Prepared Statement
of
Federal Trade Commission

Presented by

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Before The
Committee on The Judiciary
United States House of Representatives

Concerning H.r. 4277 the "Quality Health-care Coalition Act of 1998"

July 29, 1998

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to present the testimony of the Federal Trade Commission concerning H.R. 4277, which would create an exemption from the antitrust laws to enable health care professionals to negotiate collectively with health plans over fees and other terms of dealing. The Commission believes that the interests of consumers would be harmed by such an exemption. The immunity that would be granted by H.R. 4277 is unnecessary to protect legitimate collaboration among competing health care providers. It would immunize anticompetitive activities that could diminish the effective functioning of health care markets. This, in turn, could harm consumers and raise health care costs, and would likely encourage those in other industries to seek similar special interest exemptions.

We are aware that some health care providers, as well as others, have expressed concerns about the effects that certain managed care arrangements may have on the quality of patient care. We do not question the sincerity of those raising concerns about the welfare of patients. However, we do not believe that granting a broad antitrust exemption to health care providers for anticompetitive collective activity is the best way to address those concerns.

Health care markets are undergoing rapid and far-reaching changes. The issue of how best to protect consumers in the changing health care system is a matter of fundamental national importance, and the subject of substantial public debate. As Members of this Committee are well aware, Congress is currently considering various legislative proposals designed to address concerns that consumers may lack adequate protections in dealing with the health care system. While the Commission is not now offering comments on the merits of these various proposals, it respectfully submits that an exemption such as the one before this

Committee today would undermine efforts to address concerns about the current state of our health care system.

In this testimony, the Commission will first briefly discuss the role of antitrust law enforcement in the health care area, and then address the proposed legislation under consideration by the Committee. We understand that H.R. 4277 is intended to allow health care professionals to present a united front when negotiating with health plans over fees and other terms governing the plans' dealings with health care providers, and the Commission's testimony is based on its understanding of that intent.

I. THE ROLE OF ANTITRUST IN THE EVOLVING HEALTH CARE SYSTEM

A key focus of the Commission's efforts in the health care area has been to help assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. The development of these new arrangements, which have helped substantially to slow the rate of increase in health care costs, depends on vigorous competition among market participants. To that end, the Commission, the Department of Justice, and state antitrust enforcers have challenged numerous practices that restrict competition among health care providers when those restraints have harmed consumers. These practices include price fixing, ethical restrictions on the dissemination of truthful information, restraints on physician participation in HMOs and other types of managed care organizations, and efforts by some health care providers to stifle cost-containment efforts.

In over 20 years of antitrust law enforcement in the health care area, the Federal Trade Commission has addressed numerous instances of collective activity by otherwise independent health care providers aimed at third-party payers whose policies or mere existence the providers found objectionable for one reason or another. A broad range of payers, including Blue Shield plans, health maintenance organizations (HMOs) and other managed care plans, dental insurers, and state Medicaid programs, at various times, have been the targets of such actions. Early cases involved instances of collective boycotts or similar activity by physicians and other health care providers to prevent HMOs from entering the market.[(1)] Subsequently, the vast majority of cases has involved collective action aimed solely or primarily at increasing (or preventing reductions in) payment levels to providers. This collective activity has involved joint agreement and/or collective negotiation on prices or reimbursement issues, often accompanied by actual or threatened coercive boycotts to pressure payers into accepting the terms demanded by the providers.[(2)]

Most of the Commission's past enforcement actions have been directed at health care providers' efforts to forestall the development of, or raise prices charged to, privately funded health plans. Yet for many citizens, private insurance is unavailable. Many states are currently developing forms of publicly-sponsored insurance to provide medical coverage for the otherwise uninsured. One of our most recent health care enforcement actions involved such a program.

