SPECIAL

EXECUTIVE OFFICE OF THE PRESIDENT

13-May-1994 04:01pm

TO: Jacob J. Lew
TO: Jennifer L. Klein
TO: Lynn M. Margherio

FROM: Robert J. Pellicci Bob
Office of Mgmt and Budget, LRD

CC: Nancy-Ann E. Min
CC: Gregory E. Lawler

SUBJECT: Clearance of Justice's Letter on HR 4028

Please review the attached Justice letter to the House Committee on Energy and Commerce opposing HR 4028, the "Health Care Fraud and Abuse Advisory Opinion Act of 1994."

The Justice position follows the position taken by the HHS IC in a letter to Rep. Stark on March 22nd (copy attached).

Justice is very anxious to get clearance, please let me know by 3:00 p.m. on Monday, May 16th. Thanks

U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

Honorable Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is to provide the views of the Department of Justice on H.R. 4028, the "Health Care Fraud and Abuse Advisory Opinion Act of 1994." This proposal would require the Department of Health and Human Services (HHS) to issue advisory opinions on whether certain arrangements for the delivery of health care services and supplies are in compliance with statutes and rules establishing acceptable health care billing and payment practices and with statutes and rules defining health care fraud and abuse. While we agree with your goal of ensuring that the health care provider community is well-informed on fraud and abuse issues, we feel that this legislation is unwise for a number of reasons.

Our concerns are both legal and practical. First, the Attorney General's exclusive authority to enforce all federal criminal laws includes the authority to determine that a particular prosecution should not be instituted (i.e., to decline a prosecution). This authority extends to all prosecutorial decisions, including those based upon the Medicare anti-kickback statute.

In that regard, the rendering by an agency other than the Department of Justice of opinions concerning the prosecutive merit or lack of prosecutive merit of a particular case would be beyond that agency's authority -- at least as it exists under current law. Furthermore, we feel that it would be inappropriate for the Department of Justice to defer to another department's judgment, such as HHS, regarding what constitutes a prosecutable case under any criminal provision of the United States Code. Thus, as a practical matter, the only advisory opinions which could be rendered would be those which have been specifically approved by the Department of Justice.

Second, we believe that the rendering of advisory opinions is generally ill-advised. This is especially true where, as in the instant case, a violation of the statute depends on proof of a knowing or willful intent to do the act proscribed. Federal prosecutors, in exercising their decision-making authority concerning the initiation of a prosecution, consider a large number of factors, including the interests of justice and the factual circumstances of a particular case. The prosecutor's analysis of the facts and the application of the law to them is never based solely on a putative defendant's recitation of the facts. For obvious reasons, a putative defendant's presentation of the "relevant" facts is apt to be slanted and incomplete and, therefore, would be a poor basis on which to render a prosecutive judgment. Assuming that HHS is not going to conduct an investigation of each advisory opinion request which is filed, the prosecutor will, in all likelihood, have inadequate information on which to base his or her decision. We are advised that other congressional committees previously have considered and rejected similar advisory opinion provisions for these reasons.

Third, we are very concerned that advisory opinions would produce unnecessary problems in the context of a subsequent criminal prosecution (i.e., after an opinion has been issued). Although advisory opinions can be limited to the circumstances contained in the request for the opinion, such limitations would not preclude a subsequent argument that the omitted facts were not material and, even if known, would not have affected the adviser's judgment. Defendants who have read advisory opinions will argue that they carefully conducted their affairs to fall within the confines of permissible action articulated in those opinions. The net result of this would be the introduction of additional factual issues into criminal cases relating to the interpretation and applicability of the advisory opinion at issue. Such evidentiary burdens would weigh heavily against the government, especially in the context of difficult fraud prosecutions against sophisticated defendants. See e.g. United States v. Levin, 973 F.2d 463 (6th Cir. 1992).

Fourth, we need to do our best to conserve law enforcement resources and to use them in the most effective manner possible. As we noted above, because the Attorney General is vested with exclusive authority to enforce all federal criminal laws, the only advisory opinions that could be rendered would be those which have been specifically approved by the Department of Justice. We would like to use the Department's limited resources on criminal investigations and prosecutions rather than to render advisory opinions.

Finally, we note that many of the concerns expressed previously also apply with respect to civil fraud actions under the False Claims Act, including qui tam actions and common law doctrines. Just as with criminal matters, it is the Department's

attorneys who must decide whether to proceed with a civil fraud action. Prior, and possibly inconsistent, advisory opinions could present similar difficulties in those proceedings.

