IN THE MATTER OF

NISSAN MOTOR CORPORATION IN U.S.A.

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATION OF SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket C-3502. Complaint, June 29, 1994--Decision, June 29, 1994

This consent order requires, among other things, a California-based corporation to disclose clearly and prominently in each advertisement either any significant restrictions that apply to obtaining a promotional benefit in connection with a test-drive offer, or that there are significant restrictions that apply to obtaining the benefit, and prohibits the respondent from misrepresenting the existence, nature or any conditions, restrictions or limitations on any promotional benefit it offers consumers in the future.

Appearances

For the Commission: *Phillip L. Broyles, Michael Milgrom* and *Melissa R. Sternlicht.*

For the respondent: *William C. MacLeod, Collier, Shannon, Rill & Scott, Washington,* D.C.

COMPLAINT

The Federal Trade Commission, having reason to believe that Nissan Motor Corporation in U.S.A., a corporation ("respondent"), has violated the provisions of the Federal Trade Commission Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, alleges:

PARAGRAPH 1. Respondent is a California corporation, with its office or principal place of business located at 18501 South Figueroa Street, Carson, California.

PAR. 2. Respondent has advertised, distributed, offered for sale and sold (through dealers) new automobiles including the Nissan Stanza, a four door sedan.

PAR. 3. The acts and practices of respondent alleged in this complaint have been in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act.

PAR. 4. Respondent has disseminated or has caused to be disseminated advertisements for the Nissan Stanza Challenge Program, including but not necessarily limited to the attached Exhibit A. These advertisements contain the following statements:

(A) Man: Okay, so I'm thinking about a new car. I'm reading the papers, I'm looking around. I finally decide on a Camry. Or maybe an Accord. That's nice, too. Okay, so either one. But then I hear about this thing that Nissan's doing. The Nissan Stanza Challenge, they call it. What is that? I don't know, but I like a challenge, so I go to a Nissan Dealer to check it out. Now get this. They tell me that if I buy the Camry or the Accord, they're gonna give me a hundred dollars. Did you understand what I said just then? Nissan will give you a hundred dollars to buy a Toyota or a Honda! So what's the catch, I ask myself, because there has to be a catch. There's no catch! Just test-drive a Nissan Stanza first. No sweat, easiest hundred I ever made, right? Wrong. See, Nissan knows once you drive a Stanza, with its powerful engine, roomy interior, great handling --you're not gonna want a Camry. Or an Accord. That's the catch.

Anncr: See the 1990 Stanza at your nearest Nissan Dealer now, where satisfaction is standard equipment.

Legal Anncr: Offer open to licensed drivers 18 years of age or older. Proof of purchase of 1990 Camry or Accord required. See your participating Nissan Dealer for details.

(Exhibit A, transcript of radio advertisement.)

PAR. 5. Through the use of the statements contained in the advertisements referred to in paragraph four, including but not necessarily limited to the advertisement attached as Exhibit A, respondent has represented, directly or by implication, that consumers who test drove a Nissan Stanza and subsequently purchased a Honda Accord or Toyota Camry during the period of the Nissan Stanza Challenge could readily obtain the $100 payment specified in the advertisement.

PAR. 6. In truth and in fact, many consumers who test drove a Nissan Stanza and subsequently purchased a Honda Accord or Toyota Camry during the period of the Nissan Stanza Challenge could not readily obtain the $100 payment specified in the advertisement. In order to receive the $100, the consumer could not purchase the Honda Accord or Toyota Camry on the same day as the test drive, but had to purchase, take delivery, and submit documentary proof of the purchase within seven days after test driving the Nissan Stanza. Therefore, the representation set forth in paragraph five was, and is, false and misleading.

PAR. 7. In its advertising of the Nissan Stanza Challenge Program, respondent represented, directly or by implication, that respondent would pay $100 to consumers who test drove a Nissan Stanza but purchased a Honda Accord or a Toyota Camry. These advertisements failed to disclose that in order to receive the $100, the consumer could not purchase the Honda Accord or Toyota Camry on the same day as the test drive, and that the consumer had to purchase, take delivery, and submit documentary proof of the purchase within seven days after test driving the Nissan Stanza. These restrictions would be material to consumers in deciding whether to test drive a Stanza or otherwise take part in the Program. The failure to disclose that there were significant restrictions, in light of the representation made, was, and is, a deceptive act or practice.

PAR. 8. The acts and practices of respondent as alleged in this complaint constitute unfair or deceptive acts or practices in or affecting commerce in violation of Section 5(a) of the Federal Trade Commission Act.

Chairman Steiger and Commissioner Yao dissenting.

EXHIBIT A

Chiat/Day/Mojo Copy

Man: Okay, so I'm thinking about a new car. I'm reading the papers, I'm looking around. I finally decide on a Camry. Or maybe an Accord. That's nice, too. Okay, so either one. But then I hear about this thing that Nissan's doing. The Nissan Stanza Challenge, they call it. What is that? I don't know, but I like a challenge, so I go to a Nissan Dealer to check it out. Now get this. They tell me that if I buy the Camry or the Accord, they're gonna give me a hundred dollars. Did you understand what I said just then? Nissan will give you a hundred dollars to buy a Toyota or a Honda! So what's the catch, I ask myself, because there has to be a catch. There's no catch! Just test-drive a Nissan Stanza first. No sweat, easiest hundred I ever made, right? Wrong. See, Nissan knows once you drive a Stanza, with its powerful engine, roomy interior, great handling -- you're not gonna want a Camry. Or an Accord. That's the catch.

Anncr: See the 1990 Stanza at your nearest Nissan Dealer now, where satisfaction is standard equipment.

Legal Anncr: Offer open to licensed drivers 18 years of age or older. Proof of purchase of 1990 Camry or Accord required. See your participating Nissan Dealer for details.

DECISION AND ORDER

The Federal Trade Commission having initiated an investigation of certain acts and practices of the respondent named in the caption hereof, and the respondent having been furnished thereafter with a copy of a draft of complaint which the Bureau of Consumer Protection proposed to present to the Commission for its consideration and which, if issued by the Commission, would charge respondent with violation of the Federal Trade Commission Act; and

The respondent, its attorney and counsel for the Commission having thereafter executed an agreement containing a consent order, an admission by the respondent of all the jurisdictional facts set forth in the aforesaid draft of complaint, a statement that the signing of said agreement is for settlement purposes only and does not constitute an admission by respondent that the law has been violated as alleged in such complaint, or that the facts as alleged in such complaint, other than jurisdictional facts, are true and waivers and other provisions as required by the Commission's Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that the respondent had violated the said Act, and that a complaint should issue stating its charges in that respect, and having thereupon accepted the executed consent agreement and placed such agreement on the public record for a period of sixty (60) days, and having duly considered the comments filed thereafter by interested persons pursuant to Section 2.34 of its Rules, now in further conformity with the procedure prescribed in Section 2.34 of its Rules, the Commission hereby issues its complaint, makes the following jurisdictional findings and enters the following order:

1. Respondent Nissan Motor Corporation in U.S.A. is a corporation organized, existing and doing business under and by virtue of the laws of the state of California with its offices and principal place of business at 18501 South Figueroa Street, Carson, California.

2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the respondent, and the proceeding is in the public interest.

ORDER

DEFINITIONS

1. "*Promotional benefit*" as used herein shall mean any prize award or consideration, including, but not limited to, money, favorable credit terms and optional equipment packages having a *bona fide* retail value over $25.

2. "*Clearly and prominently*" as used herein shall mean as follows:

(a) In a television or videotape advertisement, the disclosure shall be presented simultaneously in both the audio and video portions of the advertisement. The audio disclosure shall be delivered in a volume and cadence and for a duration sufficient for an ordinary consumer to hear and comprehend it. The video disclosure shall be of a size and shade, and shall appear on the screen for a duration, sufficient for an ordinary consumer, to read and comprehend it.

(b) In a print advertisement, the disclosure shall be in close proximity to the representation that triggers the disclosure in at least twelve (12) point type.

(c) In a radio advertisement, the disclosure shall be delivered in a volume and cadence and for a duration sufficient for an ordinary consumer to hear and comprehend it.

I.

It is ordered, That respondent Nissan Motor Corporation in U.S.A., a corporation, its successors and assigns, and its officers, agents, representatives and employees, directly or through any corporation, subsidiary, division or other device, in connection with the advertising, offering for sale, sale or distribution of any motor vehicle in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from representing, in any manner, directly or by implication, that persons who test drive a Nissan motor vehicle can readily obtain a promotional benefit when significant restrictions prevent consumers from readily obtaining that promotional benefit without disclosing clearly and prominently in each advertisement in which the representation is

made either the significant restrictions or that there are significant restrictions that apply to obtaining the promotional benefit.

II.

It is further ordered, That respondent Nissan Motor Corporation in U.S.A., a corporation, its successors and assigns, and its officers, agents, representatives and employees, directly or through any corporation, subsidiary, division or other device, in connection with the advertising, offering for sale, sale or distribution of any motor vehicle in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from misrepresenting, in any manner, directly or by implication, the existence, nature or extent of any condition, restriction or limitation on any promotional benefit offered to consumers.

III.

It is further ordered, That, for three (3) years from the date that the advertisements are last disseminated, respondent shall maintain and, upon request, make available to the Commission for inspection and copying:

(A) Copies of all advertisements subject to paragraphs I or II of this order;

(B) Copies of all communications to affiliated dealers and all information and other materials supplied by respondent to the dealer in connection with any representation subject to paragraphs I or II of this order; and

(C) All correspondence received from consumers, whether received by respondent or by an agent of respondent, related to any promotional benefit program advertised in a manner subject to paragraphs I or II of this order.

IV.

It is further ordered, That respondent shall, within sixty (60) days of service of this order, distribute a copy of this order to each of its operating divisions and to each officer and other person responsible for the preparation or review of advertising material including outside

advertising agencies, and to a representative of each of its affiliated dealers and shall secure from each such person a signed statement acknowledging receipt of a copy of this order.

V.

It is further ordered, That respondent shall notify the Commission at least thirty (30) days prior to the effective date of any proposed change in the corporation such as dissolution, assignment or sale resulting in the emergence of a successor corporation, the creation or dissolution of subsidiaries, or any other change in the corporation which may affect compliance obligations arising out of this order.

VI.

It is further ordered, That respondent shall, within sixty (60) days after service of this order, file with the Commission a report, in writing, setting forth in detail the manner in which it has complied with this order.

JOINT DISSENTING STATEMENT OF
CHAIRMAN JANET D. STEIGER AND COMMISSIONER DENNIS A. YAO

We dissent from issuance of the consent order with Nissan Motor Corp. Because the order does not sufficiently remedy one of the alleged law violations, it may give implicit approval to the use of seemingly attractive promotional offers that many consumers simply cannot utilize because of limitations such as severe time restrictions or extremely difficult documentation requirements.

Through advertisements for the Nissan Stanza "Challenge Program," Nissan ran a promotional program inviting consumers to come to a Nissan dealership, test drive the Nissan Stanza and receive $100 if, after driving the Stanza, they bought either a Toyota Camry or a Honda Accord. The advertising expressly stated that there was "no catch" to this offer. What consumers were not told was that, in order to obtain the $100, it was necessary to purchase and take delivery of the Camry or Accord and submit detailed proof of purchase (including documents not usually retained by consumers after purchase) to Nissan, all within seven days (but not on the same day as the test drive). The complaint alleges that the failure to

disclose that the program had such significant restrictions was deceptive, and that Nissan's explicit advertising claim that the offer had "no catch" falsely represented that consumers could readily obtain the $100 payment.

In our view, the consent order may do little to remedy the failure to disclose allegation. Part I of the order prohibits Nissan from representing, directly or by implication, that persons who test drive a Nissan can "readily obtain" a promotional benefit -- when significant restrictions prevent consumers from readily obtaining that benefit -- unless Nissan also discloses either those restrictions or that significant restrictions apply. Since paragraph 5 of the complaint uses the same term, "readily obtain," to characterize the express "no catch" claim in Nissan's ad, and paragraph 4 of the complaint only references the advertisement with an express "no catch" claim, the order could be interpreted to require disclosure only when language similar to "no catch" or "no catches" is used.

To suggest otherwise -- namely that the order requires disclosure any time Nissan offers a promotion and uses very general language such as "Come on in and get a [benefit]" -- would read out of the order the "readily obtain" limiting language. Consequently, although we understand that some would read the order differently, the order might be interpreted as standing for the proposition that advertisements need not contain any disclosure of the nature or even existence of limiting conditions, no matter how onerous, unusual, or unexpected, unless the advertiser uses language similar to a "no catches" claim.

Moreover, even when an affirmative expression such as "no catches" is used in making an offer, the order would allow an advertiser to disclose only that significant restrictions apply to the offer, not what those restrictions are or where the consumer can obtain additional information about them. Although reasonable minds can differ on whether a disclosure that "significant restrictions" apply would adequately inform consumers when ready availability is implied in an advertisement, such a disclosure for an express "no catches" claim is manifestly contradictory. This order would seem to allow advertisers to claim to consumers that there are no catches in connection with the offer, so long as the ad elsewhere discloses that there are significant restrictions. The use of such contradictory statements in the same advertisement conflicts with

Commission precedent. *See* Commission Statement on Deception, 103 FTC 110, 180-81.

Finally, the order does not contain a point of sale disclosure requirement. Consequently, even if consumers understand the disclosure of "significant restrictions" as overriding the express "no catches" claim, there is no sure way of learning about the restrictions.

We do not suggest advertisers must disclose every limitation on their offers in advertising. Consumers generally expect that offers have reasonable time limits and other conditions. This order may suggest, however, that even severe restrictions -- *i.e.*, those that make the offer impractical or impossible for many consumers to redeem -- need not be disclosed in an adequate fashion. Such an approach is not without cost to consumers -- especially in cases, such as this one, where consumers usually shop for the product by visiting sales locations and, consequently, where such offers could induce them to make a special visit.

