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H. R. 3897

To ensure and foster continued patient safety and quality of care by clarifying the application of the antitrust laws to negotiations between groups of health care professional and health plans and health care insurance issuers.

IN THE HOUSE OF REPRESENTATIVES

MARCH 7, 2002

Mr. BARR of Georgia (for himself, Mr. CONYERS, Mr. NORWOOD, Mr. HOEFFEL, Mr. GANSKE, Mr. NADLER, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To ensure and foster continued patient safety and quality of care by clarifying the application of the antitrust laws to negotiations between groups of health care professional and health plans and health care insurance issuers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Antitrust Improvements Act of 2002''.

(b) FINDINGS.—Congress finds the following:

(1) A large number of Americans receive their health care coverage from managed health care plans. This represents a 10-fold increase over the last 20 years.

(2) The market power of insurance companies has increased tremendously since the early 1990's. Since 1995, there have been 321 announced managed care mergers and acquisitions. This unprecedented consolidation has provided health plans with significant leverage over health care professionals and patients in determining the scope, coverage, and quality of health care in this country.

(3) Health plans, because of the concentration and exertion of market and economic power, systematically and improperly manipulate the practice of medicine through such mechanisms as inappropriately making medical necessity determinations, down-coding and bundling, knowingly denying and delaying payment, and engaging in a variety of practices that may affect the continuity and quality of patient care.

(4) In 1992, Congress considered legislation addressing various antitrust issues within the health care industry that were problematic for health care providers and patients. Most of the legislation was

incorporated into the revised Statements of Antitrust Enforcement Policy in Health Care, issued by the Department of Justice and the Federal Trade Commission in August 1996. While the ''safe harbor'' guidance for physicians contained in the Statements was a good first step in addressing this market imbalance, it does not provide adequate parameters for the roughly 54 percent of self-employed and small physician group practices to interact, share information, and effectively and fairly negotiate with health plans.

(5) The intent of the antitrust laws is to encourage competition and protect the consumer, and the current per se standard for enforcing the antitrust laws in the health care field frequently does not achieve these objectives.

(6) An application of the rule of reason to health care professionals' business activities and interactions with health care plans will tend to promote both competition and high-quality patient care.

(7) An application of the rule of reason to health care professionals' business activities and interactions with health plans will not change the professionals' ethical duty to continue to provide medically necessary care to their patients.

SEC. 2. APPLICABILITY OF RULE OF REASON STANDARD.

In any action under the antitrust laws challenging the efforts of 2 or more physicians or other health care professionals to negotiate with a health plan, the conduct of such physicians or health care professionals shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including patient access to health care, the quality of health care received by patients, and contract terms or proposed contract terms.

SEC. 3. AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.

Notwithstanding sections 4(a) and 16 of the Clayton Act (15 U.S.C. 15(a), 26), in any action under the antitrust laws brought against a health care cooperative venture based on its negotiations with a health plan, the court at the conclusion of the action shall include an attorney's fee in the award of costs to a substantially prevailing plaintiff only if the defendant's conduct during litigation of the claim was frivolous, unreasonable, without foundation, or in bad faith.

SEC. 4. NOTIFICATIONS UNDER ANTITRUST LAW FOR HEALTH CARE COOPERATIVE VENTURES.

(a) NOTIFICATIONS.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care cooperative venture (acting on behalf of such venture) that intends,

or has begun, to negotiate with a health plan may file with the Attorney General of the United States a written notification disclosing—

(A) the identities of the parties to such venture, and the name and address of each agent representing such venture;

(B) the identity of each health plan with which such venture is or may be negotiating; and

(C) the general nature and objectives of the negotiations.

(2) SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care cooperative venture for which a notification is in effect under this section shall submit information on any change in the membership of the venture not later than 90 days after such change occurs.

(3) PUBLICATION OF NOTIFICATION.—Except as provided in paragraph (4), not later than 30 days after receiving a notification with respect to a health care cooperative venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with respect to such venture that identifies the parties to the venture, the name and address of each agent representing the venture, and

generally identifies the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the agents of the venture.

(4) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information submitted pursuant to notification and all information and documentary material obtained by the Attorney General in the course of any investigation with respect to a potential violation of the antitrust laws by the health care cooperative venture shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies except in a judicial proceeding in which such information and material are subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (3).

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(7) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

(A) IN GENERAL.—Any information disclosed in a notification submitted under paragraph (1) and the fact of the publication of a notification by the Attorney General under paragraph (3) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing that a party to a health care cooperative venture is entitled to the protections described in subsection (b).

(B) ACTIONS OF ATTORNEY GENERAL.—No action taken by the Attorney General pursuant to this subsection shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—The provisions of paragraph (2) shall apply with respect to any action under the antitrust laws challenging conduct within the scope of a notifi-

cation which is in effect pursuant to subsection (a)(1).

(B) TIMING OF PROTECTIONS.—The protections described in this subsection shall apply to a venture, and any party to such venture that has made a notification under subsection (a)(1) as of the postmarked date of the notification.