Based on all of the reasons discussed above, we respectfully oppose H.R. 4028. We would be pleased to discuss this matter and others with you and your staff at any time. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report.

Sincerely yours,

Sheila F. Anthony
Assistant Attorney General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAR 22 1994

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Stark:

On March 11, 1994, H.R. 4028, the "Health Care Fraud and Abuse Advisory Opinion Act of 1994" was introduced by Representative Peter Hoagland (D-NE). We strongly oppose this bill based on the extensive resources which it would require, its impracticality, and its harmful effect on future criminal prosecutions, particularly with respect to the Medicare and Medicaid anti-kickback statute.

The "Health Care Fraud and Abuse Advisory Opinion Act of 1994" has been referred to the Committee on Ways and Means and the Committee on Energy and Commerce. This bill would require the Department of Health and Human Services (HHS) to issue advisory opinions on whether given arrangements violate the Medicare and Medicaid anti-kickback statute, Section 1128B(b) of the Social Security Act; 42 U.S.C. § 1320a-7b(b). Similarly, HHS would be required to determine whether arrangements violated section 1877 of the Social Security Act, 42 U.S.C. § 1395nn, or any other provision of the Social Security Act. The bill would provide for charging the requester with a user fee and require HHS to provide an advisory opinion within 30 days of the request.

The Medicare and Medicaid anti-kickback statute makes it a criminal offense to pay or to offer to pay anyone to induce the referral of business covered by Medicare or the State health care programs (including Medicaid) or to induce the ordering of any item or service covered by these programs. The statute also prohibits soliciting or receiving payment in exchange for such referrals or the ordering of such business. The statute is designed to ensure that medical decisions are based on medical factors and not on a decision-maker's ability to profit from patient referrals.

The Office of Inspector General (OIG) recognizes that the statute is broad and encompasses many arrangements between health care providers, many of which may not be abusive. Because of the statute's breadth, the OIG already provides more advice to the public regarding the anti-kickback statute than is provided with regard to any other

criminal provision in the United States Code. The OIG informs the public both of practices which are "safe harbored," as well as practices we consider to be highly suspect.

The Medicare and Medicaid Patient and Program Protection Act of 1987 requires this Department, in consultation with the Attorney General, to set forth specific payment practices which, although potentially capable of inducing referrals of Medicare or Medicaid business, would be immunized from criminal or civil prosecution. To date, the OIG has published three sets of regulations containing a total of 21 final or proposed "safe harbors" immunizing specific types of arrangements. See 42 C.F.R. § 1001.952; 56 Fed. Reg. 35952 (July 29, 1991); 57 Fed. Reg. 52723 (November 5, 1992); 58 Fed. Reg. 49008 (September 21, 1993).

Complementing the safe harbors, the OIG also issues special fraud alerts, which identify activities or arrangements which the OIG believes are highly suspect under the anti-kickback statute. We have issued fraud alerts addressing joint ventures, waiver of copayments and deductibles, and hospital incentives to physicians. We believe that the continuing safe harbor process, in conjunction with the fraud alerts issued by HHS give the provider community significant practical guidance with regard to the anti-kickback statute, while avoiding the many problems with advisory opinions discussed below. See 56 Fed. Reg. 35952, 35959-60 (July 29, 1991).

The issuance of advisory opinions would require enormous resources. In the current health care environment, innumerable potential arrangements could implicate the anti-kickback statute. Based on comments from the provider community, we would anticipate a flood of thousands of voluminous requests for advisory opinions. Neither this Department nor the Department of Justice has the resources to undertake such a process without severely disrupting current activities. Responding to the anticipated volume of requests for advisory opinions would require adding potentially hundreds of employees, primarily attorneys. While we recognize that this bill provides for requesters to pay a user fee, it is unclear whether HHS would receive this fee and, if so, if the fee would adequately fund the cost of issuing the opinions.