SEPARATE STATEMENT OF COMMISSIONERS MARY L. AZCUENAGA, DEBORAH K. OWEN, AND ROSCOE B. STAREK, III

We write to respond to the concerns expressed in our colleagues' joint dissenting statement about how the consent order in this matter might be interpreted and what it would seem to allow in connection with other promotional advertisements. Like other consent orders, this order was negotiated in response to particular facts and circumstances. Although the order identifies conduct the Commission will not allow, no legal inference properly can be drawn that conduct not mentioned in the complaint and order has been approved. The legal standards by which promotional advertisements are measured are well established in sources having precedential value. As always, advertisers would be well-advised to consult these sources to determine the legal standards to which they must conform.

IN THE MATTER OF

MANZELLA PRODUCTIONS, INC., ET AL.

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATION OF THE WOOL PRODUCTS LABELING ACT AND SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket C-3503. Complaint, June 30, 1994--Decision, June 30, 1994

This consent order prohibits, among other things, a New York wholesaler of gloves, and its owner, from misrepresenting the extent to which any gloves or other items of wearing apparel are made in the United States or any other country, and from violating any provision of the Wool Products Labeling Act, and requires them to pay $7,500 in disgorgement in lieu of consumer redress.

Appearances

For the Commission: *Brinley H. Williams.*

For the respondents: *Gary L. Mucci, Saperston & Day, P.C.,* Buffalo, N.Y.

COMPLAINT

The Federal Trade Commission, having reason to believe that Manzella Productions, Inc., a corporation, and Anthony L. Manzella, Jr., individually and as an officer of said corporation (hereinafter sometimes referred to as respondents), have violated the provisions of the Wool Products Labeling Act and of the Federal Trade Commission Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, alleges:

PARAGRAPH 1. Respondent Manzella Productions, Inc., is a New York corporation which manufactures and sells gloves. Its principal office or place of business is located at 5684 Main Street, Post Office Box 1243, Buffalo, New York.

Respondent Anthony L. Manzella, Jr., is an officer and director of said corporation. He formulates, directs and controls the acts and practices of said corporate respondent, including the acts and practices herein set forth. His address is the same as that of the corporation.

PAR. 2. Respondents have manufactured, assembled, labeled and offered for sale, sold and distributed gloves under the Manzella name, which are sold through retailers to consumers. Such gloves include wool products, as "wool product" is defined in the Wool Products Labeling Act, 15 U.S.C. 68.

PAR. 3. The acts and practices of respondents alleged in this Complaint have been in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act.

PAR. 4. Respondents have sold and distributed, or have caused to be sold and distributed certain models of gloves manufactured in China. In some cases, respondent removed the foreign country of origin labels from these gloves and affixed labels containing the statement, "Manufactured in the USA exclusively by Manzella." Some of the gloves so labeled were of 85 percent wool and 15 percent nylon and some were made of leather. An example of the labels affixed by respondents is attached as Exhibit A.

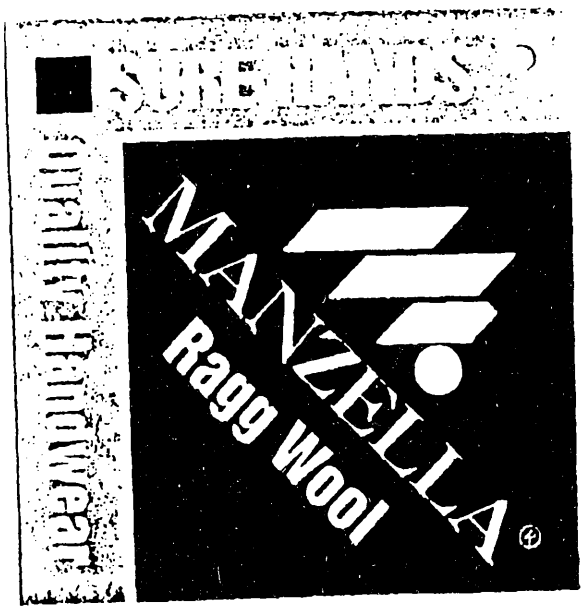
PAR. 5. Through the use of the statement contained on the labels affixed to the gloves by respondents referred to in paragraph four, including, but not necessarily limited to, the label attached as Exhibit A, respondents have represented, directly or by implication, that such gloves are made in the United States.

PAR. 6. In truth and in fact, the gloves referred to in paragraph five, were manufactured in a foreign country with foreign component parts. Therefore, the representation set forth in paragraph five was and is false and misleading.

PAR. 7. The acts and practices of respondents as alleged in this complaint in misrepresenting foreign-manufactured gloves made of 85 percent wool as made in the United States constitute a violation of the Wool Products Labeling Act and the Commission's Rules and Regulations promulgated thereunder, and constitute unfair or deceptive acts or practices in or affecting commerce, in violation of Section 5(a) of the Federal Trade Commission Act.

PAR. 8. The acts and practices of respondents as alleged in this complaint in misrepresenting foreign-manufactured leather gloves as made in the United States constitute unfair or deceptive acts or practices in or affecting commerce, in violation of Section 5(a) of the Federal Trade Commission Act.

EXHIBIT A


Manufactured in the USA exclusively by
MANZELLA'
PO Box 1243 Buffalo, N.Y. 14231
WASHING INSTRUCTIONS
Hand wash in Cool water. Dry flat.
85% Wool. 15% Nylon
MANZELLA
Ragg Wool

DECISION AND ORDER

The Federal Trade Commission having initiated an investigation of certain acts and practices of the respondents named in the caption hereof, and the respondents having been furnished thereafter with a copy of a draft of complaint which the Cleveland Regional Office proposed to present to the Commission for its consideration and which, if issued by the Commission, would charge respondents with violation of the Federal Trade Commission Act and the Wool Products Labeling Act, and the Commission's Rules adopted thereunder; and

The respondents, their attorney, and counsel for the Commission having thereafter executed an agreement containing a consent order, an admission by the respondents of all the jurisdictional facts set forth in the aforesaid draft of complaint, a statement that the signing of said agreement is for settlement purposes only and does not constitute an admission by respondents that the law has been violated as alleged in such complaint, or that the facts as alleged in such complaint, other than jurisdictional facts, are true, and waivers and other provisions as required by the Commission's Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that the respondents have violated the said Act, and that complaint should issue stating its charges in that respect, and having thereupon accepted the executed consent agreement and placed such agreement on the public record for a period of sixty (60) days, now in further conformity with the procedure prescribed in Section 2.34 of its Rules, the Commission hereby issues its complaint, makes the following jurisdictional findings, and enters the following order:

1. Respondent Manzella Productions, Inc., is a corporation with its office or principal place of business located at 5684 Main Street, Post Office Box 1243, Buffalo, New York.

Respondent Anthony L. Manzella, Jr., is an officer of said corporation. In his capacity as an officer, he formulates, directs and controls the acts and practices of said corporation, and his business address is the same as that of the corporation.

2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the respondents, and the proceeding is in the public interest.

ORDER

I.

It is ordered, That respondents Manzella Productions, Inc., a corporation, and Anthony L. Manzella, Jr., individually and as an officer of said corporation, their successors and assigns, and their officers, agents, representatives and employees, directly or through any corporation, subsidiary, division or other device, in connection with the manufacturing, labeling, advertising, promotion, offering for sale, sale or distribution of any gloves or other items of wearing apparel in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, do forthwith cease and desist from violating any provision of the Wool Products Labeling Act (15 U.S.C. 68) and the Commission's Rules adopted thereunder (16 CFR Part 300), and from misrepresenting, in any manner, directly or by implication, the extent to which any such gloves or other item of wearing apparel are made in the United States, or any other country.

II.

It is further ordered, That respondents, their successors and assigns, shall pay Seven Thousand, Five Hundred Dollars ($7,500) as disgorgement in lieu of consumer redress. Such payment shall be by cashier's check or certified check made payable to the Federal Trade Commission. Such check shall be held by counsel for the respondents until this order becomes final and then delivered to the Associate Director for Enforcement, Bureau of Consumer Protection, Federal Trade Commission, Washington, D.C., within ten (10) days of this order becoming final. In the event of any default in payment, which default continues for more than ten (10) days beyond the due date of payment, respondents shall pay interest as computed under 28 U.S.C. 1961, which shall accrue on the unpaid balance from the date of default until the date the balance is fully paid.

III.

It is further ordered, That for five (5) years after the last date of dissemination of any representation covered by this order, respondents or their successors and assigns shall maintain and, upon

request, make available to the Federal Trade Commission for inspection and copying:

(A) All materials that were relied upon in disseminating such representations; and

(B) All tests, reports, studies, surveys, demonstrations or other evidence in their possession or control that contradict, qualify or call into question such representation, or the basis relied upon for such representation, including complaints from consumers.

IV.

It is further ordered, That the respondent corporation shall distribute a copy of this order to each of its operating divisions and to each of its officers, agents, representatives or employees engaged in the preparation or placement of advertisements, promotional materials, product labels or other such sales materials covered by this order.

V.

It is further ordered, That the respondent corporation shall notify the Commission at least thirty (30) days prior to any proposed change in the corporation, such as dissolution, assignment or sale resulting in the emergence of a successor corporation, the creation or dissolution of subsidiaries, or any other change in the corporation which may affect compliance obligations under this order.

VI.

It is further ordered, That respondent Anthony L. Manzella, Jr., shall, for a period of seven (7) years from the date of entry of this order, notify the Federal Trade Commission, within thirty (30) days, of the discontinuance of his present business and of his affiliation with any new business or employment. Each notice of affiliation with any new business shall include his new business address and telephone number, current home address, and a statement describing the nature of the business or employment, and his duties and responsibilities.

VII.

It is further ordered, That respondents shall, within sixty (60) days after service of this order upon them, and at such other times as the Commission may require, file with the Commission a report, in writing, setting forth in detail the manner and form in which they have complied with this order.

Re: A program proposed by the American Medical Association and the Chicago Medical Society involving peer review of physician fees is not likely to violate federal antitrust laws. [*American Medical Association, P923506*]

February 14, 1994

Dear Messrs. Johnson and Peterson:

This letter responds to the request of the American Medical Association ("AMA") and the Chicago Medical Society ("CMS") for an advisory opinion on the permissibility under the antitrust laws of a system of professional society peer review of physicians' fees. The proposed program has two facets: a system for rendering advisory opinions on patients' complaints about fees and other matters, and a disciplinary process aimed at "egregious" practices by physicians. The Commission is of the opinion that the proposed program would not be likely to violate any law enforced by the Commission if the disciplinary process is limited to certain abusive physician practices as described in this letter. However, to the extent that the proposed program contemplates authorizing a group of physicians to discipline a competing physician on the basis of fee levels alone, without regard to abusive conduct, there is a substantial danger that the implementation of the program may injure consumers and violate the antitrust laws. Antitrust law does not preclude AMA and CMS from addressing in other ways information disparities in the market that may result in what AMA considers to be excessive medical fees. As is discussed below, AMA and CMS could adopt a fee disclosure requirement to address this issue.

The Commission has often observed that the antitrust laws do not impede legitimate professional self-regulation that benefits consumers. For example, in the American Medical Association case, in which the Commission found that medical associations had violated the antitrust laws by suppressing the dissemination of truthful information about physicians' services and fees, the Commission nonetheless emphasized that the AMA had "a valuable and unique role" to play with respect to policing deceptive advertising and oppressive forms of solicitation by physicians. *American Medical Association*, 94 FTC 701, 1029 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

The Commission has never challenged a medical society's fee peer review program. Peer review was not an issue in the AMA case, and the order entered in that case, and orders in subsequent cases, made it clear that peer review of individual physicians' fees was not categorically prohibited. On the contrary, as AMA notes in its petition, the Commission has recognized the procompetitive benefits of properly managed peer review systems. More than a decade ago, the Commission formally approved a professional association's proposal for a fee peer review program that has many features in common with the system now proposed by AMA and CMS. *Iowa Dental Association*, 99 FTC 648 (1982).

Iowa Dental established a safe harbor for a certain kind of peer review system. In addition, members of the staff have publicly invited professional groups desiring to use other models to submit them for the Commission's consideration. And at least as early as 1985, the Commission's Bureau of Competition informally invited AMA to provide information on fee review so that the staff could evaluate AMA's concerns about the adequacy of the Iowa Dental approach. Although AMA never accepted that invitation, it did provide such information in connection with the present petition.

AMA and CMS ask the Commission's opinion on three changes from the type of program approved in Iowa Dental: (1) members of the medical society would be required to participate in the peer review process; (2) physicians charging unusually high fees would be subject to discipline in certain circumstances; and (3) the fact of a disciplinary action against a physician would be made public.

On the basis of information provided by AMA and CMS, the Commission is of the opinion that a program along the lines of that presented by the petition can benefit consumers and operate without violating any law enforced by the Commission. Requiring medical societies' members to provide information needed by advisory fee review committees in the course of their deliberations can promote the important information-generating value of such peer review. AMA's proposal to discipline doctors raises issues requiring careful analysis, but the Commission is of the opinion that the antitrust laws do not stand in the way of discipline for abusive practices as discussed in this letter or discipline for violations of certain information disclosure requirements. If the disciplinary action itself is legitimate, disclosing to the public the names of doctors who have been disciplined is not likely to injure competition, and may promote competition and bene-

fit consumers. Finally, as is discussed below, efforts to provide patients with more information about price also are likely to promote competition.

