 13 and 20, strike "negotiated".

Page 138, after line 7, insert the following:

(e) ANTITRUST LAWS PRESERVED.—

(1) APPLICABILITY.—Nothing in this title shall be construed to modify, impair, or supersede any of the antitrust laws.

(2) ANTITRUST LAWS.—For purposes of paragraph (1), the term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes the Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 13 et seq.), commonly known as the Robinson Patman Act, and section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

medically underserved areas or to medically underserved populations.

(v) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(B) Whether the designation of an activity as a safe harbor under paragraph (1) will result in the following outcomes:

(i) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to negotiate payment and service arrangements which will reduce costs to consumers.

(ii) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(iii) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in subparagraph (A).

(iv) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

(d) DEFINITIONS.—For purposes of this section—

(1) the term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A);

(2) the term "health care cooperative venture" means any activities, including attempts to enter into or perform a contract or agreement, carried out by 2 or more persons for the purpose of providing health care services;

(3) the term "health care services" means any services for which payment may be made under a health benefit plan, including services related to the delivery or administration of such services;

(4) the term "medical self-regulatory entity" means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity;

(5) the term "provider of health care services" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(6) the term "standard setting and enforcement activities" means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs;

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters; or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

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

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TO: Jennifer Klein

Phone: 456-2599

Fax: 456-2878

FROM: Bob Potter

Antitrust Division

Phone: (202) 616-0964

Fax: (202) 616-2645

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

COMMENTS:

U.S. Department of Justice

Antitrust Division

Office of the Assistant Attorney General Washington, D.C. 20530

The Honorable Howard W. Metzenbaum
Chairman
Subcommittee on Antitrust, Monopolies,
and Business Rights
Committee on the Judiciary
United States Senate
Washington, D.C. 20510-6275

Dear Mr. Chairman:

I am writing in response to your letter of March 22, 1994, also signed by Chairman Brooks, requesting the views of the Department of Justice on S. 1658 and its companion bill, H.R. 3486, the "Health Care Antitrust Improvements Act of 1993." These bills would create special new broad based statutory immunities from the antitrust laws for a wide range of health care activities.

The Department is committed to reasonable and responsible application of the antitrust laws in the health care area to promote new competition in evolving markets. We have established as a priority the issuance of antitrust enforcement policy statements in the health care area designed to bring down health care costs to consumers while providing effective quality health care services. Six such statements have already been issued and others will be considered. We are committed to ongoing review and supplementation of these statements.

Effective antitrust laws have for over a century been the principal guarantor of competition in the American system and have time and again proved far superior to pervasive government review, regulation, and oversight of collective activities that may have competitive consequences. Health reform ~~needs to build and~~ should build on a commitment to competition in health care markets. Consequently, the Department of Justice opposes the broad new statutory antitrust immunities contained in these bills.

The antitrust laws are enforced so as to take fully into account increased efficiency, lower administrative and other costs, improvements in quality, and other factors that are important to the cost-effective delivery of health care services. Neither the Justice Department nor the Federal Trade Commission has ever challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical

equipment. And of the more than 250 hospital mergers since 1987, only 11 have been found by the Department or the FTC to have likely anticompetitive effects that warranted antitrust challenge. Only those combinations that will harm the American consumer by raising prices, decreasing quality or availability of services, or discouraging innovation face antitrust challenge.

The Department and the FTC have recognized that uncertainty over the application of the antitrust laws in the health care area should be addressed, and have issued specific antitrust guidance to the health care industry. In September 1993, the agencies issued several joint Statements of Antitrust Enforcement Policy in the Health Care Area. Moreover, recognizing that issues and circumstances may change over time, the agencies have committed to providing additional general guidance, and also developed an expedited process whereby health care providers can obtain the views of the Department or the FTC on specific proposed activities.

Private remedies have been an integral part of antitrust enforcement for over 100 years. Moreover, the "private" antitrust remedies are used by State attorneys general to protect consumers in their states from localized anticompetitive activity. Such actions are an important adjunct to federal enforcement: Our enforcement resources are limited, and cannot uncover or move against every anticompetitive practice that may be harming consumers. At the same time, however, there is no reason to expect that health care providers will face a multitude of baseless private antitrust suits. Private parties are unlikely to institute meritless lawsuits and even less likely to be successful in pursuing them. This is especially the case with regard to health care matters, where it can be expected that courts will take into account the views of the government, including those expressed in the DOJ-FTC Statements of Antitrust Enforcement Policy, in private antitrust actions. This will help ensure sound and reasoned decisions in private litigation.