The Commonwealth of Puerto Rico developed a program for providing health care coverage for the uninsured, known as the Reform, which currently covers about 30% of the population. In late 1996, the College of Physicians and Surgeons decided to take collective action in an attempt to raise their reimbursement level under the Reform, which would have raised the costs of health care to the citizens of Puerto Rico. The College ultimately called an eight-day strike, with physicians closing their offices and, in some cases, canceling elective surgery without notice. The potentially serious impact on patients of such anticompetitive behavior is obvious. The FTC and the Commonwealth of Puerto Rico jointly filed a complaint and obtained a consent agreement, under which the College and three large medical groups that contracted with the government paid $300,000 in restitution and agreed not to engage in future boycotts or unintegrated collective price fixing.[(3)]

We believe that sound antitrust enforcement in situations like the one in Puerto Rico has been a major factor in permitting the emergence of alternative health care arrangements that today vie for the patronage of consumers, private employers, and government purchasers. Although health care markets have changed dramatically over time, and continue to evolve, collective action by health care providers to block innovation and interfere with cost-conscious purchasing remains a significant threat to consumers. The prospect of effective antitrust enforcement therefore continues to be a crucial, positive influence on the marketplace which encourages better responses to consumer demands for high-quality and cost-effective health care.

While many of our cases have focused on health care providers' efforts to obstruct managed care plans, we wish to emphasize that the Commission does not favor any particular model of health care delivery -- whether it be fee-for-service, managed care, or some other type of arrangement. Our goal simply is to deter restraints that unduly limit the options available in the market or artificially raise prices, so that consumers will be free to choose the health care arrangements they prefer at competitive prices.

II. THE ANTITRUST EXEMPTION FOR HEALTH CARE PROFESSIONALS EMBODIED IN H.R. 4277 WOULD BE A RADICAL DEPARTURE FROM EXISTING LABOR LAW STANDARDS

As presently drafted, H.R. 4277 would create a broad antitrust exemption for price fixing and boycotts by physicians, dentists, and other health care professionals, by granting competing providers the same antitrust exemption that is accorded to employees who create legitimate labor organizations to negotiate with employers. The bill states that any group of health care professionals that negotiates with a "health insurance issuer," such as an HMO or commercial health insurer, is entitled to "the same treatment under the antitrust laws as that which is accorded to members of a bargaining unit recognized under the National Labor Relations Act." Workers in such bargaining units enjoy what is known as "the labor exemption" from the antitrust laws.[(4)] In essence, the labor exemption allows employees to unionize and use collective economic pressure against an employer to gain higher wages and more favorable working conditions. Thus, the bill would create a "collective bargaining" exemption to allow doctors and other health care professionals to

exert economic pressure on health plans to gain higher fees and other, more favorable, terms of dealing. As was noted earlier in this testimony, challenges to such collective action have been and continue to be a central focus of antitrust enforcement in the health care sector because of the harm such activity inflicts on consumers.

It is important to recognize that the labor exemption already operates in the health care sector under the same standards that apply in other industries -- that is, where there is a "labor dispute" involving a bona fide labor organization. Thus, physicians who are employees are *already* covered by the labor exemption under current law. The exemption, however, is limited to the employer-employee context. An antitrust defendant must demonstrate that the dispute at hand grew out of an employer-employee relationship -- *i.e.*, a "labor dispute" -- to successfully invoke the labor exemption.[(5)] But when independent business people combine to enhance their entrepreneurial interests, rather than to affect some employer-employee relationship, the labor exemption does not apply.[(6)]

This distinction between employees and independent contractors is fundamental to the labor relations scheme established by Congress. NLRA Section 2(3) gives the right to bargain collectively only to "employees." The 1947 Taft-Hartley amendments to the NLRA included an amendment to Section 2(3) to provide expressly that the term "employee" does not include "any individual having the status of an independent contractor." 29 U.S.C. § 152(3). The House Report accompanying the amendment stated:

> In the law, there always has been a difference, and a big difference, between "employees" and "independent contractors." "Employees" work for wages or salaries under direct supervision. "Independent contractors" undertake to do a job for a price, decide how the work will be done, usually hire others to do the work, and *depend for their income not upon wages, but upon the difference between what they pay for goods, materials, and labor and what they receive for the end result, that is, upon profits*.

H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947) (emphasis supplied).

Some self-employed physicians have contended that they must contract with dominant purchasers, and that managed care health plans control their medical practices to such a degree that they are effectively "employees." To the extent that sufficient control in fact exists to create an employment relationship, no legislative exemption, such as that proposed in H.R. 4277, is needed. Such physicians would be able under existing labor laws to function as a legitimate collective bargaining unit.