I. Background of the Request

AMA points out in its petition that patients often lack good information about the prices of medical services, as well as about the quality and necessity of the services they receive. Often patients receive medical care without any prior discussion with the physician of the price to be charged. This behavior is due to a number of factors, including patients' relative lack of information, the prevalence of third-party payment, and patients' reliance on their doctors to act in the patients' best interests. In addition, in some cases, such as those involving emergency treatment, prior agreement on price is impossible. As a result, patients often may not know what price will be charged until after the services are rendered.[1] Once informed of the price charged, a patient may believe that the charge is unreasonable or that he or she cannot evaluate the reasonableness of the charge. AMA and CMS are concerned that in some situations, the fee charged may arise from fraud, misrepresentation, undue influence, or other abusive behavior by the physician.

Advisory peer review can give patients, and payers, information about the basis for a fee and an informed opinion about its reasonableness, and help them decide whether to pay a disputed bill or to continue to patronize a particular doctor. To the extent that AMA's proposal will provide information useful to consumers or their insurers, it is likely to serve consumers and promote competition. In cases where the fee charged arose from abusive behavior, professional discipline may also improve the functioning of the market by deterring such behavior.

The program approved in the Commission's 1982 advisory opinion to the Iowa Dental Association included a number of features designed to protect against possible anticompetitive effects. In particular, the program was strictly advisory. Participation was voluntary for all parties; decisions of the committees were advisory and were based solely on the facts and circumstances of each case; fee determinations were not published to the membership of the soci-

[1] After-the-fact disputes over price are less likely to arise where third party payers negotiate prices directly with providers of health care services in advance, as is the case in many managed care plans.

ety at large; and the society did not collect fee information or conduct fee surveys for use in the peer review process.

The Commission approval of the fee review system in Iowa Dental was based on the understanding that the program was designed to resolve specific disputes between patients and their dentists, not to coerce third-party payers or to confer professional sanction on particular fee levels or reimbursement systems. In order to assure that the program remained faithful to its stated purpose, the Commission advised IDA to view the process as a means of mediating disputes, not sanctioning particular price levels; not to allow panel decisions to become widely known; to base decisions on the individual judgment of panel members, not on fee schedules or other information sanctioned by the society; not to use the process to discipline providers who engaged in disfavored competitive activities or to discourage innovation, and not to discipline members who refuse to use the peer review process or to accept its guidance; and to avoid pressure on insurance companies to use the peer review process or to abide by its decision, or to use a particular definition of reasonable or customary in making reimbursement decisions.

The proposal of AMA and CMS contains many of the features included in the Iowa Dental program. This advisory opinion focuses on the few significant ways in which AMA's proposal departs from the Iowa Dental model.

II. The Proposed Fee Review Program

AMA states that it wants to encourage its state and local constituent and component medical societies to operate fee review programs in accordance with general guidelines developed by AMA.[2] CMS desires to operate such a program. The proposed peer review structure involves two separate tracks. Patient Grievance Committees ("PGCs") would hear complaints from patients, insurers, or others regarding physician behavior, including complaints relating to fees, and would render advisory opinions on the reasonableness of fees charged. Professional Disciplinary Committees ("PDCs") would

[2] AMA states that its guidelines are merely a model that will be made available to state and local societies, and that local variations on this model may be adopted in some cases. This advisory opinion, of course, is limited to the facts set out in this letter, and the conclusions stated here may not apply to peer review systems that depart from those facts.

have the power to discipline members who engaged in certain kinds of misconduct.

In fee complaint cases, the PGC would gather information from the complainant and from the physician, and would render its opinion about the reasonableness of the fee and the appropriateness of any other behavior at issue. The opinion would be based on the specific facts of the complaint, taking into account such factors as the fees ordinarily charged by other doctors in the community, the nature and difficulty of the services performed, and any unusual complexities or other circumstances in the case. The committee members would rely primarily on their own expertise and experience, but could refer to other sources of information on fees, including third-party or government data bases or the opinions of other doctors sought out by the committee. The committee would not maintain fee data to use as a benchmark for evaluating fees. Proceedings of the PGC would be confidential, and its opinions on the reasonableness of fees would not be publicized.

Neither the complaining party nor the physician would be required to accept the opinion of the committee. The rendering of the advisory opinion is intended to facilitate an agreement between the parties on an appropriate fee, but the committees would not follow up their advisory opinions to determine whether the doctor had accepted the fee recommended by the committee.

Complaints involving charges of serious misconduct might be considered by the PGC, but they would also be referred to the Physician Disciplinary Committee or to appropriate government authorities for consideration. The PDC would conduct formal hearings, and could impose sanctions including reprimand, censure, payment of a fine, suspension, and expulsion from membership in the medical society.

III. Issues Raised by the Petition

A. Mandatory Participation in Advisory Peer Review

One significant difference between the advisory fee review proposed by AMA and CMS and the program approved in Iowa Dental is that members of the medical society would be required to participate in the Grievance Committee process; that is, society members would be subject to discipline for refusing to cooperate with the

committees or to provide relevant information. Generally, the doctor would be expected to make the patient's medical records available and to explain the basis for the fee that was charged, including any unusual factors in the case that might justify a higher than usual fee. Doctors would not be required to accept the decision of the committee as to the reasonableness of the fee, or to adjust the fee in conformance with the opinion. Thus, the advisory nature of the process would be preserved.

AMA and CMS assert that mandatory participation in peer review proceedings will make the process more available to consumers and more effective. In most cases, the committee needs access to the patient's medical records and other information in the doctor's possession in order to evaluate a complaint.

The Commission is of the opinion that requiring medical society members to participate in advisory fee review in the circumstances described above is not likely to endanger competition and is reasonably related to making available to consumers the information that the process is designed to produce. The emphasis in Iowa Dental on the voluntary nature of the peer review was designed to protect against the possibility that the process could lead to coercion of dentists or insurance companies, or to standardization of fees. These dangers do not appear to require that participation be voluntary, however, at least in the context of the system contemplated by AMA and CMS.

First, the patient and the insurer are free to decide whether to participate in the fee review proceeding, and the opinion of the committee is advisory. Therefore, the process is not likely to result in coercion of third-party payers to accept reimbursement policies favored by the profession. Second, fee review committees' opinions about fees charged are not binding on the physicians, and the societies will impose no form of penalty on physicians for failure to adhere to the committees' advice as to the fee.[3] Third, the committees will not develop a benchmark schedule of fees, and there will be no public disclosure of the committees' decisions concerning specific fees. For these reasons, it does not appear likely that the process will be used to coerce participants or to establish or enforce an agreement on fees recommended by the committee. Thus, mandatory participation in

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[3] Antitrust issues would not be raised if a doctor agrees with a patient or insurer, outside the peer review process, to abide by the committee's determination, so long as such agreement is not required by the medical society.

advisory peer review of fees does not appear to violate the laws enforced by the Commission.

Because guidance given by a professional association can sometimes be coercive, medical societies should exercise care to ensure that the advisory nature of the process is clearly communicated to all participants and strictly maintained in practice. Antitrust concerns would be raised if, for example, the peer review process became a vehicle for coercing doctors into adopting a pricing policy sanctioned by the society. The advisory nature of the program should be carefully observed in order to avoid coercion or other unlawful agreements.

B. Physician Discipline

The second, and most fundamental, departure from the fee peer review program approved in the Iowa Dental opinion is the proposal to discipline physicians in certain instances involving fee complaints. The petition states that conduct warranting discipline includes such things as fraud, intentional provision of unnecessary services, and exercising undue influence over a vulnerable patient (p. 5), and that the proposed disciplinary program would for the most part involve this type of abusive conduct (p. 20).

The antitrust laws do not prevent the imposition of professional discipline when such abusive conduct occurs. Thus, the predominant thrust of the proposed disciplinary program appears entirely consistent with the antitrust laws. However, the program creates a substantial danger that it will injure consumers and violate the antitrust laws insofar as it also proposes disciplinary action against physicians solely on the basis of fee levels, where there has been no fraudulent, deceptive, or similar abusive conduct. As is discussed below, this danger is not eliminated by making agreement to the fee by a "fully informed and competent patient," as that phrase is used in the petition, a defense to a charge of "fee gouging." A straightforward requirement that physicians disclose certain fee information, however, would not raise antitrust concerns.

1. Abusive Conduct

Nothing in the antitrust laws prohibits competitors from engaging in self-regulation to protect consumers from fraud, deception, undue influence, and other abusive practices. Such regulation is likely to

promote, rather than impede, competition, by enabling consumer purchase decisions to be made free from deceptive practices. Such practices distort the operation of a market economy, and their elimination enhances competition and consumer welfare. *See American Medical Association*, 94 FTC 701, 1009 (rules banning false or deceptive advertising and unfair solicitation may enhance competition).

Thus, AMA's proposal to discipline physicians for such abusive conduct in the context of fee peer review does not present a significant issue under the antitrust laws. For example, AMA's proposal that physicians be disciplined for intentionally providing unnecessary services is unlikely to restrict competition. Indeed, in a 1983 advisory opinion approving a code of ethics for the American Academy of Ophthalmology, the Commission stated that a rule barring "the ordering of unnecessary procedures for pecuniary gain" raised no antitrust concerns. 101 FTC 1018, 1019 (1983).

Similarly, establishing as a basis for discipline the obtaining of a fee through fraud, deception, undue influence, or other types of exploitation constitutes legitimate self-regulation that does not raise antitrust concern. As noted above, these practices distort consumer purchase decisions, and thereby harm consumers. While the Commission cannot define in advance all the circumstances of exploitative behavior that may occur in the context of fee agreements for physician services, some general principles can be identified.

First, affirmative misrepresentations of material facts about the fee to be charged, the services to be performed, the basis for the fee, or other fee-related matters are proper subjects for disciplinary action. Moreover, a representation may be deceptive because of the failure to disclose qualifying information necessary to prevent an affirmative statement from creating a misleading impression.

Second, as a general matter, an evaluation of whether a patient has been deceived in the purchase of medical services requires an evaluation of relevant surrounding circumstances, in order to assess the overall impression conveyed. For example, some patients may be particularly susceptible to deception due to the stress of a serious medical condition. *See, e.g., Travel King*, 86 FTC 715 (1975) (terminally ill consumers susceptible to exaggerated cure claims). It is appropriate, therefore, for AMA to assess deception from the perspective of such individuals.

Third, patients sometimes may be subject to undue influence that causes them to agree to treatment and to incur unexpectedly high fees. The Commission has previously recognized that in certain circumstances consumers of medical services may be vulnerable to undue influence in their in-person dealings with physicians, and has approved action by medical societies to prevent such abuses. *See American Medical Ass'n*, 94 FTC at 1030 (permitting AMA to proscribe uninvited, in-person solicitation of persons who, because of their particular circumstances, are vulnerable to undue influence). Action by medical societies to address cases where undue influence has occurred is consistent with this approach, and presents no antitrust concern.

Special circumstances are presented in cases in which the patient is unable to make a meaningful choice about a fee, for example in cases involving emergency medical treatment. In such situations, the patient may be unusually vulnerable to exploitation. Such factors may properly be taken into account in deciding whether a physician has engaged in abusive conduct.

Thus, insofar as AMA and CMS are proposing in the context of fee review to discipline physicians for fraudulent, deceptive, or similar abusive practices, the program is consistent with the antitrust laws. This advisory opinion, of course, does not provide advance approval for banning all behavior a medical society might choose to define as abusive, or authorize an otherwise unjustified action based on the assumption that all patients are always vulnerable. But medical society programs to address fraud, deception, and similar abuse of consumers present no inherent antitrust problems.

2. Discipline Based Solely on Fee Levels

While AMA and CMS expect that disciplinary cases will for the most part involve abusive conduct of the sort described above, the petition also contemplates disciplinary sanctions for "fee gouging" where there has been no such misconduct. The informational peer review system and the discipline for abusive practices that the Commission has approved in this letter are of direct assistance to consumers who have concerns about the fees charged by their doctors. Discipline in the absence of such abusive practices, however, threatens to injure consumers rather than assist them. As is discussed below, a requirement that physicians disclose certain fee-related information

to consumers would address the information disparities discussed in the petition, without posing a similar risk of consumer injury.

a. The Concept of "Fee Gouging"

As AMA and CMS recognize, serious antitrust issues are raised by a system of collective competitor regulation of prices. *See, e.g., Arizona v. Maricopa Medical Society*, 457 U.S. 332 (1982); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *U.S. v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). The petition explicitly disclaims any intention of establishing a "fee control" system. (p. 22.) In proposing discipline for "fee gouging," however, the program in part contemplates medical society discipline of physicians solely on the basis of their fee levels, without regard to abusive conduct of the type discussed above. While not identical in nature to the maximum fee schedule condemned by the Supreme Court in Maricopa, the proposed program would in effect create an agreement among competitors that none of them will charge any price that the group deems "excessive." Thus, the program would allow competitors to set the maximum fees of their rivals.[4] Moreover, because the term "fee gouging" has no clearly defined limits, medical societies would have wide latitude in regulating their members' fees, increasing the risk that the program in practice would amount to competitor control over physician pricing.

The petition bans "fee gouging" but does not make it clear what is encompassed in that term beyond the kinds of abuses discussed above, with respect to which the Commission has approved the imposition of discipline. While the "fee gouging" label evidently is designed to convey an impression of improper conduct, it is not clear how the term would be applied to particular fees, and the petition has neither provided a useable definition nor described the standards that would be used to determine when a physician has engaged in "fee gouging".

The Commission's staff has engaged in an intensive effort to learn from AMA and CMS about the operation of the proposed disciplinary system and the problems it seeks to address. At the staff's

[4] Although the program would involve a retrospective review of a fee already charged rather than an agreement on future pricing, the prospect of discipline for "fee gouging" would likely have an effect on price setting by society members beyond those actually disciplined. Indeed, AMA and CMS expect and intend that the threat of medical society discipline for "fee gouging" will have a direct impact on doctors' pricing practices.

request, AMA submitted documents relating to currently-functioning county medical society fee review committees and written responses to questions. AMA and CMS representatives also held a lengthy telephone conference with FTC staff members to explore the ramifications of the proposal. These discussions have further demonstrated the failure of AMA and/or CMS to specify a standard for determining what conduct would be subject to discipline as "fee gouging."