S. 1658 and H.R. 3486

S. 1658 and H.R. 3486[1] provide several types of broad immunities from the operation of the antitrust laws to the health care industry. Briefly, Section 2 of each bill provides antitrust immunity for any health care activity that:

(1) falls within one of the "safe harbors" described in Section 3 of the bill;

(2) falls within an additional safe harbor established by

[1]The two bills are nearly identical. The Department objects equally to both S. 1658 and H.R. 3486.

the Attorney General, after seeking public suggestions for further safe harbors via Federal Register notice under Section 4 of the bill; or

(3) is covered by a "certificate of review" issued by the Attorney General with the concurrence of the Secretary of Health and Human Services ("the Secretary") under Section 5 of the bill.

Additionally, Section 6 of each bill provides 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 accorded by S. 1658 and H.R. 3486 are unnecessary and potentially harmful. 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. This task could well overwhelm the Justice Department, seriously impeding its ability to focus on any activities that actually would have anticompetitive effects. It likely would result in a massive new bureaucracy within the Department of Justice to administer such a program. Moreover, regulatory attempts to guard against anticompetitive behavior have consistently proved to be no substitute for the standard operation of the antitrust laws. The notification-based antitrust protections in the bills, broadly covering any collective activity among health care providers, could undercut sound antitrust substantive standards and skew the balance of antitrust remedies that has served so well for over a century. And the "safe harbor" immunities in the bills, based as they would be on hard-to-amend statutory or regulatory language and legislative or regulatory history, could have unintended anticompetitive effects, whereas enforcement policy statements based on common sense, basic competitive principles, would not.

Having summarized the Department's views on S. 1658 and H.R. 3486, I will address below our concerns with each aspect of the bills in more detail.

CERTIFICATE OF REVIEW PROVISIONS OF S.1658 AND H.R. 3486

The most comprehensive and complex new antitrust immunity scheme provided by S. 1658 and H.R. 3486 is the certificate of review process set out in Section 5 of each bill. This section provides complete antitrust immunity to successful applicants for a certificate of review that may cover any activity relating to the provision of health care services. In deciding whether to issue a certificate, the Attorney General and the Secretary are to take into account the extent to which a particular activity will:

A) lead to an increase in access to health care services;

B) enhance the quality of health care services;

C) establish cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs;

D) increase the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations; and

E) improve the utilization of health care resources or reduce inefficient duplication of such resources.

They must also consider whether:

A) the activity will help health plans and other health care insurers, consumers of health care services, and health care providers to better negotiate payment and service arrangements that will reduce costs to consumers;

B) taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted;

C) equally efficient and less restrictive alternatives do not exist to meet the criteria described above; and

D) the activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

Section 5 requires the Attorney General, in consultation with the Secretary and the Chair of the FTC, to establish procedures to be used in applying for and approving certificates. It also requires published notice of each application in the Federal Register within 10 days of receipt, and action by the Attorney General and the Secretary within 90 days. If an

application for a certificate has not been denied within 90 days, it is deemed approved. There is also provision for expedited action if an applicant "indicates a special need for prompt disposition."

Further provisions in Section 5 deal with denial of applications, requests for reconsideration, fraudulent procurement, amendment and revocation of certificates, requests for compliance information, investigative authority, review of certification determinations in federal court, the effect of rejected applications, publication of decisions, annual reports, restrictions on disclosure of information, and prohibition against use of information to support or answer claims under the antitrust laws. In short, section 5 replaces the normal operation of the antitrust laws with ongoing government review and regulation of certificated activities under the comprehensive standards set out above.

Objections to the Certificate of Review Provisions

Antitrust immunity for any and all activities relating to the provision of health care services pursuant to the complex certificate of review process contained in S. 1658 and H.R. 3486 is unnecessary and potentially harmful. There is no evidence that establishment of such a pervasive regulatory scheme or such a substantial departure from the antitrust standards and procedures applicable in virtually all other sectors of the economy is necessary to foster the innovative health care delivery systems envisioned by the Health Security Act and most of the other reform proposals currently before the Congress. Justice Department and FTC policy and practice have accorded favorable treatment to the vast majority of cooperative activities in the health care area. Nor does the ability of health care providers, consumers or third party payers to seek redress of antitrust grievances through private litigation warrant the substitution of continuing government oversight of health care activities for the discriminating application of sound antitrust law.