(2) LIMITATION ON RECOVERY TO ACTUAL DAMAGES AND INTEREST.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover only the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

SEC. 5. TYING ARRANGEMENTS.

Any rule, policy, agreement, or other action of a health plan that has the effect of requiring a health care professional to participate in a product, all products, or

product lines offered by the health plan in order to participate in a particular product or product line, shall be construed to be an illegal tying arrangement under the antitrust laws unless the health plan demonstrates that it lacks market power in the market for the tying product or product lines.

SEC. 6. DEMONSTRATION PROJECTS ALLOWING HEALTH CARE PROFESSIONALS TO NEGOTIATE WITH HEALTH PLANS.

(a) ESTABLISHMENT OF DEMONSTRATION PROJECTS.—The Attorney General, in accordance with the recommendations of the advisory committee appointed under subsection (b), shall establish demonstration projects (in this section referred to as ''projects'') under which health care professionals in the States designated as project sites may act together to jointly negotiate contracts and agreements with health plans to provide health care items and services for which benefits are provided under such health plans. Projects shall be established for the purpose of testing various options in the health care market to allow negotiations and agreements by health care professionals that will enhance efficiency, quality, and availability of health care, while promoting competition in the health care market.

(b) ADVISORY COMMITTEE.—(1) Not later than 180 days after the date of the enactment of this Act, the Attorney General shall appoint an Advisory Committee on Health Plan Negotiations to advise the Attorney General with respect to the carrying out of the Attorney General's functions under this section. The duties of the Advisory Committee shall include, but not be limited to, providing recommendations regarding implementation and design of projects and monitoring and reporting on the impact of projects as required under subsection (e).

(2) The Advisory Committee shall consist of 13 members, appointed without regard to the civil service laws. Seven members shall be representatives of health care professional organizations, 2 of whom shall be self-employed physicians (allopathic or osteopathic). The remaining members shall have expertise in health care quality, economics, or insurance, but at least 1 of such remaining members shall be a representative of consumers.

(3) The Attorney General shall furnish to the Advisory Committee an executive secretary and such secretarial, clerical, and other services as may be necessary to conduct its business, and may call upon other agencies of the Government for statistical data, reports, and other information which will assist the Advisory Committee in the performance of its duties.

(4) Members of the Advisory Committee, while serving on business of the Advisory Committee (inclusive of travel time), shall be entitled to receive the daily equivalent of the annual rate of basic maximum rate of pay payable from time to time under section 5376 of title 5, United States Code, for each day and, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as provided in section 5703 of title 5, United States Code, for individuals in the Government employed intermittently.

(5) The members shall serve until submission of the report pursuant to subsection (e)(2), at which time the Advisory Committee shall terminate. A vacancy arising in the Advisory Committee shall be filled in the same manner as the original appointment is made. A majority of members shall constitute a quorum, and action shall be taken only by a majority vote of those present and voting.

(c) APPLICATION FOR STATES TO PARTICIPATE IN PROJECTS.—

(1) IN GENERAL.—Not later than 180 days after appointment of the Advisory Committee, the Attorney General shall establish, taking into consideration the recommendations of the Advisory Committee, an application process that shall allow health

care professional organizations to apply for 1 or more States to be designated as a site for 1 project to be implemented under subsection (d). Such health care professional organizations shall be permitted a 3-month period to submit applications. At the end of the 3-month application period, the Attorney General shall have 3 months to designate not fewer than 6 States in which projects shall be implemented regardless of the number of applications submitted.

(2) CRITERIA FOR SELECTION.—The Attorney General shall determine the States to be designated in accordance with the recommendations of the Advisory Committee, and taking into account the level of managed care penetration in the particular State, as well as other factors that demonstrate a need to address unfair negotiations, based upon factual information submitted by the applicants or otherwise found by the Advisory Committee. The designated States shall represent an appropriate environment for a study on the imbalance in contractual negotiations between health care providers and health plans.

(d) PROJECT IMPLEMENTATION.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act the At-

torney General shall implement not fewer than 6 projects, limited to 1 project in each State designated under subsection (c) and satisfying subparagraphs (A) and (B).

(A) QUALITY HEALTH CARE COALITION DEMONSTRATION.—For not fewer than 3 of such States, the following provisions shall apply to projects in such States:

(i) IN GENERAL.—Notwithstanding the antitrust laws (except as provided in clause (ii)), health care professionals may act jointly to negotiate and enter into contracts and agreements with health plans to provide health care items and services for which benefits are provided under such health plans.

(ii) LIMITATION.—

(I) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE.—Clause (i) shall not provide health care professionals with any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(II) OTHER CONDUCT UNDER ANTITRUST LAW UNAFFECTED.—Nothing in this section shall exempt from the application of the antitrust laws any agreement or otherwise unlawful conspiracy that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care professional or group of health care professionals with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation.

(iii) PROTECTION FOR GOOD FAITH ACTIONS.—Actions taken by health care professionals in good faith reliance on clause (i) shall not be subject under the antitrust laws to criminal sanctions or civil damages, fees, or penalties other than actual damages.