While it seems clear that the petition implicitly defines "fee gouging" to include charging a fee that is very high relative to prevailing charges for comparable services, AMA and CMS have not been able to delineate a consistent or practical standard to guide peer review committees' actions on "fee gouging" complaints. At one point, the petition's discussion of "fee gouging" gives as an example charging a fee 2 to 3 times the "market level" for a major procedure (p. 12). At another point, the petition points to Opinion 6.05 of the Code of Medical Ethics as the "current reference point for what constitutes fee gouging." (p. 12, n.15) That provision defines as "excessive" any fee that a reviewer would have "a definite and firm conviction . . . is in excess of a reasonable fee," in light of all the relevant circumstances. In a separate letter to the staff, AMA appeared to distinguish between fees that are merely "excessive" under Opinion 6.05, which would be subject only to advisory fee review, and fees "so high as to border upon fraud," which would be subject to the disciplinary process.[5] This letter defined the latter category as fees "at least 50 percent above the range of usual and customary."

These alternative definitions demonstrate the absence of a clear standard for discipline. AMA and CMS seek to have medical societies exercise significant disciplinary power while providing little guidance as to how that power ought to be exercised. Moreover, medical society opinions about "market level" price, a "reasonable" fee, and "usual and customary" fees, even if guided by some data, will ultimately represent subjective judgments by physicians serving on disciplinary committees. While a medical society's opinion about the reasonableness of a fee provided through the sort of advisory fee review that the Commission has approved can provide useful information to consumers and third party payers, basing a disciplinary sys-

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[5] Letter from Michael L. Ile, AMA, to Judith A. Moreland, FTC, February 18, 1993.

tem on such subjective judgments would place great power in the hands of medical society review committees.[6]

In addition, correspondence and other statements of AMA and CMS representatives suggest that conduct other than charging a very high fee would also be considered "fee gouging." In particular, discipline could be based on a pattern of fees that exceeded the prevailing level by a relatively small amount.[7] The possibility of such an approach is further indication that the proposed discipline for "fee gouging" could evolve into a system involving substantial competitor control of fee setting. Furthermore, a disciplinary program that threatened sanctions for doctors who fail to adjust pricing behavior in accordance with a PGC's advisory determination that a fee was "excessive" would fundamentally undermine the advisory nature of PGC fee review. As is discussed above, the assurance that fee review is voluntary is the foundation of the Commission's approval of that part of the program.

In sum, while AMA and CMS have stated that their intent is not to establish a fee control program, the disciplinary system as currently described in the petition would give medical societies significant power to regulate the fees charged by their members, and little guidance as to how that power ought to be exercised.

b. The Disclosure of Fee Information

The Commission has considered whether the concerns raised by the breadth of the "fee gouging" concept would be reduced by the provision in the petition that conduct will not be deemed "fee gouging" where there has been prior agreement to the fee by an informed patient:

> Fees much higher than normal would not constitute fee gouging if agreed to by a fully informed and competent patient that was not subject to undue influence.

(pp. 12-13.) This provision, which in effect makes nondisclosure an element of "fee gouging," does not in its present form reduce the antitrust risks inherent in the proposal.

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[6] As is discussed below, such an aggregation of power in the hands of competing providers of medical services carries significant risk of consumer injury.

[7] Letter from Michael L. Ile, AMA, to Judith A. Moreland, FTC, February 18, 1993.

The breadth of the ban on "fee gouging" -- and the resulting risk of consumer harm -- could be reduced by including nondisclosure as an element of the concept of fee gouging, by specifying that physicians would not be subject to disciplinary review if they had disclosed relevant fee information.[8] The proposed program's disclosure provision does not have this effect, however, because the information that would have to be disclosed to ensure that a patient is "fully informed" is so extensive that it is unlikely that a physician could ever make disclosures sufficient to avoid discipline. Thus, even if patients knowingly selected an expensive specialist on the recommendation of their primary care physician, and if the specialist fully discussed his or her services and fees and other material information in his or her possession in a meeting with the patient, the specialist's fee apparently could later be attacked as fee gouging. This occurs because under the current proposal, in order for the patient to be "fully informed," the specialist would have to disclose the fees of other physicians and perhaps other information to which the specialist may not have access.[9]

In short, the concept of a "fully informed consumer" set forth in the petition does not significantly reduce the antitrust concerns noted above because it appears unlikely that a physician would possess all the necessary information or that physicians could be confident that their disclosures would be deemed adequate.[10] Thus, physicians would be subject to discipline based on broad and essentially standardless review of their fee levels by their competitors.

While the proposed program's "fully informed consumer" provision does not eliminate the competitive concerns already discussed, AMA and CMS can take steps to address the information disparities

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[8] In most cases, the physician should be able to disclose in advance the fee that will be charged for the service or procedure, and the possibility of additional charges should complications arise. There may also be other information helpful to patients that doctors could disclose. For example, in many cases physicians may have information that would permit them to estimate the extent of the patient's insurance coverage, and therefore the extent of the patient's liability after insurance payment. Alternatively, the doctor might inform the patient that insurance may not cover the whole fee, and that the patient might want to contact the insurance company to find out what its maximum payment for the service would be, or to inquire about what other doctors are likely to charge.

[9] According to the petition (p. 13, n.16), for a patient to be fully informed the physician must not only disclose his or her own fee, but make sure that the patient knows what other physicians in the area charge for the service. Elsewhere, the petition (p.21) suggests that a patient has received adequate disclosure only if given "full information about comparable fees and the quality and need of the service being offered . . . ."

[10] Moreover, the petition suggests that in some circumstances a fee could be considered "fee gouging" even if it had been agreed to in advance by a fully informed patient. (p. 21)

discussed in the petition. For example, there is no reason under the antitrust laws why AMA and CMS could not adopt an across-the-board requirement that physicians disclose relevant fee information in advance of treatment whenever it is possible to do so,[11] just as they currently require physicians to disclose in advance the possible risks of treatment in order to obtain informed consent to the treatment.[12]

In some contexts, disclosure requirements can result in less information rather than more being available to consumers. For example, the Commission has recognized that requiring excessive disclosures in advertising can discourage advertising by increasing its costs.[13] However, each required disclosure must be evaluated in its own context, and in the context of discussions between physicians and patients about appropriate medical care, requiring some information about price to be provided would not appear to raise inherent problems under the antitrust laws. As long as the disclosure requirements were not unduly burdensome and were a legitimate response to the information disparities noted in the petition, they would not be likely to restrain competition unreasonably.[14]

3. Consumer Harm Resulting from Discipline Based Solely on Fee Levels, Without Regard to Abusive Conduct

A program that based discipline solely on the level of the fee charged, without regard to the presence of fraud, deception, or other exploitation, would pose a substantial danger of consumer harm in various ways. As noted above, such a program would amount to competitor regulation of fee levels. As the law recognizes, the as-

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[11] AMA has proposed, as part of its health care reform proposal, that health care providers be required to release price information to patients before treatment. It recognizes that the availability of price information can increase the role of competitive forces in health care markets and encourage cost-conscious patient decision-making. American Medical Association, Health Access America (2d. edition) at 5, 6. To date, however, AMA has not required its members to disclose to patients the cost of treatment in advance. In 1992, the AMA House of Delegates adopted a resolution "encouraging" doctors to post the prices of their most commonly performed procedures.

[12] *See* Council on Ethical and Judicial Affairs, AMA, Code of Medical Ethics and Current Opinions, Opin. 8.08 (Informed Consent) at p. 38 (1992).

[13] *See, e.g.*, Advertising of Ophthalmic Goods and Services, Statement of Basis and Purpose and Final Trade Regulation Rule, 43 Fed. Reg. 23992, 24002 (1978).

[14] Since no proposed disclosure requirement is before the Commission, it cannot render an opinion of the permissibility under the antitrust laws of any particular requirement. AMA and CMS, if they choose to adopt a disclosure requirement, should evaluate in the first instance what kinds of disclosures might be useful to patients without being unduly burdensome to the doctors.

sumption by competitors of the power to control market prices poses inherent dangers to consumers. *See, e.g., United States v. Trenton Potteries*, 273 U.S. 392, 397-98 (1927). The Commission does not question that the disciplinary system is not intended to lead to uniform fees or to establish a price floor. But however well-intentioned, an agreement among competitors that allows them to regulate prices creates a dangerous probability that such an aggregation of power will ultimately result in increased prices for consumers. *Id.*; *see also Arizona v. Maricopa Medical Society*, 457 U.S. 332 (1982).

Moreover, an agreement among competitors not to charge in excess of what the group deems to be "reasonable" could have a variety of adverse effects on consumers aside from an ultimate increase or standardization of prices. It could, by instituting competitor control over price levels, operate to discourage entry into the market and deter innovation. For example, a program of fee level discipline could be used to discourage the introduction of superior but more expensive medical treatments or procedures. Competitors unable or unwilling to offer a particular procedure themselves could declare that those who did so were "price gougers" if the procedure were significantly more expensive than the procedure for which it was a substitute. Such a program of fee level control could infringe on consumers' ability to decide that unusual qualities of a physician's services justified a higher than usual price, substituting instead the collective judgment of competitors as to what a consumer should want to purchase.

Finally, any system of discipline lacking clear standards is susceptible to arbitrary enforcement and abuse. Discipline based on a vague concept of "fee gouging" could be used to obstruct doctors who, for whatever reasons, are not in favor with their colleagues, including those who are aggressive competitors, more in demand, or simply better qualified.

C. Disclosure of Disciplinary Actions

AMA proposes to publicize the fact that a physician has been disciplined, but not the amount of the fee in question, when the infraction giving rise to the discipline involved a fee matter. Assuming that the underlying disciplinary action did not itself violate the antitrust laws, as is discussed above, the Commission is of the opinion that making disciplinary decisions public without disclosure of the fee in

question does not endanger competition, and would not be likely to violate the antitrust laws.

IV. Conclusion

Accordingly, the Commission concludes that the proposed fee review program, insofar as discipline would be imposed in cases involving abuses such as fraud, deception and undue influence, would not violate Section 5 of the Federal Trade Commission Act or any other statute enforced by the Commission. Because the potential breadth of the petition's concept of "fee gouging" raises sufficient possibility that other aspects of the proposed disciplinary system could injure consumers, the Commission cannot give advance approval to those aspects of the proposal as currently framed in the petition. As is indicated above, however, AMA and CMS can, consistent with the antitrust laws, require physicians to disclose certain price-related information to their patients in advance of services, in order to redress information disparities that exist in the market.

This advisory opinion, like all those issued by the Commission, is limited to the proposed conduct described in the petition being considered. It does not, of course, constitute approval for specific instances of implementation of the program that may become the subject of litigation before the Commission or any court, since application of the program in particular situations may prove to cause significant injury to competition and consumers, and thereby violate the Federal Trade Commission Act. The Commission retains the right to reconsider the questions involved, and with notice to the requesting parties in accordance with Section 1.3(b) of the Commission's Rules of Practice, to rescind or revoke its opinion in the event that implementation of the proposed program results in significant anticompetitive effects, should the purposes of the program be found not to be legitimate, or should the public interest so require.

Letter of Request

April 30, 1992

Dear Mr. Clark:

Pursuant to 16 CFR 1.1, the American Medical Association (AMA) and the Chicago Medical Society (CMS) hereby request an advisory opinion that would permit the AMA, its constituent medical societies, and its component medical societies to engage in professional peer review of physician fees pursuant to procedures developed by the AMA.[1]

Under the AMA's contemplated program, state or county societies would perform most of the professional peer review of fees.[2] State societies would also act as appellate bodies for opinions or decisions of the county medical societies, and under some circumstances would act as the initial forum for peer review of fees. The AMA would participate as the appellate body for opinions and decisions of the state societies, and under rare circumstances would initiate its own peer review proceedings.

The Federal Trade Commission (FTC) has issued advisory opinions about the operation of professional peer review of fees.[3] The FTC has recognized that, properly managed, professional fee peer review can yield important procompetitive benefits.[4] In particular, fee peer review can increase the flow of information about physician

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[1] Pursuant to the AMA's Constitution, constituent medical societies are "medical associations of states, commonwealths, territories or insular possessions which are, or which may hereafter be federated to form the American Medical Association." Component societies "are those county or district medical societies contained within the territory of and chartered by the respective state associations."

[2] The AMA believes that many of these medical societies will adopt the proposed fee peer review procedures if they are found to be compatible with the antitrust laws by the Federal Trade Commission. *See* the letters of support from state and county societies submitted with this request. Indeed, CMS, which is the largest county medical society in the nation, has chosen to join the AMA in this request because it desires to conduct the review of complaints about physician fees in the manner requested for the procompetitive reasons that are discussed *infra*.

[3] *See, e.g., Medical Society of Passaic County* (January 3, 1986); *American Podiatry Association* (March 13, 1984); *Iowa Dental Association*, 99 FTC 648 (1982).

[4] *Ibid.*, and *see* "Peer Review and the Antitrust Laws," Remarks of Mark J. Horoschak, Assistant Director for Health Care, Bureau of Competition, Federal Trade Commission, before the AMA National Leadership Conference, February 25, 1990; and for the perspective of the Antitrust Division of the U.S. Department of Justice *see*: "Business Self Regulation. An Enforcement Policy of Cautious Tolerance. Remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, Before the Chicago Bar Association, January 27, 1989.

fees to patients, enabling them to compare fees when selecting a physician.