The dangers of a comprehensive certification/antitrust immunity scheme are manifest. First, such a scheme would place the entire responsibility of initially and prospectively detecting anticompetitive threats and continually monitoring approved health care activities on the Departments of Justice and HHS. In light of the breadth of the scheme, analyzing and processing certification applications could be overwhelming, impeding the Justice Department's ability to screen proposed activities for anticompetitive effects, and diverting its staff from their primary mission--the detection and prosecution of antitrust violations and the prevention of anticompetitive mergers and joint ventures. Competitive harm in such circumstances is entirely predictable.

The certification scheme provided by S. 1658 and H.R. 3486 also would require unwarranted and continuing government oversight of an unknown and potentially vast number of day-to-day activities of health care providers. Government agencies would have the ability to approve a wide range of individual or collaborative activities, perhaps on condition that they be altered in a particular way. In addition, the agencies would have the power, and indeed the obligation, after certification to intervene in a regulatory manner whenever they determined that the complex and judgmental criteria in the bill were no longer met. Constant monitoring of existing certificate holders would be required to determine whether a certificate should be amended or revoked. To effectively administer such a scheme would require a massive new bureaucracy within the Department of Justice. Finally, the certification scheme in the bills likely would impose increased costs on the health care industry as providers spent substantial sums preparing and filing requests for certificates for activities that typically raise no colorable antitrust issues.

NOTIFICATION PROVISIONS OF S. 1658 AND H.R. 3486

Section 6 of each bill would create a notification procedure whereby any "health care cooperative venture" would be guaranteed a "rule-of-reason" antitrust analysis if challenged under the antitrust laws, and any antitrust relief granted against such a venture would be limited to actual rather than treble damages. Parties could obtain such protection by affirmatively notifying the Attorney General of their activities, but in addition many types of ventures would be "deemed" to have submitted such a notification. These include any ventures that have applied for a certificate of review under Section 5, and any health care cooperative ventures of a certain size[2] among non-institutional providers who share risks.[3]

Objections to the Notification Provisions

As with certification schemes, rule-of-reason/single damage protection via notification for unknown and potentially broad

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[2]For a nonexclusive network, any group including 50 percent or fewer of the providers in a relevant market and 50 percent or fewer of the members of any one specialty within that group; for an exclusive network, any group including 35 percent or fewer of the providers or specialists in a relevant market.

[3]H.R. 3486 deems either ventures below the size limits in Note 2 supra or ventures wherein providers share risks to have been notified; S. 1658 imposes both size limits and risk sharing before ventures will be deemed to have been notified. H.R. 3486 also omits the "non-institutional" qualifier.

categories of collaborative health care activities is unnecessary and potentially harmful. There is no indication, in light of the sound enforcement policies applied to health care activities, that cost-saving or otherwise efficient joint ventures in the health care area are unusually vulnerable to antitrust attack. In fact, quite the opposite is clear from the record. There is no sound reason to extend antitrust protection to joint ventures that present no anticompetitive risks and that would not be in danger of challenge in the first place. Moreover, such a provision could actually increase costs in the health care industry as the costs of notifications were passed on to consumers.

A notification scheme such as that set out in S. 1658 and H.R. 3486 could be harmful to competition and consumers by providing unwarranted rule-of-reason or single damage protection to potentially anticompetitive activities. There is no indication that procompetitive joint activity in the health care area is being placed at unusual or undue antitrust risk. Moreover, there is no legitimate distinction between health care and other industries such that potential treble damages should not produce the same salutary compensatory and deterrent effects in the health care area that they do generally.

Absent clear and convincing evidence of aberrations or abuse, antitrust standards and remedies should not be abrogated by special industry-specific protection for broad ranges of activities. Blanket, automatic protection for any "health care cooperative venture," which is defined in the two bills as "any activities, including attempts to enter into or perform a contract or agreement, carried out by two or more persons for the purpose of providing health care services," and for broad categories of activities that without any notice at all would be "deemed" to have filed a notification, would significantly constrain appropriate antitrust enforcement and deterrence. The rationale behind notification schemes is to give the government an opportunity to step in and stop potentially harmful activities, and the trade-off is that parties who notify are given rule-of-reason and single damages protection if they come forward. In light of the thousands of ventures that could potentially be presented to the Department under a notification scheme, there is a very real danger that potentially harmful arrangements would be granted a degree of protection that they do not deserve, and that could result in substantial harm to consumers.