Even if sufficient resources were made available to hire the necessary additional staff, we do not think it would be appropriate or practical for HHS to issue advisory opinions regarding the anti-kickback statute. The statute requires the Government to prove "beyond a reasonable doubt" knowing and willful intent to induce or arrange for referrals or for other business reimbursable under Medicare or Medicaid. The existence of unlawful intent generally can only be determined after a thorough investigation. Advisory opinions would presumably be based on the paper submissions of the party or parties who wished to enter a particular arrangement. The factual basis for the opinion would be the facts set forth by the requester, who is clearly an interested party who may not give a complete and objective description of the arrangement. In this context, a paper submission would rarely, if ever, provide enough information for the reviewer conclusively

[redacted] Fortney H. Stark

[redacted] the intent of the parties, which is the key to determining liability under the

Even assuming the legality of a given arrangement could be determined, advisory opinions can be a source of unnecessary problems in the context of a subsequent criminal prosecution of the requester or of another person who has read the advisory opinion(s). We recognize that advisory opinions can be specifically limited in their applicability to the facts and circumstances delineated in the request for the opinion. However, imposing such a limitation would not preclude later argument by the requester (or others) that the omitted facts were not material and, even if known, would not have affected the adviser's judgment. Defendants who have read advisory opinions will argue that based on their reading of the opinion(s), they carefully conducted their affairs to fall within the confines of permissible action. The net result of this would be the introduction of additional factual issues into the criminal case; e.g., what did the opinion mean; what did the defendant think the opinion meant; and how do the facts delineated in the opinion compare with the facts which form the basis of the criminal case? Particularly in the context of difficult fraud prosecutions against sophisticated defendants, the existence of multiple advisory opinions would severely compromise the Government's ability to prosecute kickback cases. Even where opinion letters do not specifically address the anti-kickback statute, they can prevent a kickback prosecution of individuals and entities other than the letters' recipients. See, e.g., United States v. Levin, 973 F.2d 463 (6th Cir. 1992).

For all of these reasons, we oppose H.R. 4028 or any other legislative initiative to require HHS to provide advisory opinions regarding the anti-kickback statute or any other statute with a mental element. Furthermore, we strongly suggest that you solicit the Department of Justice's opinion regarding this bill. If you have any questions regarding this issue, please contact D. McCarty Thornton at (202) 619-0335.

Sincerely yours,

June Gibbs Brown
Inspector General

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
Senate judiciary Committee
United States Senate
Washington, D.C. 20510-6275

Dear Mr. Chairman:

I am writing in response to your letters to Harold Ickes of February 16, 1994, regarding antitrust issues in the Health Security Act ("the Act"). Your specific concern is focused on Section 1322(c) of the Act, which recognizes that providers may jointly negotiate with Health Alliances with respect to fee-for-service rates.

The antitrust laws have long recognized that citizens have a legal right to collectively provide input to a governmental decision maker. That right was recognized by the Supreme Court in Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961) and United Mine Workers v. Pennington, 381 U.S. 657 (1965). The so-called Noerr-Pennington doctrine is based on first amendment principles--that citizens have a right to petition their government. Pursuant to the Noerr-Pennington line of cases, competitors can jointly seek to communicate their views on such matters as legislation, licensing, standards and fee levels. It is in recognition of the Noerr-Pennington doctrine that the Act sets forth the right of providers to jointly negotiate with alliances with respect to the fee-for-service rate levels.

Alliances can be established either as an agency of the state, an independent state agency, or a non-profit organization whose board of directors represents employers and consumers. Clearly, if an alliance is either an agency of the state or an independent state agency, it will be treated as a state actor for purposes of the antitrust laws and thus Noerr-Pennington protections would apply to joint provider negotiations with respect to that alliance. The Administration believes that the same result is appropriate if the alliance is established by the state as a non-profit organization.

Under section 1322(c), the alliances will be engaging in a governmental function--rate setting with respect to the fee-for-service schedule. In this regard, and in view of their unique status under state and federal law, we believe that it is appropriate to treat the alliances as state actors for purposes of the fee-for-service schedule, and that it is reasonable to allow citizens, in this case providers, to jointly petition the alliance regarding the schedule.

Your letter also discusses several policy reasons why you think Section 1322(c) of the Act is problematic. Your first two points express the concern that the fee-for-service rate would, in your view, become the rate in all instances; no provider would negotiate a lower rate with managed care plans. While we respect your opinion, we respectfully disagree with your prediction in this regard. As you know, providers, as well as other businesspeople, often are faced with a price/quantity decision in determining how they will price their product or services. Managed care plans can induce providers to lower their rates to the managed care plan in return for a volume of business the provider would not expect to receive under a fee-for-service plan. In such fashion, the provider can become more profitable, even charging a lower rate. Individual providers can be expected to take advantage of this opportunity to increase their overall profitability. If providers jointly agree not to deal with plans at lower rates, either explicitly or implicitly, such actions would violate the antitrust laws and subject them to prosecution. For these reasons, we do not expect the fee-for-service rates to be mirrored across other types of plans.