However, the FTC has also expressed concern that improperly managed fee peer review could result in price-fixing agreements and the[5] advisory opinions and guidelines issued by the FTC have been so restrictive that few medical societies engage in fee review today. We believe they are unnecessarily restrictive and are thereby depriving patients of an important public service.[6] In particular, we object to the FTC guidelines which advise that:

1. Opinions of the peer reviewers must be advisory only and not coercive--that physicians must not be required either to participate in the review process or to comply with the opinion of the reviewers; and

2. That physicians must not be subject to discipline for charging any particular fee or for refusing to adhere to the opinion of reviewers.

A complete summary of the AMA's proposed procedures for professional fee peer review is included in subsequent portions of this letter. In brief, the procedures would generally adhere to the FTC guidelines, but we make the two important changes described above. The process would involve mediation of complaints about fees, but physician participation would be mandatory under the AMA procedures and physicians can be disciplined for fee gouging.[7] While the emphasis of the AMA's proposed program is on mediation, the AMA and the CMS believe that medical societies should be able to discipline members who engage in egregious conduct.

The AMA and CMS believe that these differences would enhance the procompetitive benefits of professional fee peer review by medical societies. Almost all fee peer review carried on by component societies is in response to patient complaints. Mandatory participation would increase the flow of information to patients about fees, and it would increase patient confidence in the market for physician

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[5] *See* ftn. 3. *supra.*

[6] Horoschak, ftn. 4, *supra.*

[7] Fee gouging has been long been considered unethical by the profession. *See* Opinion 6.05, "Fees for Medical Services" in the Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1992).

services. The ability to discipline fee gougers would also increase patient confidence in the market.

When a medical society cannot require a member to participate in fee peer review in response to a complaint, the patient is always unhappy, sometimes harmed and the profession is denied the ability to enforce its code of ethics in a critical respect.

The AMA has had intermittent discussions with prior Chairmen of the FTC for the relief sought here for over seven years. We have sensed greater flexibility and a broader perspective from this Commission on certain matters and we submitted a draft of this request for an advisory opinion to the staff of the Bureau of Competition for an informal reaction. Staff has responded by requesting a substantial amount of information in addition to the material set forth in this request. Some of the questions asked by staff are clarifications that have been addressed by modifying this letter. Other information requested can only be obtained by calling upon the experiences of the constituent and component societies. The AMA and the CMS are in the process of gathering that information and will submit it shortly, but we do not believe it is necessary given the nature of the modifications we are seeking. For the reasons stated here and in the cover letter to Chairman Steiger, it is past time to grant the relief we seek.

The Procedures Proposed By The AMA For Professional Peer Review of Physician Fees

a. Intent of the AMA's Proposed Procedures

This request for an advisory opinion is being submitted as part of a broad, procompetitive effort to enhance professional self regulation by physicians. The goal is to respond to widespread disenchantment with the health care system by addressing the complaints of patients, payers, and others about individual physicians in light of the ethical code of the profession. It is essential that physicians address this lack of confidence if the market for physician services is to function effectively. The object of enhanced self regulation is to restore confidence by providing a means to resolve patient and payer complaints about individual physicians and by promoting adherence to high standards of conduct by physicians.

This effort to enhance professional self regulation is procompetitive because it should result in greater protection of patient interests

and provide a greater flow of information about physicians to patients, payers, and others. Patients will have greater confidence that their interests will be observed and that they will not be exploited when being cared for by a physician. In addition, there will be more information available for patients to compare the characteristics of physicians when choosing a provider. Further, individual physicians will obtain more information about the patient perspective and are likely to respond by changing their practice procedures to improve the experience of the patient.

The AMA hopes to achieve enhanced self regulation by reviving a professional peer review structure that was once active, but which has become increasingly inactive in certain matters in recent years. The AMA and its constituent and component societies have in place the organizational structure necessary to handle complaints about fees and other matters from patients, payers, and others. In fact, most of these medical societies have bylaws that provide for standing committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. Some of these societies hear patient complaints about fees. However, these committees have become inactive or under used in many, if not most, geographic areas. There are some county and state societies with active grievance committees, but most do not review complaints about fees. The disciplinary function has virtually stopped in most areas.

The AMA has proposed the fee peer review procedures at issue in this request for two reasons. First, the AMA and the constituent and component medical societies view fee peer review as an important activity. Second, because of its importance, an FTC approved set of procedures that enhances the ability of these committees to mediate complaints about fees and to discipline fee gougers would provide an excellent means to promote the use of the peer review system. As is discussed in the next section of this letter, one of the reasons why the peer review structure has become increasingly inactive is fear of litigation, especially antitrust litigation. An advisory opinion from the FTC which found that the proposed guidelines for fee peer review are compatible with the antitrust laws would provide assurances to medical societies that peer review can take place without excessive liability risks.

Medical societies consider professional fee peer review to be important because most medical societies regularly receive complaints from patients and institutions or regulators, has done the best

job at taking the actions necessary to build public confidence in the market for physician services.[8]

b. The Existing Committee Structure

1. Patient Grievance Committee and Physician Disciplinary Committees

As of 1987, almost all of the county medical societies had "patient grievance committees" (PGCs) and physician disciplinary committees (PDCs).[9] The purpose of a PGC is to take complaints from patients about physicians and to resolve them, primarily through mediation. If a complaint involves a serious charge of misconduct, the PGC may refer it to a PDC or to a state or federal regulatory agency. PDCs hear serious charges of ethical violations by a physician that might result in an action that affects the physician's membership.

State medical societies also operate PGCs and PDCS. However, county medical societies are intended to handle initial complaints, with state medical societies acting as an appellate body for parties dissatisfied with the opinions or decisions of the county societies. State PGCs and PDCs will handle initial complaints for counties in rural areas that do not have sufficient members or staff to operate committees. In addition, state PGCs and PDCs usually have discre-

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[8] Throughout its history, the profession has responded to the need to solve health care problems and to regulate itself in the public interest. During the mid and late 19th century, the profession organized medical societies and developed a code of ethics to distinguish physicians from the many competing health care practitioners that did not adhere to safe and scientific methods. Subsequently the profession initiated and helped operate the system of state licensure of allopathic physicians. At the turn of the century, the profession reformed the medical education industry and succeeded in eliminating the practice of granting diplomas for a fee and in closing substandard medical schools. A system of accrediting medical schools was developed that continues today, and which is operated by organized medicine. During the early part of the twentieth century, systems for accrediting graduate medical education programs and hospitals were developed by the profession, and the board certification of the American Board of Medical Specialties was organized. The net result has been the training of hundreds of physicians of high levels of competency and integrity, and their efforts to deliver high quality medicine has been an extraordinary success story. The impetus and basic organizational structure for the system has come from the profession itself, in particular, the American Medical Association. *See* generally, Morris Fishbein, M.D., A History of the American Medical Association, 1847-1947, W.D. Saunders Company, Philadelphia, Pa. (1947); Frank D. Campion, The AMA and U.S. Health Policy Since 1940, American Medical Association, Chicago, Illinois (1984); and Paul Starr, The Social Transformation of American Medicine, Basic Books, New York (1982).

[9] Directory of Activities, Volume II, 1987, State and County Medical Associations. American Medical Association. Chicago, Illinois (1987).

tion to handle initial complaints from any area in appropriate situations.

The AMA does not have a PGC or a PDC. However, the Council on Ethical and Judicial Affairs of the AMA (CEJA) acts as an appellate body for parties dissatisfied with opinions or decisions of state PGCs and PDCs. CEJA also is authorized to conduct its own investigation and hearings into charges of unethical conduct in appropriate situations.

The most active PGCs are operated by county societies that cover large metropolitan areas. These counties have a substantial membership, sometimes larger than rural states, and have the resources to operate active PGCs. The AMA believes that many counties do not have active PGCs, and states are not very active in this area either.

Counties and states have not been active in operating PDCs. The AMA does not have precise information about the operations of PDCs, but it appears that PDC activity has almost halted except in a few large states or counties.

There are several likely reasons for the low level of activity in PDCs. One is fear of litigation. As of 1987, ten state societies and 13 county societies reported that they had been investigated by the FTC, the United States Department of Justice (DOJ), or another government agency during the previous five years. Ten state societies and 20 county societies were sued by a member or a nonmember physician during the same period.[10] Many of the investigations and lawsuits concerned antitrust issues associated with membership. Defense of a lawsuit is a major expense to a state or county society. Many have decided to minimize their exposure to lawsuits by reducing PGC activity and PDC activity.

In addition to fear of litigation, other factors that may cause a low level of activity are a shortage of resources, and a natural disinclination to engage in disciplinary functions that might adversely affect a peer. These factors, combined with fear of becoming embroiled in expensive litigation, have been powerful disincentives.

Currently, the AMA is encouraging county and state medical societies to activate their PGCs and PDCs. As part of this effort, the AMA is preparing to handle more appeals from state PDCs and PGCs, and it is also providing guidance to state and county societies about how to operate the committees.

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[10] Directory of Activities, Ftn. 10, *supra.*

2. Chicago Medical Society's Existing Committees

Pursuant to its bylaws, the CMS has standing Ethical Relations and Physicians Review Committees and Subcommittees on Fee Mediation and on Medical Practice. Under the CMS bylaws, failure to cooperate with these committees and subcommittees is grounds for discipline. However, as a matter of custom and practice, CMS has excepted fee peer review from mandatory participation. Members have not been required to cooperate with fee peer review and have not been disciplined if they refuse to participate.

The CMS Ethical Relations Committee is comparable to a PDC and is responsible for disciplinary actions against members, which could include censure, probation, suspension or expulsion.

The CMS Physicians Review Committee is comparable to a PGC. Its Subcommittee on Medical Practice is responsible for complaints concerning the quality and utilization of medical care and has as its goal to open up communications, through mediation, to reach a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. An opinion adverse to the physician may be appealed to the Physicians Review Committee and, in turn, to the Illinois State Medical Society.

The Subcommittee on Fee Mediation is responsible for complaints concerning physician fees and has as its goal to open up communications, through mediation, to encourage a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. If it is the opinion of the Subcommittee that the fee is above the range of usual and customary fees charged in the geographical area for similar medical services, the physician may appeal to the Physicians Review Committee. Decisions rendered by the Physicians Review Committee in a fee mediation case cannot be appealed.

The efforts of CMS' Subcommittee on Fee Mediation have been frustrated by the Subcommittee's inability to discipline physicians engaged in egregious conduct, such as repeated instances of fee gouging.

c. Guidelines for the Operation of PGCs & PDCs

As stated earlier, the AMA has developed guidelines for the operation of PDCs and PGCs. These guidelines include procedures for ensuring basic fairness to the parties involved, such as minimizing

conflicts of interest among reviewing physicians and other "due process" style safeguards. In addition. the guidelines have other features designed to provide for the appropriate disposition of various types of complaints. Many of the guidelines are drawn from the historical practices of the PGCs and PDCs, and some of the guidelines are new. As a whole, the guidelines are a blend of existing practices and new recommendations.

These guidelines apply to all types of complaints handled by PDCs and PGCs, including the handling of complaints about fees. The guidelines also include a section about the handling of fee complaints in particular. The general guidelines are summarized below, and a summary of the guidelines for fee complaints follows immediately after.

1. General Guidelines

The AMA recommends that PGCs and PDCs screen complaints immediately after receipt to determine whether they should be handled by the committee, or referred to another committee or entity, or both. For example, state PGCs should generally refer complaints to the county PGC where the physician involved resides. PDCs should refer complaints that do not involve serious charges of misconduct to PGCs, and PGCs should refer complaints to a PDC when there is reason to believe that serious misconduct is involved.

If there is reason to believe that a threat to the health of the physician's patients exists, then the state's licensing board and the physician's hospital should be notified immediately. When there is reason to believe that a violation of law has occurred, then the appropriate government law enforcement agencies should be notified. A PGC or PDC might hold parallel proceedings when a state licensing board or licensing agency is notified, or it might wait for the outcome of any government actions, depending on the circumstances.

After screening of a complaint by a PGC, it should be investigated by one or more members of the PGC. An investigation should include interviews of the complaining party and the physician complained of,[11] interviews of other physicians in the physician's field of practice, review of relevant documents, and other materials. Upon completion of the review, the reviewer should make a report to the

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[11] At the present time, physician cooperation with investigations of fee complaints is voluntary.

full PGC, which should then make one of the following findings: (a) the physician did not act improperly, (b) the matter should be referred to the PDC and/or another entity for further proceedings, (c) the physician acted inappropriately but not enough to warrant disciplinary proceedings or proceedings by an outside agency, or (d) efforts should be made to resolve the matter through mediation. In situations where a physician has acted inappropriately, but not enough to warrant further proceedings, the PGC may require the physician to receive some education and agree to desist from the inappropriate conduct.

During mediation, the PGC should encourage the physician and the complainant to fully discuss their relative positions, with a view towards arriving at a settlement. Mediation should include education of both the complainant and the physician regarding the appropriate expectations and conduct of each. While settlements are voluntary, the medical society may also require the physician to pursue certain educational activities as a condition of the settlement. The educational activities are designed to prevent repetition of the conduct which led to the complaint.

PGC decisions may be appealed. Some societies allow internal appeals from the PGC decision, others do not. Once proceedings are final at the society which heard the complaint, the decision may be appealed to the next level of society. Counties appeal to states, and the state PGC decisions or appellate decisions can be appealed to the AMA. During appeals, complaints are not reinvestigated. The PGCs findings of fact are accepted if reasonable in view of the record.

PDCs should be independent of PGCs -- there should not be overlapping membership between the two committees in a society. The procedures followed by PDCs are also more formal. They are designed to qualify for the safe harbors provided by the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11111 *et seq.*, which immunizes the participants in good faith peer review from civil liability if procedures designed to ensure fairness to the physician under review are followed. The procedures are also tailored in any given state to meet additional requirements imposed by state law for the conduct of peer review. Specific steps are spelled out for providing notice of the grounds for potential disciplinary action, notice of the disciplinary proceedings, the conduct of the hearings, providing notice of the decisions, and appeals.