Typically, however, the relationship that self-employed physicians have with health plans differs in many ways from that of an employer-employee relationship. For example, recently a group of New Jersey physicians who contract with a large HMO in their area asserted that their relationship to the HMO met the requirements for the labor exemption. The NLRB Regional Director, in rejecting their argument, concluded that the physicians were independent contractors rather than true employees entitled to the labor exemption, citing numerous factors that distinguished the physicians from such employees.[(7)] The Director noted that:

- The physicians themselves make the fundamental decisions that determine the profitability of their practices. For example, they decide whether to be sole practitioners or join a group practice, have virtually total control over their expenses (such as the cost of their offices, equipment, and staff), and can vary their incomes by choosing to work more hours.

- The physicians spend only a minority of their time and derive only a minority of their incomes from services provided to the HMO's members. They treat patients who are members of other HMOs, are covered by other types of private health insurance or the Medicare program, or who pay directly for physicians' services.

- Many of the restrictions and procedures imposed on the physicians by the HMO's contracts were mandated by state law, either directly or by virtue of state law requiring certification by an accrediting organization whose standards require the procedures in question. Under labor law principles, restrictions and procedures imposed by governmental regulation do not amount to control by an employer.

In sum, H.R. 4277 is designed to confer the labor exemption on those whose situations are vastly different from those eligible for the exemption under long-standing and well-established principles of labor law. Moreover, the bill makes no provision for bringing these providers within the regulatory scheme of the labor laws that applies to others entitled to the labor exemption. Instead, it would merely grant them a broad immunity to present a "united front" when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest. The Commission believes that enacting a labor exemption for health care providers who are not employees is not justified, and would seriously harm competition and consumers. In addition, providing such an exception to a requirement that applies to all other professionals -- that they must be employees in order to qualify for the labor exemption -- is likely to encourage others who do not meet that standard to seek such special treatment. H.R. 4277, therefore, would be the first step on a slippery slope.

III. THE PROPOSED EXEMPTION IS NOT NEEDED TO ALLOW PROVIDERS TO RAISE CONCERNS ABOUT MANAGED CARE QUALITY, OR TO OFFER THEIR OWN ALTERNATIVE PLANS TO CONSUMERS

The broad exemption from the antitrust laws that H.R. 4277 would create is unnecessary for health care providers to effectively express their concerns about the quality of managed care plans, or to offer to consumers what they believe to be a superior alternative. The antitrust laws already allow health care professionals to create joint ventures and to negotiate collectively with health plans where those ventures are likely to produce procompetitive benefits for consumers. Such negotiations are analyzed under the "rule of reason" if the group involves integration that may significantly enhance efficiency, and if the joint price setting is reasonably necessary to achieve that procompetitive goal. These arrangements will pass muster under the rule of reason unless their anticompetitive effects outweigh their contributions to consumer welfare.

As some Members of this Committee may recall, in 1996 the Federal Trade Commission and the Department of Justice revised their health care guidelines to emphasize that providers can organize network joint ventures in a variety of ways without raising antitrust problems.[(8)] The goal was to ensure that unwarranted fears about the antitrust laws did not discourage innovation by providers that would stimulate competition and benefit consumers. Those revised guidelines have been widely cited for reducing uncertainty and recognizing that a wide range of joint activities by health care providers potentially can be procompetitive and benefit consumers.[(9)] In addition, since issuing the revised guidelines the agencies have issued 15 advisory opinions and business review letters approving proposed provider networks (and disapproving none).

Thus, collaboration among providers in dealing with health plans and other purchasers, in circumstances where it is likely to benefit consumers through enhanced efficiency, already is permitted under the antitrust laws and has been encouraged by the Agencies' health care guidelines and advisory opinion programs. Provider networks can organize and contract directly with employers and other payers, and thereby compete with health plans that providers believe offer fees and other contractual terms that they consider unfair or potentially harmful to patients. Simply put, if health care providers believe that a health plan does not offer consumers good quality, those providers are free to establish and offer the public their own, better, product without fear of the antitrust laws. And if purchasers agree with the providers and prefer their approach, such plans should flourish in the marketplace. Congress has concurred in this approach by recently amending the Medicare program to allow physicians and other health care providers, through the establishment of "provider sponsored organizations," to offer alternatives to the Medicare HMOs currently available in the market.[(10)]

In addition, there are a variety of other ways in which health care providers can express their concerns about both price and quality issues relating to managed care. Current law permits collective efforts, such as standard setting and certification, by physicians and other health care providers to promote quality, provided that such efforts are properly circumscribed to achieve that purpose, and thus do not unreasonably injure competition. Such actions, and more generally the offering of a professional group's opinion on issues affecting quality, are unlikely to restrain, and in fact can improve, the ability of consumers to choose among competing alternatives. The value and lawfulness of providers giving information and views also is explicitly recognized in our health care guidelines.[(11)] What is forbidden under current antitrust law standards is for anyone -- including medical groups -- to enter agreements that coercively impose on the market their view of what choices should be available to consumers and what prices they should receive.