CODIFICATION OF SAFE HARBORS

Section 3 of each bill would create several categories of statutory health care antitrust immunities that are in part patterned on the safety zones described in the six Department of Justice/FTC Statements of Antitrust Enforcement Policy in the

Health Care Area issued in September 1993. The "safe harbor" immunities in S. 1658 and H.R. 3486, however, are broader, and there are seven categories of exemptions instead of six. Section 4 of each bill would create a process whereby the public could submit suggestions for additional safe harbors to be established by the Attorney General, in consultation with the Secretary and the Chair of the FTC.

Objections to Codification of Safe Harbors

Statutory "safe harbors" from antitrust scrutiny for health care providers would be both unnecessary and potentially harmful. Such protections are unnecessary because the Department and the FTC have already set out significant safety zones in their joint Statements of Antitrust Enforcement Policy in the Health Care Area that inform health care providers of activities that are clearly lawful. We have committed to continuing review and supplementation of these Statements, and have complemented them with an expedited process through which health care providers may obtain the views of the Department or FTC on specific proposed health care activities, whether or not they are covered by the existing policy statements.

The harm that the Department foresees from codification of health care antitrust safety zones is that it could have unforeseen consequences and needlessly encumber law enforcement and development in areas that may require fine tuning for some time to come. Consumers, health care providers and enforcement officials all need leeway to adjust to changes in relevant markets as health care systems evolve and competition and efficiencies in health care delivery become better understood. Statutory antitrust immunities are not easily amended, and their intended effects can be distorted by interpretations of both statutory language and legislative history. On the other hand, the articulation of safety zones in flexible, competition-oriented enforcement policy statements such as those set out by the agencies last September is a process much more geared to an optimal outcome for both providers and consumers. What looks like a perfectly reasonable activity today could have unforeseen anticompetitive ramifications in the future and, similarly, what appears to be a problematic activity today may be perfectly reasonable in the future. Although it is extraordinary for one particular industry to have a set of specific guidelines put forth for its benefit, the Department and the FTC have done so for the health care industry. It would be totally unprecedented for such guidelines to be codified.[6]

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[6]We would also note that some of the particular safe harbors defined in the two bills are substantially broader than the safety zones in the DOJ/FTC Statements of Enforcement Policy, and

(continued...)

* * *

In sum, the Department of Justice opposes S. 1658 and H.R. 3486. I appreciate very much your interest in the importance of sound antitrust enforcement and the preservation of competitive health care markets. The Department is committed to reasonable and responsible application of the antitrust laws in the health care area and will continue to work to promote a fair and competitive health care marketplace; however the broad new statutory antitrust immunities in these bills could be detrimental to the goals of health care reform.

This Department has been advised by the Office of Management and Budget that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

Anne K. Bingaman
Assistant Attorney General

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[4](...continued)
may protect anticompetitive conduct that significantly harms consumers.

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

July 29, 1994

Anne K. Bingaman
Assistant Attorney General
Antitrust Division
United States Department of Justice
Washington, D.C. 20530

Re: Health Care Policy Statements

Dear Ms. Bingaman:

I am writing to urge the Department to update and expand the Statements of Antitrust Enforcement Policy in the Health Care Area that it issued last September jointly with the Federal Trade Commission ("FTC"). As you know, I have been a strong advocate for providing antitrust guidance to the health care community. I was enormously impressed with the policy statements issued by the Antitrust Division and the FTC last September. They dealt with pressing issues that had created antitrust confusion among health care providers and could have chilled new and innovative health care deals among hospitals and other providers. The policy statements were of great benefit to health care providers when they were issued last September, and I believe that updating and expanding them as soon as possible is needed to continue that progress.

Three separate groups have contacted me with their concerns about the policy statements. First, the American Hospital Association (with which I have worked cooperatively since it first raised the issue of antitrust guidance) has indicated that there are four additional areas in which hospitals require antitrust guidance in the near future. They are multi-provider network formation and operation; joint ventures for services and existing equipment; efficiency considerations in mergers and joint ventures; and application of the state action doctrine to deals involving hospitals. I feel confident that the Antitrust Division will be able to provide speedy additional guidance to hospitals in these areas through policy statements.