(B) QUALITY HEALTH CARE COOPERATIVE DEMONSTRATION.—For any remaining States

designated under subsection (c), the following provisions shall apply to projects in such States:

(i) IN GENERAL.—Notwithstanding the antitrust laws, any health care professionals may act jointly to negotiate and enter into contracts and agreements with health plans to provide health care items and services for which benefits are provided under such health plans.

(ii) OVERSIGHT.—(I) If the Attorney General has reason to believe that 2 or more health care professionals have jointly engaged in conduct described in clause (i) with a health plan, that is intended to substantially harm both competition and the quality of health care received by patients, the Attorney General shall serve upon such health care professionals a complaint alleging such conduct.

(II) The complaint shall accompany a notice of hearing to be held not less than 60 days after the date of service, requiring the health care professionals to show cause why an order should not be made directing

them to cease and desist from engaging in such conduct.

(iii) ADMINISTRATIVE ADJUDICATION.—(I) The Attorney General shall make a determination of the charge alleged in the complaint based on the record after an opportunity for a hearing.

(II) If the Attorney General determines that such health care professionals have jointly engaged in conduct described in clause (i) with a health plan that is intended to substantially harm both competition and the quality of health care received by patients, the Attorney General shall issue and cause to be served upon such health care professionals, an order reciting the facts on which the determination is made and directing such health care professionals to cease and desist from engaging in such conduct.

(III) A health care professional aggrieved by such determination may commence a civil action in an appropriate district court of the United States, not later than 60 days after receiving such order,

for review of such determination on the record of the Attorney General.

(IV) As part of the answer to the complaint, the Attorney General shall file in such court a certified copy of the record on which such determination is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(iv) JUDICIAL REVIEW.—(I) The district courts of the United States shall have jurisdiction to review in accordance with this subparagraph determinations made and orders issued under clause (iii).

(II) CONTEMPT.—Failure to obey any such order may be punished by such courts as a contempt thereof.

(C) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT OF 1964.—Nothing in this section shall be construed to affect the application of title VI of the Civil Rights Act of 1964.

(e) MONITORING AND REPORT.—

(1) MONITORING IMPACT.—During the effective period of projects implemented under this section,

the Attorney General shall, in accordance with the recommendations of the Advisory Committee, closely monitor and measure the impact of projects in each State on the quality of and access to health care services, choice of health plans, changes in health plan enrollment, and other relevant factors. The Attorney General shall, in accordance with the recommendations of the Advisory Committee, determine the criteria for evaluating the impact on the quality of health care services.

(2) REPORT.—Not earlier than 3 years and not later than 4 years after commencement of all of the projects implemented pursuant to subsection (d), the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives 1 report on the progress of all of the projects implemented under this section, including a comparison of the matters monitored under paragraph (1) among the different designated States and as compared to the Nation as a whole.

(3) PROJECT TERMINATION.—Unless the report submitted pursuant to paragraph (2) demonstrates by factual evidence that consumers have been harmed by a decrease in quality of or access to

health care services as a direct result of a project implemented under this section and without any offsetting benefits, the Attorney General may not terminate such project. Projects that are implemented under this section and that are not terminated under this paragraph shall be extended by the Attorney General to additional States.

SEC. 7. NO APPLICATION TO FEDERAL PROGRAMS.

Nothing in this Act shall apply to negotiations, agreements, or other obligations between health care professionals and health plans that pertain to benefits provided under any of the following:

(1) The Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The Medicaid Program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) The SCHIP program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(5) Chapter 17 of title 38, United States Code (relating to veterans' medical care).

(6) Chapter 89 of title 5, United States Code (relating to the Federal Employees' Health Benefits Program).

(7) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 8. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) ANTITRUST LAWS.—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) HEALTH PLAN.—The term ''health plan'' means a group health plan or a health insurance issuer that is offering health insurance coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under

the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(4) MEDICAL CARE.—The term ''medical care'' means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to medical care referred to in subparagraph (A); and

(C) insurance covering medical care referred to in subparagraphs (A) and (B).

(5) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(6) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization

(including a health maintenance organization) that is licensed to engage in the business of insurance in a State and that is subject to State law regulating insurance. Such term does not include a group health plan.

(7) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a)));

(B) an organization recognized under State law as a health maintenance organization; or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(8) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms ''group health plan'' and ''health insurance issuer'' include a third-party administrator or other person acting for or on behalf of such plan or issuer.

(9) HEALTH CARE COOPERATIVE VENTURE.—The term ''health care cooperative venture'' means 2

or more health care professionals who are engaged in negotiations with a health plan, including any attempts to enter into negotiations with a health plan, regarding the provision of health care services to insureds, enrollees, or beneficiaries of a health plan.

(10) HEALTH CARE SERVICES.—The term ''health care services'' means any services for which payment may be made under a health plan, including services related to the delivery or administration of such services.

(11) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual or entity that provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

(12) HEALTH CARE PROFESSIONAL ORGANIZATION.—The term ''health care professional organization'' means any nonprofit association, society, or organization whose membership consists of health care professionals.

(13) PERSON.—The term ''person'' includes a State or unit of local government.

(14) STATE.—The term ''State'' includes the several States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

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