IV. THE EXEMPTION WOULD PERMIT CONDUCT THAT COULD INJURE CONSUMERS

The antitrust exemption language contained in H.R. 4277 is prefaced by a statement that the bill's purpose is "[t]o ensure and foster continued patient safety and quality of care." Yet the activities protected by the bill are not limited to conduct furthering those purposes; rather, the bill would authorize a broad range of anticompetitive joint conduct by

physicians and other health care professionals that could seriously harm consumers and undermine efforts to make available and promote high quality, cost-effective health care for consumers. For example, the bill would permit otherwise competing health care providers to jointly agree to raise their prices and increase their payments from insurers and other payers, at the expense of consumers. Like the physicians in the Puerto Rico case discussed above, they could "strike" by refusing to provide services to patients covered by payers who did not accede to their payment and other demands.

Third-party payers, attempting to respond to the demands of their customers to control costs, increasingly have sought to obtain lower fees from providers, and to develop ways to control what previously was the providers' virtually unrestricted ability to provide expensive health care services to patients, even when such services were unnecessary or inappropriate. Not surprisingly, at various times payers have faced concerted opposition to their cost-containment efforts from some health care providers, in an effort to thwart what the providers perceived as unwarranted intrusions into their professional practice autonomy.[(12)] Many of these instances involved assertions that the collective conduct was aimed, at least in part, at protecting consumers and assuring quality of care. For example, this was precisely the rationale used by the AMA to justify its ethical prohibition on its members providing their services on other than a fee-for-service basis, or affiliating with HMOs or other novel arrangements for delivering health care services.[(13)]

This is not to say that many of the issues raised by physicians and other health care providers regarding changes in the health care system are not motivated by genuine concerns about their patients' welfare. The Commission shares those concerns. But "quality-of-care" arguments also easily can be invoked as a justification for even the most egregious anticompetitive conduct. They have been advanced to support, among other things, broad restraints on almost any form of price competition,[(14)] policies that inhibited the development of managed care organizations,[(15)] and concerted refusals to deal with providers or organizations that represented a competitive threat to physicians.[(16)] Thus, even if the antitrust exemption in H.R. 4277 were limited to conduct aimed at protecting patient safety and quality, history nevertheless cautions that the exemption could be subject to abuse.

The bill could also make it harder to develop innovative approaches to health care delivery and financing. For example, small HMOs, facing the aggregated power of provider collective bargaining, could find it more difficult to enter or succeed in the market.[(17)] Ironically, this effect would undermine the purposes of H.R. 4277, since such thwarted market entrants could have been competitive alternatives to the larger health plans whose policies and operations health care providers seek to respond to under the bill's protection.

Allowing providers to enter agreements that restrict the price/quality mix of health care services available to consumers in the market, even if motivated in part by genuine quality-of-care concerns, removes that choice from consumers. Moreover, it could force many consumers to forgo health care coverage altogether because they would be unable to afford the only available arrangements that result from providers' jointly determined prices and

other terms for the market.[(18)]

CONCLUSION

The health care system is a complex and dynamic sector of our economy. New arrangements and approaches to delivering and paying for care are continually emerging in the private sector, as well as in Medicare, Medicaid, and other government programs. Competition is the basic approach that our nation increasingly is relying upon to control costs and assure quality in the delivery of health care services, with resort to regulatory intervention only as needed to address specific problems that the market cannot cure. The result is a complex, difficult, and ongoing process. Different options are being tried. Some are successful, while others proving less so have been or will be abandoned. Problems that arise will need to be addressed one way or another -- either by making the market work better or, if that fails, by regulations designed to protect consumers. But in either case, the solution does not lie in eliminating competition and granting health care providers the right collectively to raise their prices and jointly agree on the terms and conditions under which their services will be available in the market.