Second, I have also been contacted by a number of non-physician providers. They have requested that the policy statements be revised to specify that they apply to deals involving nurses, nurse-anesthetists, optometrists and other non-physician providers. This seems to be a request that can be accommodated easily.

Third, I have been contacted by a number of my colleagues

about expanding the policy statements to address the special needs of rural hospitals and other providers. Rural providers have requested that additional illustrative examples be included in the policy statements to deal with the antitrust questions that arise in sparsely populated areas of the country, including small towns. They have also requested that the Antitrust Division and the FTC develop a plan to disseminate more widely the updated policy statements among rural providers. That could be accomplished in a variety of ways, including closer coordination with the Department of Health and Human Service's Office of Rural Health. However, I would appreciate any other recommendations that you might have on ways to get the policy statements into the hands of more rural providers.

Thank you for your assistance with this matter. I look forward to working with you on updated and expanded policy statements for health care providers.

Sincerely,

Howard M. Metzenbaum
Chairman,
Subcommittee on
Antitrust, Monopolies &
Business Rights

CC: George J. Mitchell
Edward M. Kennedy
Patrick J. Leahy
Thomas A. Daschle
Tom Harkin
James M. Jeffords
John H. Chafee

U.S. Department of Justice

Antitrust Division

DRAFT

Office of the Assistant Attorney General *Washington, D.C. 20530*

The Honorable Howard M. Metzenbaum
Chairman
Subcommittee on Antitrust, Monopolies
and Business Rights
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter of July 29, 1994, in which you urge the Department to update and expand the Statements of Antitrust Enforcement Policy in the Health Care Area that it issued jointly with the Federal Trade Commission in September 1993. As your letter reflects, those policy statements dealt with a number of issues that had been identified by the health care community and the agencies as warranting guidance to dispel unwarranted antitrust uncertainty that may be deterring mergers, joint ventures, and other joint conduct that does not present serious competitive problems. Indeed, such activities may significantly further the goals of improving health care quality and access at lower costs, increasing innovation and efficiency, and reducing costs in the health care sector.

We have been informed by representatives of health care providers and other interested groups that our policy statements are serving their intended purpose of reducing antitrust uncertainty and providing greater clarity with respect to the application of the antitrust laws in the health care area. The agencies have not challenged any activity falling within one of the "safe harbors" in those statements, nor are we aware of any private cases challenging such activities.

As you know, health care delivery systems and markets continue to evolve, emphasizing the need for careful, continuing attention to antitrust enforcement policy in this crucial sector of the economy. Recognizing this, the agencies have continued to meet with interested members of the health care community to consider possible revisions to our existing policy statements and additional statements covering other health care antitrust issues. We have benefitted greatly from the suggestions of many in the health care community over the last few months in this

regard. We fully intend to revise and update our policy statements, and are nearing completion of our first effort to do so. I expect that new Department of Justice/Federal Trade Commission health care antitrust enforcement policy statements will be issued very soon.

Our September 1993 statements covered a number of important areas identified to us by health care providers: 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. Notwithstanding the breadth of the 1993 statements, however, we recognized when we released them that additional antitrust guidance might be warranted in the areas they covered, as well as in other evolving health care contexts. The comments and suggestions we have received from the health care community since the issuance of our September 1993 statements have provided valuable input in this regard.

Your letter notes concerns regarding additional policy statements expressed to you by the American Hospital Association. We have been working closely with the AHA as to how best to address the issues that are important to hospitals in particular, and I believe that we have made substantial progress in addressing those issues. Your letter also notes concerns expressed to you by non-physician providers that the policy statements should appropriately be revised to specify that they apply to such providers as well. These same concerns and recommendations have been expressed directly to us, and I believe that they have merit. Finally, your letter notes contacts by your colleagues about expanding the policy statements to address the needs of rural hospitals and other providers. We are acutely aware of rural providers' concerns about the application of antitrust principles in rural settings. Rural providers have requested additional illustrative examples of the policy statements as they apply in sparsely populated areas. Addressing the desire of rural health care providers for additional antitrust guidance through illustrative examples is but one example of our current efforts to update and expand our health care antitrust enforcement policy statements. We agree with you that widespread dissemination of our policy statements in rural areas is vital and will work to accomplish that goal.