Your third point is based on the concern that only premium caps can control providers' ability to demand high prices from alliances. Under the Act, however, the alliances have ultimate authority over the rates to be set. While they will negotiate, alliances have the final say as to the rates to be set, and providers may not boycott the alliances. As a result, providers will not be able to extort high prices from the alliances. This also relates to your fourth point, a concern over the interpretation of the word "boycott" in Section 1332. Let me assure you that the Administration does not intend to allow providers the ability collectively to refuse to deal with an alliance until it meets their demands for higher prices.

Fifth, you are concerned that treating the alliances as state actors eliminates the requirement of active state supervision from the antitrust laws. For the reasons discussed above, we feel it is appropriate to treat the alliances as state actors under the antitrust laws for the purposes of setting the fee-for-service rate levels. The Administration deemed it essential to clarify this in the Act. If overall reform is to be accomplished successfully, we must avoid years of unnecessary,

and potentially quite harmful litigation, litigation that can be obviated by including this clarification in the Act.

Finally, you express concern that the inclusion of Section 1322(c) will encourage demands by provider groups for antitrust loopholes that will undermine the Administration's efforts to lower the cost and improve the quality of health care. The Administration opposes antitrust loopholes that would defeat the purposes of health care reform and believes that any such demands should be resisted.

I thank you for your letter. I hope that this response has explained the Administration's thinking with respect to Section 1322(c), and we look forward to working closely with you to produce a bill that produces affordable health care for all Americans.

Best regards,

Anne K. Bingaman
Assistant Attorney General

U.S. Department of Justice

Antitrust Division

Office of the Assistant Attorney General

Washington, D.C. 20530

APR 14 1994

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 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 the Attorney General, after seeking public suggestions for

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

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.[4]

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[4]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.

U.S. Department of Justice

Antitrust Division

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

APR 14 1994

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 letter of March 22, 1994, also signed by Chairman Metzenbaum, 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 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 the Attorney General, after seeking public suggestions for further safe harbors via Federal Register notice under Section 4 of the bill; or

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

(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 <u>either</u> ventures below the size limits in Note 2 <u>supra</u> 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.[4]

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[4]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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[6](...continued)
may protect anticompetitive conduct that significantly harms consumers.

cc: Melanne, Jennifer, Maureen Shea

HOWARD M. METZENBAUM
OHIO

United States Senate

WASHINGTON, DC 20510-3502

COMMITTEES:
JUDICIARY
LABOR AND HUMAN RESOURCES
SELECT COMMITTEE ON INTELLIGENCE
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SUBCOMMITTEE ON ANTITRUST
SUBCOMMITTEE ON LABOR

February 16, 1994

Mr. Harold Ickes
Deputy Assistant to the President
1600 Pennsylvania Avenue
Washington, D.C.

Dear Harold:

I am writing to follow up on the antitrust issues that I raised with Mrs. Clinton when the Health Security Act ("HSA" or bill) was introduced in the Senate. Last year, I had a number of conversations with Mrs. Clinton, Ira Magaziner and other members of the health care team about the need for vigorous enforcement of our nation's antitrust laws to contain the cost of health care for consumers. Consequently, when an antitrust exemption for provider negotiations was included in the bill, I considered seriously whether I should withdraw as a cosponsor. I grew even more concerned when I read in the October 30th Boston Globe, that the American Medical Association ("AMA") claimed to have White House support for the exemption and "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 fee schedules."

However, prior to introduction of the HSA both Mrs. Clinton and Tom Daschle assured me that my concerns about the exemption would be dealt with promptly when the session began this year. Based on those assurances, I agreed (and am proud) to be an original cosponsor of the bill. However, I continue to oppose the antitrust exemption and expect to drop off as a cosponsor of the bill if the exemption remains.

As I read it, the exemption in section 1322 (c) of the bill gives provider groups blanket antitrust immunity to collude on prices and then "negotiate" those prices with Health Alliances in order to develop a fee-for-service payment schedule. Although the exemption might seem to be relatively limited, I believe that it will have broad-ranging effects and will actually increase the cost of health care for consumers.

I am not alone in this view. For example, on January 25, 1994, the American College of Nurse-Midwives testified before the House Subcommittee on Health and the Environment in opposition to the exemption. They said:

> Even though the exemption ... could possibly benefit [us] by permitting us to negotiate with the alliances over fees, we continue our opposition to such special interest legislation. We adopted this position because we believe that antitrust exemptions are contrary to the spirit and principles of health care reform and harmful to consumer welfare.