A physician found by a PDC to have engaged in unethical conduct may be subject to a range of sanctions.[12] They include:

(a) Requiring the physician to undertake a specific program of remedial education.

(b) Requiring the physician to participate in a program of public service.

(c) Reprimand, censure, suspension of membership or expulsion from membership.

(d) Monitoring of the physician's practice for a specified period of time to ensure that corrective action has been taken.

(e) A fine to be paid to the medical society, or, if appropriate, restitution to the patient.

(f) Report to the state medical board with a recommendation that action or investigation be initiated.

(g) A combination of the sanctions listed in (a)-(e).

Factors in determining a sanction include not only the severity of the misconduct, but whether it was a first offense or part of a pattern of misconduct. More serious sanctions can also follow if, for example, a physician fails to participate in a program of remedial education or public service.

As is the case with PDCs, appeals may or may not be available within the society. Once the decision is final, it may be appealed to the next level, normally a state society, and then to the AMA.

Adverse actions taken by a PDC may be subject to federal and state reporting requirements. Under the federal Health Care Quality Improvement Act, any "professional review action" which adversely affects the membership of a physician must be reported to the state licensing board, which in turn reports to the National Practitioner Data Bank. Under the Act, "professional review actions" are those based on the competence or professional conduct of a physician, where the professional conduct affects or would adversely affect the health or welfare of a patient.[13] An action adversely affects member-

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[12] At the present time, sanctions do not apply to fee gouging.

[13] It is uncertain whether fee gouging would fall within the definition of a professional review action. Economic injuries such as being overcharged do not seem likely to affect the "health" of patients, but they might be considered to affect the "welfare" of patients.

ship by reducing, restricting, suspending, revoking, denying, or failing to renew membership.[14]

Many states require by law that determinations of unprofessional conduct related directly to patient care be reported to the licensing board. In addition, a PDC may make other disclosures. If there is a finding that substandard care has been provided, the peer review committee of the physician's hospital should be notified. Normally, reports of adverse actions by PDCs should be disclosed to the society's membership and the public through vehicles such as state medical society journals. However, in some cases it may make sense to impose a sanction privately, as where the offense is not egregious and the physician is a first time offender, or where there is a referral to an impaired physician program.

Ordinarily, PGCs and PDCs will have jurisdiction over medical society members only. Participation and cooperation with PGC and PDC activities is mandatory, and failure to cooperate is grounds for discipline. However, the AMA recommends that county and state societies encourage nonmembers to participate in PGC or PDC proceedings when complaints are received about them. In practice, some societies will accept a complaint about a nonmember only if the physician agrees to abide by the PGC or PDC procedures and decision. In the absence of an agreement, these societies will refer the complaint to the state licensing board or to another appropriate institution. Other societies will process a complaint against a nonmember without the nonmember's consent. The AMA believes that serious complaints about non-members who refuse to participate in a professional society's fee review process should be referred to the state licensing board.

Complaints may be filed by any person. Most commonly complaints are filed by patients, but they may also be filed by family or friends of patients, colleagues of the physician, or by third party payers.

d. How Fee Complaints Would Be Handled By PGCs and PDCs

Complaints about fees would be handled according to a specific set of procedures newly developed by the AMA. All fee complaints

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[14] A physician who is being considered for disciplinary action may seek to avoid the procedure by resigning. Under the Health Care Quality Improvement Act, resignations which take place during the pendency of a hospital peer review procedure must be reported. However, it is not clear whether resignations during the pendency of a medical society peer review process must be reported.

would first be referred to a county PGC covering the area where the physician resides, or the applicable state PGC if there is no county PGC. All complaints would be screened by the PGC to determine whether they should be referred to a state licensing board or a government enforcement agency. No complaints would be referred to a PDC without first being investigated by a PGC.

After investigation, a PGC would determine whether a fee complaint was a "level I" complaint or a "level II" complaint. A level I complaint would be a complaint that did not involve egregious conduct by the physician involved, and a level II complaint would be one which involves an allegation of egregious conduct that has a credible foundation. Egregious conduct would include situations where the fee charged arose from fraud, the exercise of undue influence over a vulnerable patient, taking advantage of the lack of knowledge of a patient, failing to inform a patient that an unusually high fee would be charged, intentionally providing unnecessary services, or other misconduct. It would also include charging a fee so high, for example two or three times the market level for a major procedure, as to constitute fee gouging.[15] Fees much higher than normal would not constitute fee gouging if agreed to by a fully informed and competent patient or payer that was not subjected to undue influence. Complaints about fee gouging made by colleagues of the treating physician or by persons other than the patient would be reviewed to determine if the fees involved had been agreed to by a fully informed and

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[15] FTC staff has asked for clarification about what constitutes fee gouging, and, in particular, what standards would be used to evaluate whether gouging occurred. The current reference point for what constitutes gouging is provided by Opinion 6.05 of the Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1992), which is entitled "Fees for Medical Services". The Opinion states as follows:

A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:

A. The difficulty and/or uniqueness of the services performed and the time, skill and experience required;
B. The fee customarily charged in the locality for similar physician services;
C. The amount of the charges involved;
D. The quality of performance;
E. The nature and length of the professional relationship with the patient; and
F. The experience, reputation and ability of the physician in performing the kind of services involved.

competent patient. If there was such an agreement, the complaint would not be acted upon.[16]

All level I complaints would be referred for mediation by the PGC. Level II complaints are those involving egregious conduct. The underlying patient or payer grievances in level II complaints would go through mediation for the purpose of resolving the complaint. However, level II complaints would also be referred to a PDC to evaluate whether the physician involved should be disciplined.

During mediation of complaints, each party would express views about the fee involved and any other conduct which gave rise to the complaint. The panel would express opinions about the reasonableness of the fee charged and the appropriateness of any other behavior at issue. Panel opinions would be based on their own expertise and experience in view of the circumstances of the complaint. The panel would consider the nature of the services performed, the difficulty of providing the services to the patient involved, any unusual problems or complexities that had to be managed, and other factors.

The opinions of the panel about the fee could be supplemented with other information about fees obtained from payer data bases, government fee schedules, academic studies, and the opinions of similarly situated physicians sought out by the panel. However, the medical society involved would not collect and maintain its own information about fees charged by physicians in its jurisdiction for use as a benchmark. Likewise, opinions of the panel about any other behavior of the physician involved could be supplemented by ethical codes and ethical opinions, articles about physician ethics, academic studies about the effects of certain conduct, and other materials. The object of the process would be to allow each side to gain an appreciation for the perspective of the other, and to be educated about the legitimate expectations of each party in the physician-patient relationship.

The goal of mediation would be to arrive at a settlement between the physician and the complaining party. No person, including the physician, would be required to agree to a settlement. However, par-

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[16] FTC staff has asked what the effect of a prior agreement between the physician and patient would be if the patient subsequently alleged a fee to involve fee gouging. If the patient was fully aware of what other physicians were charging for the services when the agreement was entered, and if the patient was not misled about some other factor which might lead a reasonable person to pay more than the market rate for a service, then the patient would be viewed as not having a valid complaint and the fee would involve gouging. However, if the patient was not aware of the market rate, or was misled into believing that the presence of another factor warranted paying substantially more than the market rate, then the patient would be viewed as having a valid complaint.

ticipation in mediation by member physicians would be mandatory, and failure to cooperate with mediation would be grounds for discipline. Refusal to enter a settlement by a physician would not constitute lack of cooperation. Participation by the complaining party would be voluntary.

Settlements would not be limited to fee adjustments. The PGC could suggest, and the physician might agree to, other undertakings by the physician. These would be nonprice undertakings designed to educate physicians about how to prevent the type of incidents that give rise to patient complaints. These include how to manage the physician's office in ways that are considerate of the needs and interests of patients, how to communicate with patients, how to manage billing procedures so as to prevent errors, and other issues. For example, if repeated complaints about a physician are found to result from coding errors on claims forms, then education about coding may be appropriate.

If warranted, the PGC could require a physician to engage in a nonprice undertaking designed to prevent future complaints or misconduct. While these undertakings might arise out of mediation of the fee disputes they would be directed towards nonprice issues that came to light during review of the complaint.

Proceedings during mediation would be kept confidential. No part of the proceedings would be open to the membership or the public. The report of the initial investigation would be kept confidential, and any record created or documents collected would also not be disclosed. Likewise, any settlement reached, including settlements that are conditioned on nonprice undertakings, would not be disclosed to the membership or to the public.

PDCs would review level II complaints to determine whether the physician should be disciplined. The procedures specified by HCQIA would be followed to ensure fairness to the physician charged with unethical conduct. Participation in the PDC proceeding would be mandatory for the physician involved.

PDCA would keep their proceedings confidential. However, PDC decisions would be publicly disclosed. No information about the fee levels involved in a discipline for fee gouging would be disclosed, but the occurrence of the discipline would be made public. The purpose of disclosure would be to inform the public about the discipline.

The FTC Guidelines For Professional Peer Review of Fees

FTC staff have noted that, properly managed, professional peer review of physician fees results in three procompetitive benefits.[17] First, it is a means of providing information to patients about physician fees and other issues. That is procompetitive because the information allows the patient to decide whether a fee is excessive in relation to those charged by other physicians. It is an important benefit because there are often wide disparities in fee information between patients and health care providers.

Second, fee peer review can be an efficient and low cost method for resolving disputes about fees between physicians, patients, and payers. That is procompetitive because it facilitates the expedient and fair resolution of disputed transactions. At present, there is no effective forum available to resolve disputes. Courts are expensive and difficult to use, and they are often very slow. State licensing boards are not designed to resolve individual disputes. Instead, they investigate physicians in response to complaints. At present, most licensing boards have sufficient resources to investigate only the most serious complaints.[18]

Third and finally, fee peer review builds confidence in the market for physician services. Patients develop confidence because they believe that they will be treated fairly, and that they will receive objective information in the event of a dispute.

However, an improperly managed fee peer review program can be anticompetitive and violate the antitrust laws. FTC advisory opinions note that antitrust violations may occur if fee peer review becomes a device to coerce physicians to adhere to certain fee levels or to coerce payers into accepting fee levels, if it is used to discipline physicians who engage in legitimate competitive activities or innovative practices that are frowned upon by other practitioners, or if it becomes a vehicle for physicians to agree among themselves about fee levels.[19]

The advisory opinions note that antitrust violations can be avoided if all concerned parties view fee peer review solely as a means of

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[17] *See* Horoschak and *see* Rule at ftn. 4, *supra.*

[18] "State Medical Boards and Medical Discipline," Inspector General, Department of Health and Human Services (August 1990).

[19] *See* Advisory Opinions cited at ftn. 3, *supra.*

mediating specific fee disputes, rather than a process for the collective sanctioning of fee levels or particular practices. Mediation involves the expression of opinion by peer review panel members about a fee charged for a particular service provided to a patient. That expression of opinion allows the patient or payer involved to decide whether to pay the fee in question.

Certain guidelines designed to prevent anticompetitive abuse of fee peer review can be drawn from the FTC advisory opinions. These guidelines can be summarized as follows:

(1) Participation in professional peer review of fees is voluntary for the physicians and any complaining or affected party, such as the patient. The FTC is concerned that proffered guidance in fee peer review could become coercive if the process is not voluntary.

(2) Determinations made by the peer reviewers about the physician's fees are advisory, and have no coercive aspects. The FTC is concerned that coercive determinations could threaten independent pricing.

(3) Peer review decisions about fees are based solely on the facts and circumstances of the particular case. The FTC is concerned that independent pricing could be threatened if determinations about particular past prices become generalized in future fee peer review opinions.

(4) Peer review decisions about the appropriateness of fees are kept confidential and are not disclosed except to the physician and complaining patient or payer. The FTC believes that dissemination of peer review opinions about fees could threaten independent pricing.[20]

(5) The association of physicians sponsoring professional peer review of fees does not collect information on fees charged by its members and does not use the information to establish a pricing benchmark. The FTC believes that the difficulty and complexity of a procedures should be evaluated based on the individual judgment and expertise of the peer reviewers. To the extent that any reference is made to external factors or benchmarks, consideration should be

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[20] The AMA understands that confidentiality is limited in information about the fee level itself as opposed to the fact of a peer review action. The AMA believes that medical societies may publicize information about the number and nature of peer review actions taken, and could publicize the names of individuals disciplined for fee gouging, provided that the fee amounts involved were not disclosed.

limited to fee information not sponsored or sanctioned by the medical society.

For the most part, the procedures proposed by the AMA would adhere to these guidelines, but there would be some significant departures. In particular, the proposed process would not be voluntary in all respects. The emphasis of the program would be mediation, but participation would be mandatory for members. Participation would be required because the public would not be well served by a peer review process that members could ignore when patients file complaints about them.

For the same reasons, the program would be coercive in some situations. Medical societies would discipline members who engaged in egregious fee gouging. The purpose would be to give the public confidence that physicians who engage in egregious fee gouging will be held accountable.

The AMA's Proposed Procedures For Peer Review of Fees Are Procompetitive

The judicial decisions relevant to peer review of fees are generally consistent with the current policy of the Commission in that they would permit self-regulation activities that do not constitute or enforce a price-fixing agreement. The AMA's proposed procedures for peer review of fees would clearly fall within the range of conduct deemed reasonable by the courts, and any departures from existing FTC guidelines would be procompetitive and lawful.

The Supreme Court has held that an agreement affecting price should only be condemned after a "quick look" to determine whether it has clear anticompetitive consequences and lacks any redeeming virtue. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 19-20 (1979). As noted above, the Commission recognizes the procompetitive benefits that result from peer review of fees. The AMA's proposed fee peer review is thus not inherently suspect; it presents antitrust concerns only if the fee peer review serves to establish or enforce a price-fixing agreement.

