Federal Trade Commission

PREPARED STATEMENT

OF

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FEDERAL TRADE COMMISSION

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COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

CONCERNING ANTITRUST ENFORCEMENT

AND HEALTH CARE REFORM

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Mr. Chairman and members of the Subcommittee: I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust enforcement and health care reform.[1]

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

There is intense interest in proposals for containing the rapidly increasing cost of health care in the United States. I am not, of course, in a position to discuss any particular proposal,[2] but as Chairman of an agency that has for years been an advocate and defender of the role of competition in health care, I want to discuss an element that has figured prominently in the reform discussions to date -- reliance on competition in the health care field, including the development of managed care and other alternative delivery plans.

I have two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform. I will not suggest that any particular antitrust exemption would doom any particular health care plan. However, proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate

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[2] The Administration's Health Care Reform Task Force is currently scheduled to announce its proposals during May.

the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost reductions.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. Instead, the Commission endeavors to keep markets competitive so that consumers may choose whatever health care option they prefer. We do not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, we try to level the playing field so that each plan may develop and grow as they meet the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede or block the development of health care alternatives that consumers might elect to use. This background on the function of the Commission in enforcing the antitrust laws is a useful starting point for understanding our role in this process.

Through sound antitrust enforcement the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care

delivery systems grew as consumers were attracted by the services or lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust enforcement.

Before I develop these points in greater detail, however, let me offer a general caveat. Although I firmly believe that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. My suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. I believe that the Federal Trade Commission will continue to play a significant, constructive role in this process.

I. The Contribution of Antitrust Enforcement to the Development of Health Care Plans

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970s, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multi-specialty group practices were rare, and health care plans that sought to compete by signing up a limited panel of selected physicians were impeded by a variety of restrictions. Most

hospitals operated in a similarly independent fashion, with few limitations on what they could charge.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges.[3] In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization.[4] The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, providers of alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or Health Maintenance Organization ("HMO"),

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[3] See P. Feldstein, Health Associations and the Demand for Medical Care 40-44 (1977).

[4] American Medical Ass'n v. United States, 317 U.S. 519 (1943).

"underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.[5]

HMOs and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offered are worth accepting their limitations. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to operate effectively.

The advertising aspect of the Commission's AMA case also benefited consumers. Doctors had been prohibited by the AMA's ethical rules from disseminating truthful information to the public about the price, quality, or other aspects of their services (such as office hours, acceptance of Medicare assignment or credit cards, use of Spanish-speaking staff, or house-call

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[5] American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982).

services).[6] The Commission found that this ban on truthful advertising had a particularly adverse impact on newly emerging plans such as HMOs, which needed to advertise precisely because they were novel, and thus unfamiliar to consumers.[7] The ability to advertise is particularly important to a new market entrant.

Even after the Commission's AMA case freed physicians to affiliate with health care plans, these plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, our experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy conduct such as obstructing hospital privileges for HMO physicians[8] and boycotting a hospital that was planning to open an HMO facility.[9]

Within the last two years alone, the Commission has issued a series of orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic.[10] The

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[6] See Id. at 846-48. See also Broward County Medical Society, 99 F.T.C. 622, 624 (1982) (consent order).

[7] 94 F.T.C. at 1006.

[8] Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

[9] Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988) (consent order).

[10] Diran Seropian, M.D., Dkt. No. 9248, 57 Fed. Reg. 44,748 (1992) (consent order); Medical Staff of Holy Cross Hospital, C-3345, 56 Fed. Reg. 49,184 (1991) (consent order); Medical Staff

(continued...)

Cleveland Clinic is a nationally known provider of comprehensive health care services. The Clinic, which operates as a multi-specialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. Our orders prevent such activity from recurring.