Let me explain why I oppose the exemption. First, the exemption would make it virtually impossible for cost conscious health plans to negotiate lower prices with providers. The fact is that providers who collude on the prices they charge under a fee-for-service plan would be poised to insist on the same high prices from every health care plan that operates under a Health Alliance. Such collusion would increase -- not decrease -- the cost of health care.

Let me give you an example. In a recent submission to the Department of Justice's Antitrust Division, Independence Blue Cross of Philadelphia ("IBC") cited evidence that its costs were substantially higher when the state of Pennsylvania required it to negotiate prices with hospital providers as a group. IBC stated that it saved $57 million the first year that it was permitted to negotiate with hospitals separately and that it ultimately expected to realize savings of over $500 million. I am sure that you will agree that savings of that magnitude are a remarkable achievement and will be necessary in the future if we are to bring down the high cost of health care. However, such savings will be difficult -- if not impossible -- to achieve if payors are forced to negotiate fees with groups of providers who have been permitted to collude on prices.

Second, the exemption would create an overwhelming disincentive for providers to lower their prices for managed care plans. That is because providers would risk having Health Alliances reduce their negotiated fee schedules if they accepted lower fees from a managed care plan or other low cost provider. The fact is, a Health Alliance would be much more likely to reduce fee schedules for providers who agree to charge managed care plans lower prices. That means providers would be under enormous pressure not to lower their fees for any health care plan. I am certain that the administration did not intend for the exemption to create a powerful disincentive for providers to reduce their fees for managed care plans. However, I believe that would be the result of enacting this exemption.

Third, if the premium caps in the bill are eliminated or even weakened, it would remove the only possible constraint on providers' ability to extort high prices from Health Alliances and health plans. As you know, I strongly support rigid caps on spending. However, many provider groups oppose them. That concerns me because if some less effective method of cost control

were to be enacted, Health Alliances would find it virtually impossible to resist the demands of provider groups for steep price increases. That would send the cost of health care through the roof.

Fourth, a recent Supreme Court decision interpreting the term "boycott" has undercut the only protection that consumers were to have had against unreasonable demands by price-gouging providers. Specifically, the bill prohibits a "boycott" by providers. That seems as if it would prevent providers, who were dissatisfied with their fee negotiations, from refusing to deal with a Health Alliance and consumers. However, in Hartford Fire Insurance v. California, 113 S.Ct. 2891 (1993), the Supreme Court stated that a "'boycott' encompasses just those refusals to deal that are 'unrelated' or 'collateral' to the objectives sought by those refusing to deal." Consequently, if providers refused to deal with a Health Alliance until it met their demands for higher fees, technically, that might not constitute a "boycott." I am sure that the administration did not intend to leave consumers without adequate protection against a provider boycott over fees. However, the exemption has done just that by relying on the term "boycott."

Fifth, the exemption eliminates an important source of consumer protection under the antitrust laws. It does so by abolishing the requirement under the state action doctrine that anticompetitive activities directed by a quasi-governmental, private nonprofit or corporate entity be actively supervised by accountable state officials. The active supervision test underpins the state action doctrine by insuring that consumers are protected if state officials delegate the power to set prices and restrict output to others outside state government. The exemption eliminates that test entirely. Consequently, it could put consumers at risk and give Health Alliances, which are not state run, greater freedom to act in an anticompetitive manner that harms consumers and disfavored providers.

Finally, the exemption will encourage demands by provider groups (many of which have opposed cost controls) for antitrust loopholes that would benefit their narrow special interests at the expense of consumers. For example, the January 13th New York Times reported that the AMA intends to launch a campaign to win antitrust exemptions for their members, including immunity to "negotiate on behalf of physicians to set terms of practice, including payment levels and medical services for patients" with Health Alliances and health plans. The AMA's own documents, dated January 19, 1994, state that the AMA will lobby for costly antitrust loopholes that "take advantage of opportunities laid out in discussions with senior Administration officials." I belive that if provider groups, particularly the AMA, win antitrust exemptions allowing them to fix prices and standardize medical services, it will undermine the administration's efforts

to control the cost and improve the quality of health care. Moreover, it would allow special interest groups to determine how much consumers, hospitals, managed care plans and health insurers would pay for their services. That would be a disaster for consumers.

I hope that we can resolve this issue promptly. I look forward to working closely with you to assure that the Senate enacts a strong and comprehensive health care bill that provides real protection for all Americans. The sooner we resolve our differences over the antitrust exemption the sooner we can begin that important work.

Warm regards,

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

cc: Hillary Rodham Clinton
Senator Tom Daschle
Ira Magaziner