I would also note that we have met with representatives of other members of the health care community, including the American Medical Association, regarding their suggestions for revisions or supplements to our policy statements. I believe that a number of the suggestions that we received also can be accommodated by our current effort to update and expand these statements before Congress passes health care reform legislation.

Thank you again for your thoughtful letter. The Department believes strongly that sound, reasoned antitrust enforcement is the best way of preserving and promoting competition in this crucial and dynamic sector of the economy. We are committed to and well along the way toward issuing revised and updated health care enforcement policy statements, and we appreciate very much your continuing strong support of our efforts.

Sincerely,

Anne K. Bingaman
Assistant Attorney General

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO:		
Jennifer Klein	Take necessary action	☐
Bob Pellicci	Approval signature	☐
Adrien Silas	Comment	☒
Chris Parker	Prepare reply	☐
Jim Murr	Discuss with me	☐
Jim Jukes	For your information	☐
	See remarks below	☐

FROM: Ingrid Schroeder

DATE: August 1, 1994

REMARKS

Attached is a draft letter to Rep. Pomeroy from Chris Edley concerning HR 9 - Insurance Antitrust. Chris would like to send this out today. Please provide comments by 4pm - today - 8/1/94. If I do not receive your comments by the above deadline I will assume that you have no comment on the letter.

Note: Chris Edley added a sentence to the last paragraph. I am in the process of getting A clearance.

i:\data\pomeroy.ltr

Honorable Earl Pomeroy
U.S. House of Representatives
Washington, D.C. 20515-3401

Dear Congressman Pomeroy:

It was a pleasure speaking with you Friday regarding H.R. 9, the Insurance Competitive Pricing Act of 1993. We have reviewed this bill and agree with the position enunciated by the Justice Department in the attached letter.

By making antitrust laws generally applicable to the insurance industry, we believe H.R. 9 would promote competition and enhance economic efficiency. The "safe-harbors" set forth in the bill would permit the continued sharing of a variety of historical loss-related data and other information critical to the evaluation of risk. However, the bill would prohibit collective insurer determinations about the cost of future losses after a short transition period. This would promote price competition among insurance companies and discourage anti-competitive activity.

H.R. 9 would lay the foundation for a more flexible and dynamic insurance industry. It would promote price competition, which would benefit the American consumer.

Thank you again for sharing your views with me regarding this bill. I want to assure you that OMB and White House staff took a "fresh" look at this, and consulted with knowlegeable Justice Department officials, as you suggested.

Sincerely,

Christopher Edley, Jr.
Associate Director for
General Government and Finance

Jennifer Klein's markup

U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General — Washington, D.C. 20530

DRAFT

The Honorable Jack Brooks
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing in response to your request for the views of the Department of Justice on H.R. 9, the Insurance Competitive Pricing Act of 1993, as reported favorably by the Subcommittee on Economic and Commercial Law. As Assistant Attorney General Bingaman testified before the Subcommittee on July 29, 1993, the Administration supports a narrowing of the current broad exemption for the business of insurance in the McCarran-Ferguson Act ~~to more carefully crafted protection for activities that are demonstrably procompetitive and economically efficient. However, we believe that if such legislation is to be successful, it must also allow insurance companies of all sizes to serve consumers fairly and efficiently, and permit insurers to maintain financial strength and profitability.~~ The Department of Justice believes that ~~the bill~~ as reported by the Subcommittee is an appropriate balance of the need to narrow the current broad antitrust exemption for the business of insurance and the need of the industry to operate efficiently and effectively in an increasingly competitive environment. Thus, the Department supports the thrust and scope of H.R. 9 as reported by the Subcommittee. As you know, the Administration is also proposing the repeal of the McCarran-Ferguson exemption for the business of insurance to the extent that such business relates to the provision of health benefits.

H.R. 9

Like H.R. 9 as introduced, the bill as reported would narrow the current antitrust exemption for the business of insurance. It differs in form from the bill as introduced, however, in that it simply applies the antitrust laws to the business of insurance, except for certain categories of conduct to the extent that such conduct is regulated by state law. This format is similar to that of the current exemption and provides, we

believe, a workable way to narrow the exemption to specified conduct without creating unnecessary uncertainty.