The AMA's proposed process contains several elements designed to assure that the peer review conducted will not establish or enforce a price-fixing agreement. First, the PDCs will act on a complaint of alleged fee gouging only (1) when the complaint originates with a patient, or (2) when the complaint originates with another physician

and the patient states that he or she either did not agree to pay the high fee, or would not have agreed to pay a fee that was extraordinarily high in comparison to those charged by comparable physicians. Only in extreme circumstances, such as where there is evidence of fraud or a mentally impaired patient, would a PDC pursue fee peer review when the patient is satisfied with the fee charged. This policy limits the possibility that a fee peer review action will be undertaken for the purpose of enforcing a price-fixing agreement among physicians. It would also focus fee peer review activity on those cases in which an imperfect information exchange between physicians and patients has created a distortion in the market which the physician has used to his or her financial advantage.

Second, PDCs will not develop any formal or informal benchmark schedule of reasonable fees with which to resolve fee disputed. Each allegation of fee gouging will be addressed under the unique circumstances in which it arose, and the PDC will simply determine whether the fee charged in that case was excessive. Third, there will be no public disclosure of any fee amounts determined to be excessive, or of the PDC's view of the reasonable fee in each case. These latter two elements limit the possibility that fee peer review will facilitate the development of a price-fixing agreement by physicians.

The Commission has expressed its concern that fee peer review may be used improperly to discipline physicians who compete by offering a new product or service. The substantial due process procedures contained in the AMA's proposal are intended to lessen the possibility of exclusionary conduct in the guise of peer review. The courts recognize that industry self-regulation is usually found lawful when such procedural safeguards are employed. *Allied Tube & Conduit Corp. v. Indian Head Inc.*, 486 U.S.,492 (1988); *Silver v. New York Stock Exchange*, 373 U.S. 341, 36-67 (1963).

Finally, the Supreme Court's decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), is not inconsistent with the AMA's proposed process. In Maricopa, the physicians clearly agreed to limit their charges to patients who contracted with a particular insurer. The AMA's proposal involves no such agreement affecting price, and fee peer review is not likely to result in price-fixing. The courts have noted that if an ethical rule is not itself illegal, neither is enforcement of the rule. *See e.g., Vogel v. American Society of Appraisers*, 744 F.2d 598 (7th Cir. 1984).

The AMA's proposed procedures for peer review of fees generally adhere to the guidelines developed by the FTC for a procompetitive fee peer review program. The limited ways in which the proposed procedures depart from the FTC guidelines are designed to make enforcement of the ethical rule against fee gouging more effective in a procompetitive manner. These departures actually reinforce the core concepts underlying the FTC guidelines and will not have any anticompetitive effects.

The departures from FTC guidelines in the AMA proposed procedures are as follows:

- Participation in fee peer review by members is mandatory.
- Members who engage in egregious conduct, including fee gouging may be disciplined.
- Discipline for egregious conduct will not be kept confidential.

Each one of these departures will be discussed below.

a. *Mandatory Participation of Members in Fee Peer Review and Mediation*

A primary procompetitive benefit of fee peer review is to provide information to the patient about physician fees and charges. The process helps reduce the disparity of information between physicians and patients. The information helps the patient decide whether to pay all or a portion of the fee in question, and whether to patronize other physicians.[21]

Mandatory participation in fee peer review by medical society members improves the information made available to the patient during mediation. A physician who cooperates with the PGC will provide patient records and other documents, will discuss the physician's perspective about the patient's treatment, and will explain the reasons for the fee. There will be a much better basis upon which to judge whether the fee was reasonable, whether the physician made any mistakes in billing, whether there was a foundation for nonprice complaints by the patient, and other matters.

In addition, the physician receives information from the patient that may help the physician operate a more competitive practice. The physician may find out about office management problems that need

[21] Horoschak, *supra*, footnote 4.

to be corrected, about office staff that are not interacting well with patients, or about problems that the physician has in communicating with patients. In addition, the PGC can help inform the physician about educational programs that can help correct the problems revealed during mediation.

Finally, mandatory participation increases the likelihood that settlements acceptable to the patient and the physician can be arrived at. Satisfactory settlements build confidence in the market for physician services. Patients develop confidence that they will be treated fairly, and that they can have complaints resolved.

Mandatory participation in PGC proceedings is not anticompetitive because the focus is on mediation. The only requirement is that the physician participate, not that the physician adhere to any fee or fees recommended by a PGC or the medical society. Further, the physician is not subject to discipline by the PGC for fees charged. (Mandatory participation in disciplinary proceedings conducted by the PDC is discussed below). Participation in remedial education may be required, but only for nonfee aspects of the physician's practice.

b. Disciplines for Fee Gouging

The possibility of PDC discipline for egregious conduct is procompetitive. It provides the patient with information about physicians who have engaged in unconscionable fee gouging or other misconduct. That allows the patient involved and other patients to decide whether or not to continue dealing with the physician. In addition, it builds confidence in the market because patients know that physicians who engage in egregious conduct can be held accountable.

Discipline for fee gouging is not anticompetitive. In most situations, the complaint about an egregious fee will arise out of nonprice conduct such as fraud, the provision of inappropriate services, the provision of substandard services, or other misconduct. Disciplinary actions that are primarily based on such misconduct do not reflect a maximum price fixing agreement.

Even if the discipline concerns fee gouging only, it will not likely reflect maximum price-fixing. Patients who complain about being gouged normally have not agreed, with full information about comparable fees and the quality and need of the service being offered, to

pay a fee that is extraordinarily high. Such a patient normally will not have been informed about the extraordinary nature of the fee before receiving the service and, if so informed, would not have agreed to it in advance. Therefore, these are transactions that would not have occurred but for disparities in information between the physician and the patient.

It is unlikely that a patient who, for whatever reason, agreed to an extraordinarily high fee while being fully aware of the fees charged by comparable physicians will file a complaint. Such incidents are likely to be few, and the PDC will address them only in extreme circumstances.

The colleagues of a physician who charges extraordinarily high fees may complain to the applicable medical society. Disciplinary actions that result from a physician complaint about another physician's high fees might reflect enforcement of a maximum price-fixing agreement. However, as discussed above, that possibility can be remedied by restricting discipline to situations where there are patient complaints. If a physician complains about a colleague who charges extraordinarily high fees, a PGC would investigate to determine whether the physician's patients were fully informed and agreed to pay the fee without being subject to undue influence. If the patients were generally satisfied, there would be no grounds for discipline.

c. Disclosure of Discipline

Finally, publicly disclosing disciplinary actions for fee gouging is procompetitive. It provides information to consumers about physicians who have been charging extraordinarily high fees in situations that have been unfair to patients. That helps patients decide which physicians to patronize, and it builds confidence in the market for physician services.

Moreover, public disclosure of disciplinary actions provides a deterrent effect among the physician community and increases the effectiveness of enforcement of the profession's ethical code.

No information would be disclosed about the fees charged by the physician disciplined or the fees considered reasonable by the PDC. Therefore, disclosure would not constitute a signal about the fee levels that could facilitate a physician fee agreement on fees.

d. Effect on Health Care Expenditures

FTC staff has asked whether the proposed procedures for professional fee peer review will reduce health care expenditures. The AMA cannot promise that precisely discernible savings will result that will be directly attributable to the procedures, but the AMA and the CMS expect that the procedures will help control health care costs. As stated earlier, the program is designed and intended to comply with the antitrust laws and therefore will emphasize the mediation of fee disputes. The program will not, and cannot under the law, be a fee control program which could result in precisely discernible and quantifiable savings. It is expected that the program will reduce the incidence of fee gouging, and therefore result in some directly attributable savings, but fee gouging is not common and its elimination is not expected to result in substantial savings overall. It is expected that the program will help detect and reduce the incidence of fraud, which should also result in cost reductions.

In addition, the information provided to patients through the peer review process will enable them to compare physician fees more effectively, and it will give them a better understanding of medical practice and medical decision making that should make them more effective consumers. The process should also help patients develop a better understanding of what benefits are realistic to expect from physicians, and the extent of the resources that are necessary to provide effective health care. Also, physicians will become more sensitive to the complaints of patients and will change their practice patterns to respond to them. The result of more informed consumers and more sensitive physicians should be an improved market.

Conclusion

For the reasons stated above, the AMA and CMS believe that the AMA's proposed fee peer review procedures will be procompetitive and facilitate the operation of the market for physician services. Equally important, the procedures will enhance the protection of patients where the market does not operate efficiently and thereby increase the trust of patients in their physicians, which is the heart of the physician/patient relationship. The AMA and CMS request an

opinion that the proposed procedures are not anticompetitive and would not be subject to FTC enforcement actions.

Sincerely,

Kirk B. Johnson, General Counsel
Edward Hinshfeld
American Medical Association

John M. Peterson
Howe & Hutton, Ltd.
Counsel for Chicago
Medical Society

February 18, 1993

Dear Judy:

This will provide a response to your January 14 letter in advance of our teleconference scheduled for Monday, February 22. As we discussed by telephone today, the American Medical Association and Chicago Medical Society petition essentially seeks a modification of the *Iowa Dental Association* opinion, 99 FTC 648 (1982), such that medical societies would be able to (1) compel members to participate in fee peer review and (2) discipline egregious fee gougers. We do not seek specific Commission approval for the detailed procedures that would be followed by medical societies. I understand that you require a better understanding of that process in order to respond appropriately to our request. In that light, following are brief responses to the four issues raised in your recent letter. I expect that our teleconference on Monday will flesh out these points.

1. Standards for Review of Fees.

An excessive fee will be one that, in the professional judgment of committee members, is unreasonable in light of the criteria set forth in Opinion 6.05. A range of usual and customary fees will be used as a benchmark by which to judge the fee in question, but will not provide a complete answer to whether the fee is reasonable. The fee review committee will compare the fee in question to the range of usual and customary fees charged for the service by comparable practitioners. The range will be determined using the knowledge and experience of the committee members, as well as the opinion of consultants when necessary. However, the purpose of fee peer review is

not to enforce compliance with an acceptable range of fees. Rather, it is to identify instances when, under all relevant circumstances, a fee in unreasonable.

A fee found to be unreasonable will usually result in efforts to mediate the patient's complaint. However, a second level, or standard, is triggered when a fee is so high as to border upon fraud. A fee of this kind, 50 percent or more above the range of usual and customary, would provide grounds for disciplinary action. A pattern of excessive fees could also subject a physician to the threat of discipline.

2. Operation of Patient Grievance Committees.

The committee response would be in writing to the complainant. No specific fee figures would be presented or recommended. The substance of the committee response would be that the fee was in a reasonable range, above the range or below it.

There would be no routine collection of fee data, such as in the form of an average fee schedule. Fee data may be collected in exceptional cases when necessary to provide a benchmark range of usual and customary. In this instance, the opinion of consultants would be sought on an *ad hoc* basis. The data received would be used for the individual complaint at issue only, maintained as confidential, and not publicly disclosed.

No face to face meeting of patient and physician, under the auspices of the medical society, would generally occur. Patient-physician discussion and attempted resolution of disputed fees are usually recommended before the filing of a grievance. Physicians against whom a complaint is filed will be invited to meet with the committee, when necessary, to provide information or discuss a proposed resolution of the matter.

Where "fee gouging" occurs and disciplinary action is taken by the society, the results will be a matter of public record and treated precisely as any other disciplinary action.

Opinions on whether insurance company reimbursement is within the range of usual and customary will only be rendered where an insurance company files a complaint.

3. Patient Information Issues.

The American Medical Association and Chicago Medical Society seek to address the inability of the profession to discipline physicians who egregiously overcharge. In such cases, the patient has usually not provided informed consent to a fee that is significantly in excess of the range of usual and customary fees. (If they have, no medical society action will be taken). In general, patients lack adequate information about physicians' fees. The AMA has sought to address the problem of consumer information about physicians' fees. At its 1992 Annual Meeting, the House of Delegates adopted a resolution which encouraged physicians to post the price of their services.

Discipline of fee gougers will add to the public's information about physicians. Patients often call local medical societies for physician referrals. Information on disciplinary actions taken against a physician will be given upon inquiry. Moreover, disciplinary actions will often be reported by local media, and provide a source of information to the public.

4. Physician Discipline.

The vast majority of physicians are ethical. When the few who are not learn that disciplinary action may be taken if they egregiously overcharge, we believe that the practice of overcharging will diminish significantly.

It is critical that medical societies have the ability to enforce their ethical codes. They have no other way of assuring that their members meet the standards of the profession. Without the threat of discipline, medical societies are powerless to protect the public by distinguishing ethical physicians from those who are not.

Sincerely,

Michael L. Ile

August 24, 1992

Dear Mr. Horoschak:

This will respond to your request for additional information regarding the petition filed by the American Medical Association (AMA) and the Chicago Medical Society (CMS) for a Federal Trade Commission advisory opinion concerning professional peer review of physicians' fees. As we stated in our petition, we believe that a more than adequate basis has long existed to grant the AMA-CMS petition in full given the procedural safeguards contained in our proposal. Nonetheless, this letter will address each of the nine issues raised in your letter. In addition, enclosed are documents reflecting examples of fee peer review conducted by CMS, the Los Angeles County Medical Association (LACMA) and the Orange County (Cal.) Medical Association (OCMA). These societies were selected because they have active fee peer review committees that employ a variety of procedures, and a review of their documents should answer the questions contained in your letter. They confirm both the broad interest in, and the unnecessary obstacles to, effective peer review of fees. The documents are described briefly below.