The Commission also played an important role in taking enforcement action to end barriers to the emergence of independent health care prepayment plans. The first medical and hospital prepayment plans -- forerunners of today's Blue Cross and Blue Shield plans -- were outgrowths of state or local medical societies and hospital associations. These groups initially had direct control of the plans, but in the early 1970s the Blue Cross plans began to split off from the hospital associations. Provider control of Blue Shield plans lasted longer. An important factor in the debate about provider control of Blue Shield plans was a Commission staff report detailing evidence that medical societies had used control of the plans to

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[10](...continued)
of Broward General Medical Center, C-3344, 56 Fed. Reg. 49,184 (1991) (consent order).

increase physicians' fees and to obstruct competition from non-physician providers and from health care plans.[11]

One of the first Blue Shield plans to become independent of a medical society was Blue Shield of Michigan. Once independent, this plan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In Michigan State Medical Society, the Commission prohibited such joint "negotiations."[12]

The Commission has since enjoined a number of other conspiracies to obstruct cost containment measures, in cases such as Federal Trade Commission v. Indiana Federation of Dentists,[13] where the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the efficient operation of utilization control mechanisms.[14] More recently, we obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply

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[11] Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission (1979).

[12] 101 F.T.C. 191, 296, 313-14 (1983).

[13] Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447 (1986).

[14] Id. at 461.

operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.[15]

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, our review of hospital mergers, as I will discuss later, helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives.

The antitrust enforcement actions I have just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus expand the variety of health care plans, particularly more cost-containment options. For example, the Commission has brought cases that challenged unjustified restrictions on the delivery of health care services by non-physician providers, such as nurse-midwives or podiatrists.[16] The Commission does not side with non-physicians against physicians, or vice versa, of course, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able -- so far as possible -- to compete on a level playing field. The resulting expanded

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[15] Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992).

[16] For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Corp., 102 F.T.C. 1232 (1983) (consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986) (consent order)).

range of choice benefits both health care plans and individual health care consumers.

The Commission has also acted against provider efforts that directly sought to frustrate cost-containment programs. The Commission has entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.[17]

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. Last year, the Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[18] This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, $20 million a year.[19]

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[17] E.g., Southeast Colorado Pharmacal Ass'n, C-3410, 57 Fed. Reg. 52,631 (1993) (consent order); Peterson Drug Company, No. D-9227 (1992) (Commission adopted opinion of administrative law judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D-9227, 56 Fed. Reg. 9223 (1991); Orange County Pharmaceutical Soc'y, No. C-3292, 55 Fed. Reg. 31,441 (1990) (consent orders).

[18] Sandoz Pharmaceutical Corp., C-3385, 57 Fed. Reg. 36,403 (1992) (consent order).

[19] This was one of two tying cases brought by the Commission. In the other case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, No. C-3290, 55 Fed. Reg. 27,686 (1990) (consent order).

Last year, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WIC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WIC program.[20]

Finally, I would be remiss if I did not mention some of the merger cases brought by the Commission in the health care area. In addition to the hospital merger cases, which I will discuss later, in the last three years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone, and wheelchair lifts.[21] By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the

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[20] FTC v. Mead Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent order); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992) (consent order). The Commission is also pursuing allegations of price fixing against a third manufacturer which did not agree to settle the Commission's allegations. FTC v. Abbott Laboratories, 1992-2 Trade Cas. (CCH) ¶ 69,996 (D.D.C. 1992).

[21] Dentsply International, Inc., C-3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C-3331, 56 Fed. Reg. 26,108 (1991) (consent order); Roche Holding Ltd., C-3315, 55 Fed. Reg. 53,191 (1990) (consent order).

Commission's merger enforcement contributes to the overall health care cost containment effort.

II. Antitrust Exemptions and Health Care Reform

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. Our experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures from antitrust scrutiny. Others seek an exemption for various forms of concerted action -- in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and hospitals may be based on questionable arguments about the nature of competition in health care markets and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such

as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

A. Hospital Exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents pose two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. We believe that the available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. Let me put the issue in

perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about two dozen formal investigations, mostly involving larger metropolitan hospitals, and has challenged, on average, less than one hospital merger a year.

Our assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed by some others. Hospital merger and joint venture activity has been so vigorous that a recent article in Modern Healthcare was entitled "Mergers Thrive Despite Wailing About Adversity."[22] After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Similarly, a Department of Health and Human Services task force recently examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.[23]

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[22] Modern Healthcare, Oct. 12, 1992, at 30.