Section 2 of the bill sets forth rules of construction to clarify the intent and the effect of the legislation. One such rule preserves the legal standards applicable under the existing McCarran-Ferguson Act with respect to conduct in the bill's "safe harbors" (categories of conduct that will remain exempt from the antitrust laws to the extent regulated by state law). Another rule of construction preserves the current provisions relating to acts of boycott, coercion or intimidation in section 3 of the McCarran-Ferguson Act. Still another preserves the availability of the state action defense to persons engaged in the business of insurance to the same extent such defense is available to other persons. Other rules of construction preserve existing state taxing and regulatory authority as provided in section 2 of the McCarran-Ferguson Act, and preserve antitrust immunities that may be applicable under other laws.

Section 3 of the bill would effectively narrow the current antitrust exemption for the business of insurance to certain "safe harbors" specified in the bill. Safe harbors are provided for joint conduct involving the collection, compilation and dissemination of historical data; the determination, using standard actuarial techniques, and dissemination of a loss development factor or developed losses; the development and dissemination of standard policy forms, provided that there is no agreement to adhere to such forms or to require adherance to such forms; the provision of insurance through public necessity market mechanisms (often referred to as assigned risk pools); the provision of insurance as a historic underwriting capacity risk pool (certain "grandfathered" pools specified in the bill); the development of or participation in certain specified fire inspection programs; and the development of or participation in a program, pursuant to a worker's compensation insurance plan filed with the state entity that regulates the business of insurance under state law, to measure an employer's experience with respect to occupational accident or illness of its employees against comparable experience of other employees and to make a modification for an individual employer based on such comparisons, if an affected employer has a reasonable opportunity to appeal a determination under such a program to a government agency. We believe that these safe harbors are well-considered and appropriate.

The bill also provides, during a 2 year transition period beginning on the effective date of the bill (1 year after the date of enactment), a safe harbor for conduct that consists of making an agreement or engaging in joint conduct to determine or disseminate a trend factor (an adjustment to developed losses to account for any change that is anticipated to affect losses). It further provides that subsequent to the transition period, the

independent purchase of a trend factor by a person engaged in the business of insurance from a person not engaged in (and not affiliated with a person engaged in) providing insurance shall be presumed not to violate the antitrust laws. While we do not believe that trending should be permanently safe-harbored, we have no objection to the transition period in the bill during which trending will remain exempted from the application of the antitrust laws.

Section 5 of the bill provides that the Attorney General shall issue a "business review letter" (a statement of the Department's antitrust enforcement intentions with respect to specific conduct) in response to a written request by any person engaged in the business of insurance with respect to the activities of an underwriting risk pool in accordance with 28 C.F.R. § 50.6 (describing the Department's business review procedure). The Department already provides guidance to the insurance and other business communities through the use of the business review procedure contained in the Code of Federal Regulations. We will be sensitive to the needs of insurers and others affected by the passage of H.R. 9 in responding to requests for business review letters that they may submit pursuant to that procedure. We are, however, firmly opposed to statutorily invoking the Department's business review procedure. There is no need to do so given the Department's longstanding business review policies and procedures. Moreover, a statutory provision could encourage unnecessary business review requests that otherwise would not be made and that could be costly both to the industry and to the Department. And private antitrust counsel are also available to advise the industry on specific pooling practices, guided by the business reviews issued by the Department in the normal course. Finally, business reviews are not currently provided for by statute, and such a provision in McCarran-Ferguson reform legislation would set a dangerous precedent for similar provisions in other areas where the affected industry argues that some level of antitrust uncertainty warrants special consideration.

Aside from this important objection, we believe that H.R. 9 as reported by the Subcommittee is a highly workable solution to the long-debated issue of McCarran-Ferguson reform. We thank the Committee for the opportunity to contribute to this historic legislative effort. We look forward to continuing to work with you on this legislation through its successful passage and enactment into law.

This Department has been advised by the Office of Management and Budget that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

Sheila F. Anthony
Assistant Attorney General

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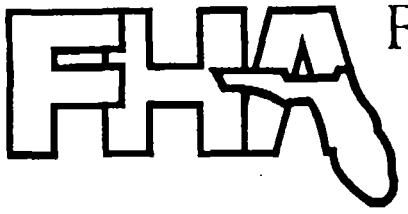

FLORIDA HOSPITAL ASSOCIATION

ANTITRUST PROBLEMS AND ASSUMPTIONS FOR FLORIDA'S FUTURE

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