The Commission believes that H.R. 4277 would do just that. It would allow health care providers to aggregate their market power and impose their collective will on consumers and the marketplace. It would erase more than 20 years of effective effort to allow health care markets to function competitively so as to better meet the needs and wants of consumers. For the reasons discussed above, the Federal Trade Commission believes that H.R. 4277 would harm consumers, and for that reason respectfully opposes its enactment. Instead, we believe that it would be better to continue the approach we took two years ago when we and the Department of Justice revised the health care guidelines. This involves continued enforcement of the antitrust laws to ensure that consumers have choice in competitive health care markets, while at the same time making clear that the antitrust laws do not stand in the way of collaborative efforts by health care providers to offer alternatives to consumers that will lower costs and assure quality for their patients.

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1. *See, e.g., Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979) (consent order) (hospital medical staff, including physicians, dentists, and podiatrists, agreed not to discriminate against medical staff members who were associated with HMOs, and not to exclude applicants for hospital privileges simply because they provided services on other than a fee-for-service basis); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976) (consent order) (physician-controlled Blue Shield plan and affiliated physicians' association agreed to cease conduct that discriminated against HMOs, or against physicians who practiced with an HMO or on other than a fee-for-service basis). *See also Physicians Group, Inc.*, 120 F.T.C. 567 (1995) (consent order); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988) (consent order); *Medical Staff of Doctors' Hospital of Prince George's County*, 110 F.T.C. 476 (1988) (consent order); *American Medical Association*, 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).

2. *See, e.g., M.D. Physicians of Southwest Louisiana, Inc. (MDP)*, FTC File No. 941-0095, 63 Fed. Reg. 33423 (June 24, 1998) (proposed consent order); *Mesa County Physicians Independent Practice Association, Inc.*, Dkt. No. 9284, 63 Fed. Reg. 9549 (February 25, 1998) (proposed consent order); *FTC and*

Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. October 2, 1997) (consent order); *Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc.*, C-3704, 62 Fed. Reg. 11,201 (March 11, 1997) (consent order); *Physicians Group, Inc.*, 120 F.T.C. 567 (1995) (consent order); *La Asociacion Medica de Puerto Rico*, 119 F.T.C. 772 (1995) (consent order); *McLean County Chiropractic Association*, 117 F.T.C. 396 (1994) (consent order); *Southbank IPA, Inc.*, 114 F.T.C. 783 (1991) (consent order); *Patrick S. O'Halloran, M.D.*, 111 F.T.C. 35 (1988) (consent order); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988) (consent order); *New York State Chiropractic Association*, 111 F.T.C. 331 (1988) (consent order); *Rochester Anesthesiologists, et al.*, 110 F.T.C. 175 (1988) (consent order); *Preferred Physicians, Inc.*, 110 F.T.C. 157 (1988) (consent order); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *Association of Independent Dentists*, 100 F.T.C. 518 (1982) (consent order).

3. *FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. Oct. 2, 1997).

4. The labor exemption from the antitrust laws is derived from Sections 6 and 20 of the Clayton Act and Section 4 of the Norris-LaGuardia Act. The exemption has two branches: (1) the "statutory exemption," which is based on the express wording of the statutory provisions; and (2) the judicially created "nonstatutory exemption," which harmonizes the policies underlying the National Labor Relations Act of 1935 ("NLRA") with the antitrust laws.

5. *See, e.g., H.A. Artists & Assocs. v. Actors Equity Ass'n*, 451 U.S. 704, 717 n.20 (1981) ("a party seeking refuge in the statutory exemption must be a bona fide labor organization and not an independent contractor").

6. *Columbia River Packers Ass'n v. Hinton*, 315 U.S. 143 (1942). *Accord, Los Angeles Meat and Provision Drivers Union, Local 626 v. United States*, 371 U.S. 94 (1962); *United States v. National Ass'n of Real Estate Boards*, 339 U.S. 485 (1950); *United States v. Women's Sportswear Mfg. Ass'n*, 336 U.S. 460 (1949); *American Medical Ass'n v. United States*, 317 U.S. 519, 533-36 (1943) (rejecting assertions that the labor exemption to the antitrust laws applied to joint efforts by independent physicians and their professional associations to boycott an HMO in order to force it to cease operating).