[23] Report of the Secretary's Task Force on Hospital Mergers, at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions.

The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings."[24] We believe that the task force report supports our contention that antitrust enforcement does not inhibit efficient mergers in the hospital area.

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of our merger enforcement, we have expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.[25]

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[24] Id. at 9.

[25] University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) (consent order) (exempting a wide range of support service joint ventures). See Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). See also The Reading Hospital, FTC Docket No. C-3284, 55 Fed. Reg.

(continued...)

These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

The great majority of hospital mergers and joint ventures -- like those in most lines of business -- do not endanger competition. Most hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition.

Similarly, many hospital joint ventures are efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some forms of joint venture activity. To cite but one example, virtually all

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[25](...continued)
3264, 3266, 15,290 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory and biomedical equipment repair services).

hospitals acquire many of their day-to-day supplies through buying cooperatives.[26]

But the fact that most hospital mergers and joint ventures are procompetitive does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In our hospital merger investigations, we examine a broad range of evidence concerning the likely impact of the merger on health care costs. We do not rely on market concentration figures standing alone. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When we review hospital mergers, we consider whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

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[26] See Nearly All Hospitals Use Group Purchasing, Modern Healthcare, Dec. 24-31, 1990, at 40.

Finally, let me address the argument that merger enforcement in the health care area actually leads to higher, not lower health care costs. The argument we hear with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission by Hospital Corporation of America in defense of a proposed merger a few years ago. The Commission found that the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector . . . will allow natural market forces to slow the price spiral."[27]

The Commission's experience in merger enforcement in the health care area has demonstrated that often procompetitive mergers can result in the elimination of duplication of services. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. The Commission is aware, however, that care must be given to ensure that eliminating duplication of services does not become simply avoiding competition.

B. Exemptions for Professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of

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[27] Hospital Corp. of America, 106 F.T.C. 361, 478-87 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-containment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but

rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, we are not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

But we need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the Michigan State Medical Society case I mentioned. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The point is straightforward. Physicians can engage in forceful

advocacy and provide information to health plans without an antitrust exemption.[28] The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).[29] But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately we have also heard the claim that antitrust enforcement interferes with responsible self-regulation by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Let me assure you that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet minimal quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.[30] As the Commission emphasized in

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[28] The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the Chain Pharmacy Association matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12,534, 12,541 (1991).

[29] See, e.g., Southbank IPA, Inc., C-3355, 56 Fed. Reg. 50912, 50914 (1991); 57 Fed. Reg. 2913 (1992); Rochester Anesthesiologists (formerly Jose F. Calimlim, M.D.), 110 F.T.C. 175, 180-81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307-08, 314 (1983).

[30] See American Psychological Ass'n, C-3406, 58 Fed. Reg. 557 (1993) (Commissioner Azcuenaga concurred in part and dissented in part); National Association of Social Workers, C-3416, 57 Fed. Reg. 61,424 (1992) (Commissioner Starek dissented).

its 1979 opinion in the AMA case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.[31]

Before leaving the subject of self-regulation, let me also say a brief word about the AMA's request for an FTC advisory opinion on peer review of doctor's fees by medical societies, because I have heard several public references to it recently. More than a decade ago the Commission approved the concept of advisory fee review by professional organizations.[32] Such programs can provide valuable information to patients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns. The AMA has asked the Commission to approve a type of fee review that goes beyond the kind of peer review that has been approved in the past, because it would involve not only the provision of information to consumers about the reasonableness of specific fees, but also possible disciplinary action against physicians in certain circumstances.

In order to analyze the AMA's proposal, several months ago the Commission's staff asked the AMA to provide additional

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[31] American Medical Ass'n, 94 F.T.C. at 1029.

[32] Iowa Dental Ass'n, 99 F.T.C. 648 (1982) (advisory opinion approving proposal of dental association to institute a peer review program which would aid the cost containment efforts of third-party payers, so long as the fee review program was voluntary and non-binding, guidance in particular disputes was not disseminated to members generally as an indication of appropriate pricing, and the judgments of the peer review panel did not proceed from pre-agreed price standards).