7. Letter from Dorothy L. Moore-Duncan, Regional Director, Region Four, NLRB, to Robert F. O'Brien (January 8, 1998). The decision currently is on appeal to the full NLRB.

8. United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, issued August 28, 1996, 4 Trade Reg. Rep. (CCH) ¶ 13,153.

9. *See, e.g.*, Reardon, "Oral Statement of the American Medical Association to the Joint Venture Project of the Federal Trade Commission in Collaboration with the United States Department of Justice, Re: Impact of Federal Antitrust Law and Enforcement Policy on Physician Network Joint Ventures," (July 1, 1997) (". . . we believe that they [the revised statements] have facilitated the formation of physician networks." *Id.* at 1-2; "The AMA believes that all three sets of statements of antitrust enforcement policy for health care issued by the agencies, including the 1993, 1994, and 1996 versions, have facilitated the formation of certain kinds of POs [physician organizations]." *Id.* at 7); Hirshfeld, "Key Changes in Federal Antitrust Enforcement Policy for Physician Joint Venture Networks," 10 *The Chronicle* 9 (Fall 1996) ("The AMA believes that the new guidelines provide a rich source of tools for physicians to form different kinds of networks, and that there are now many options open to physicians to meet the needs of their markets in a realistic and practical fashion." *Id.* at 12); Grady, "1996 Revised Antitrust Policy Statements: Building a Bridge to Network Competition," 24 *Health Law Digest* 3 (October 1996) ("The 1996 Statements provide a much better clarification of and insight into the Agencies' position on physician networks and multiprovider networks. . . . [They] should go a significant way to responding to claims by physicians and other providers that the Agencies are hostile to provider networks. . . . [T]he Agencies' 1996 Statements provide a welcome guide to appropriate antitrust analysis of provider networks." *Id.* at 11); Horoschak, "The Revised DOJ/FTC Health Care Enforcement

Policy Statements: An Overview," 10 *The Chronicle* 2 (Fall 1996). *See, generally*, Hirshfeld, "Interpreting the 1996 Federal Antitrust Guidelines for Physician Network Joint Ventures," 6 *Ann. Health L.* 1 (1997); Miles, "Joint Venture Analysis and Provider-Controlled Health Care Networks," 66 *Antitrust L. J.* 127 (1997).

10. Section 4001 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, August 5, 1997.

11. *See, e.g.*,United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, issued August 28, 1996, *supra* n. 8, at Statement 4 ("Providers' Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services") and Statement 5 ("Providers' Collective Provision of Fee-Related Information to Purchasers of Health Care Services").

12. *See, e.g., Indiana Federation of Dentists*, 101 F.T.C. 57 (1983), *rev'd*, 745 F.2d 1124 (7th Cir. 1984), *rev'd* 476 U.S. 447 (1986); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *Texas Dental Association*, 100 F.T.C. 536 (1982) (consent order); *Indiana Dental Association*, 93 F.T.C. 392 (1979).

13. The AMA's ethical prohibitions on such purely price-related issues as physicians' being paid "on a basis other than the traditional fee-for-service norm," or on "contractual arrangements which affect the adequacy of fees, [or] involve underbidding" were justified by the AMA on quality grounds, since such payment methods were viewed as "terms or conditions which tend to interfere with or impair the free and complete exercise of . . . [a physician's] medical judgment and skill or tend to cause a deterioration of the quality of medical care." *American Medical Association*, 94 F.T.C. 701, 1011-12 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

14. *See American Medical Ass'n*, *supra*.

15. *Id.*

16. *E.g., State Volunteer Mutual Insurance Corp.*, 102 F.T.C. 1232 (1983) (consent order) (physician-owned malpractice insurance company agreed not to unreasonably discriminate against physicians who work with independent nurse midwives).

17. Even very large payers that are well-established in a local market may not have the ability to reject provider demands, however unreasonable, in the face of such concerted provider power.

18. On March 12, 1998, the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which included representatives from a broad range of interests involved with the health care system, issued its final report, entitled "Quality First: Better Health Care For All Americans." While addressing an array of issues, and offering numerous recommendations, the Commission nowhere suggested that reducing competition among health care providers and eliminating antitrust law enforcement in the health care sector were approaches likely to lead to better quality health care for consumers.