We ask the Commission to act favorably on the petition to give the profession the authority it needs to self-regulate in this important area. It has been nearly seven years since the AMA first approached the Commission on this issue. At that time the Commission's staff was not receptive to any self-regulatory endeavor involving fees, and little progress was made. We appreciate the apparent seriousness with which the Commission is reviewing the current petition. We are prepared to meet at your earliest convenience, hopefully within a month, to discuss the issues raised by our request.

Sample Fee Peer Review Documents

1. CMS. The enclosed CMS documents contain:

(1) Twenty-four fee mediation complaints and related records from the latter part of 1991 and the first part of 1992. Physician and patient identifiers have been removed.

(2) A summary of these particular files entitled "Summary of the 24 Most Recent Cases To Be Closed in the Fee Mediation Committee."

(3) Six forms or form letters used by the CMS in its fee mediation process.

(4) A summary of the number of CMS fee mediation cases during the last five years.

(5) A summary of 16 complaints relating to one particular doctor covering the past nine years.

A general description of the CMS peer review structure is contained in the April 30, 1992, AMA-CMS petition at page 8. A review of the twenty-four fee mediation complaints and related records provides a more complete picture of the CMS fee peer review process. The CMS Fee Mediation Committee receives complaints or inquiries from patients, insurance companies, and physicians. The CMS receives a fee from insurance companies to cover administrative costs. Complaints from patients are handled free of charge. Based on information submitted by the patient (or insurance company) and the physician, as well as their own knowledge and experience, the members of the Fee Mediation Committee provide an advisory opinion whether the fee in question is within, above, or significantly above the range of usual and customary. The CMS makes no effort to compel a physician to set fees within any range; it merely provides an opinion as to the fee the physician has decided to charge. Nevertheless, if the Fee Mediation Committee determines that the fee is above or significantly above the range of usual and customary, it first notifies the physician to provide an opportunity for an appeal to the CMS Physician Review Committee before notice of the decision is sent to the patient.

Until January of this year, physicians were not compelled to participate in the fee mediation process, even if they were CHS members. The CMS decided that the credibility and effectiveness of its peer review process would be improved through its ability to compel members to participate. It is too early to determine the effect of this change in policy.

The effectiveness of the CMS fee peer review system continues to be adversely affected by the inability to discipline physicians for fee gouging. The decisions of the Fee Mediation Committee are advisory only; the CMS does not discipline physicians in any manner for charging excessive fees, even in the most egregious circum-

stances. Included in the enclosed CMS documents is a summary of sixteen complaints filed against one physician over a period of nine years. Of the fourteen complaints of which records still exist, the CMS found the physician's fee to be above the range of usual and customary in five cases, and significantly above the range of usual and customary in another five cases. The CMS committee specifically directed this physician to discuss the level of her fees with patients in advance, yet the complaints continued. It is therefore likely that this physician did not receive informed consent for the excessive fees. This case history provides an example of physician behavior that would merit disciplinary action. The physician was found to have repeatedly and regularly charged fees above (and significantly above) the range of usual and customary fees. It is evident that a pattern of egregious conduct of this kind cannot be stopped simply by a series of mediations.

2. LACMA. The enclosed LACMA documents contain a representative sample of twelve completed case files of the LACMA Committee on Insurance Review (CIR). Unlike CMS, LACMA does not mediate complaints from patients regarding physician fees. Instead, LACMA provides advisory opinions on the degree of liability of the insurance company to the patient for the physician services rendered in each case. The review is conducted following the submission of a claim by the insurance company to LACMA, including a small fee to offset administrative costs. LACMA refers the claim to one or more physician reviewers, who make a recommendation to the CIR on such questions as whether the physician's fee was above the prevailing fee for the area (Case 2), whether a procedure was "cosmetic" (Case 1), or whether diagnostic tests (Case 3) or an assistant surgeon (Case 6) were medically necessary. The CIR usually, but not always (Case 5), concurs with the recommendation of the physician reviewers. The opinion of the CIR is advisory only, but can be appealed to LACMA for re-review or to the California Medical Association. The CIR advisory opinion is specifically limited to the question of the amount of the physician's fee for which the insurance company bears liability; LACMA does not express an opinion as to the amount the physician should bill the patient. In other words, LACMA does not mediate disputes between physicians and patients. It focuses solely on the amount of the physician's bill to be paid by the insurance company. LACMA's reluctance to take

direct action with regard to the level of physicians' fees reflects a fear of litigation exposure.

3. OCMA. The OCMA Public Services Committee (PSC) receives requests for fee review from insurance companies, physicians and patients. Requests from insurance companies are subject to a small administrative fee. OCMA member physicians may submit one request per year. Requests from patients constitute the largest volume of claims, and are handled free of charge as a public service.

Requests for review, together with additional necessary documentation, are sent to a physician member of the PSC who practices the same specialty as the physician who provided the services under review. The physician reviewer then presents the case to the full PSC, which must decide whether the services provided were medically necessary and/or whether the fee was reasonable. Questions of medical necessity may be referred to the OCMA Medical Review and Ethics Committee. The reasonableness of the fee is determined by comparison to the results of an *ad hoc* survey of at least five members of the same specialty in the county or, if necessary, larger geographic area. The results of the survey, as well as all of the review file, remain confidential.

If the PSC finds that the care provided was not medically necessary or that the fee was unreasonable, then the physician is given two weeks to request an appeal before the insurance company or patient is notified. Insurance companies and patients may also appeal findings in the physician's favor.

Clarification Requested by Commission Staff

Following is a discussion of the specific issues raised in your letter. A review of the CMS, LACMA and OCMA documents shows the variety of procedures currently employed in fee peer review. Some degree of variety is likely to survive the Commission's advisory opinion in this matter, whatever form it takes. Nevertheless, we will attempt to respond to your inquiry as directly and completely as possible.

1. While the number of cases varies from year to year, large county medical societies that still engage in fee peer review (many have stopped) process a substantial volume of complaints regarding physician fees. For example, the CMS Fee Mediation Committee

handled 73 cases in 1987, 92 in 1988, 71 in 1989, 98 in 1990, and 133 in 1991. The Public Service Committee of OCMA receives approximately 300 fee complaints each year. These numbers might even be higher if medical societies felt free to publicize fee peer review services.

These data indicate that a significant number of fee disputes arise between physicians and patients. The ability of the profession to resolve these disputes in a satisfactory manner contributes to patient's confidence in the fairness of the health care system. Of course, not all complaints result in a finding that the physician has charged an excessive fee. To the extent that fee peer review identifies excessive fees and causes physicians to accept a lower fee, there are obvious cost savings for patients and payers. Clearly, these cost savings would be greater if fee peer review were more widely and aggressively practiced. Today, relatively few medical societies engage in fee peer review, and even fewer feel comfortable in compelling members to participate. The very existence of a more vigorous fee peer review system may deter physicians from charging excessive fees. But the cost savings attributable to fee peer review are extremely difficult, if not impossible, to quantify. We are aware of no empirical data which reflect the contribution of fee gouging to the overall level of health care costs.

Cost savings, though beneficial to the public, are not the primary reason that the profession performs fee peer review. The principal focus of fee peer review is mediation. It is not designed to regulate physician fees, but to identify particular instances in which the physician has charged an excessive fee under the circumstances. Charging an excessive fee represents a serious breach of the trust patients have in their physicians. Patients must be able to rely on the fact that the profession will not permit physicians to exploit, for personal financial gain, a relationship in which patients trust their health and lives to physicians.

2. Issue 2 contains several questions, many of which use the word "usually". A review of the enclosed documents indicates that fee peer review arises in a variety of contexts and for a variety of purposes. It may not be possible to describe a "usual" scenario. Fee review committees often are asked to determine whether a particular fee charged for a particular service was reasonable, or in the range of usual and customary (or prevailing), by patients, insurance companies, or even the physician involved. A patient may wish to know

whether the amount she was balance billed was appropriate; an insurance company may wish to know whether the amount it has paid for a service meets its obligation to its insured (the patient); and a physician may seek assistance in resolving a fee dispute with a patient. In many cases the medical necessity of the service performed, as well as its cost, will be at issue.

Our best information suggests that physicians and patients often do not agree on fees in advance, at least for non-elective procedures. This may occur for several reasons. In many cases, it is difficult to predict in advance the precise nature or complexity of services required. For example, physician reimbursement for Medicare patients under the RBRVS system often cannot be known *a priori*; for many procedures, the appropriate CPT code to be used (and therefore the appropriate level of reimbursement) depends on variables that can only be known after the service has been provided. A possible range of fees could be given to the patient in advance, but a broad range would still leave room for dispute as to the appropriate fee.

The very nature of the physician-patient relationship may explain why a prior agreement on fees does not occur with more frequency. Patients may be reluctant to select physicians in the same manner as a television or automobile: that is, as an essentially fungible commodity in which price is the critical decision making element.

Finally, patients with insurance coverage may be concerned less with the physician's fee than with the amount of the physician's fee not covered by the insurance company. Indeed, many of the complaints received by fee peer review committees are from patients facing a large physician bill after the insurance company has paid its share, requesting advice whether the physician's fee was excessive or whether the insurance company failed to meet its obligations (or both). The patient often cares little what the answer is, as long as the final bill is reduced.

3. The experience of current fee peer review committees suggests that physicians who agree to participate in the mediation process generally accept the decision, or advisory opinion, of their peers, and reduce fees found to be excessive. Often, the fee dispute is resolved without formal action by the committee. Simply by filing a complaint, the patient may initiate a dialogue with the physician that will resolve the dispute. This process fails completely if physicians refuse to participate. Medical societies should have the authority to require their members to participate in the mediation process. Absent

unusual circumstances (discussed in issue 5 below), the physician will not be disciplined for refusing to reduce an excessive fee. Nevertheless, medical societies must be able to require, as a condition of membership, that physicians make a good faith effort to participate in the peer review process. If they cannot, the process lacks credibility and effectiveness.

The determination of whether a fee was reasonable under the circumstances requires the exercise of professional judgment by members of the peer review committee. The committee members may rely on their own knowledge and experience, or they may seek input from other physicians, perhaps in the form of an *ad hoc* survey. The AMA Council on Ethical and Judicial Affairs lists the following factors as relevant in determining the reasonableness of a fee: "A. the difficulty and/or uniqueness of the services performed and the time, skill and experience required; B. the fee customarily charged in the locality for similar physician services; C. the amount of the charges involved; D. the quality of performance; E. the nature and length of the professional relationship with the patient; and F. the experience, reputation and ability of the physician in performing the kind of services involved." As the enclosed peer review files demonstrate, committees often review substantial documentation in making their determinations.

Notice of the committee's decision is usually given first to the physician in cases in which the physician is found to have charged an excessive fee. This provides the physician an opportunity to request an appeal of the decision, either from a second committee of the local medical society or from the state medical society. Notice is then provided to the complainant. Sample correspondence of this type is contained in the CMS, LACMA and OCMA documents.

4. Mediation or grievance committees usually provide at least one level of appeal for parties dissatisfied with the decision of the committee. Because the decisions of these committees are not enforced, a further appeal would have little value. In contrast, disciplinary actions taken by local medical societies may be appealed to the state medical society and then to the AMA's Council on Ethical and Judicial Affairs (CEJA), which is the ultimate appellate body for organized medicine.

5. Fee gouging can be defined as conduct by a physician which demonstrates flagrant disregard for the physician's fiduciary duty to the patient. Following are examples of conduct that would meet this

definition. Using the CEJA factors listed in the response to issue 3 above, grievance or disciplinary committees should be able to identify (probably rare) cases in which the physician's fee exceeds the range of usual and customary, or reasonable, fees by a substantial amount. For example, it would be difficult to justify a fee two or three times the usual and customary fee for the procedure. (Of course, even a fee this high would not constitute actionable fee gouging if a fully informed and competent patient agreed to the fee in advance.) Other examples of fee gouging would include outright fraud, the exercise of undue influence over a patient, performing unnecessary services, and deliberately "unbundling" services for billing purposes to inflate the fee. The circumstances under which this conduct arose would be extremely relevant, as would evidence of repeated similar behavior by the physician under review.

The analysis of new procedures or treatments will be handled in the manner described in the preceding paragraph and in the response to Issue 3. The committee will gather information relevant to the CEJA factors and determine whether the fee charged was reasonable under the circumstances. It is increasingly rare to find only one physician in a relevant geographic area performing any particular procedure, even a new one. Nevertheless, committees can, and do, survey physicians from other geographic areas to acquire information about emerging technologies when there are insufficient local sources of information to permit the committee to make an appropriate decision about a complaint. Committees will limit their inquiry to the reasonableness of the fee charged for the procedure performed, and will not attempt to ascertain whether a different, less expensive, procedure may have been appropriate. Note, however, that the inquiry over the fee charged may involve a discussion of the medical necessity of the procedure itself.

6. All documents generated in the peer review process will remain confidential. There will be no public disclosure of fees considered to be excessive, nor will the medical society publish information concerning reasonable fee levels. The review committees will simply decide the complaints submitted to them, and notify the parties involved of the result of the process. Members of the medical society who are not members of the committee will have no access to fee review information. Medical societies may publish a statement that a Physician has been disciplined for fee gouging in appropriate

cases, just as it would when disciplining a member for any ethical violation.

7. Medical societies would have the option of pursuing a fee mediation process even if there were a prior agreement between the patient and physician as to the fee to be charged. Such a process would enable the society to determine whether the patient knowingly consented to the fee, including whether the patient knew the fee to be substantially above the range of usual and customary. However, no disciplinary action would be taken against a physician for fee gouging if the patient were competent and gave informed consent to the fee.

CEJA Current Opinion 8.08 (Informed Consent) provides that "the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." In the context of fees, informed consent would require, at a minimum, disclosure that the fee to be charged is above the range of usual and customary, and the factors which justify the fee (such as unusual complexity of the procedure). A patient who is incompetent or misled about any material information cannot provide informed consent to the fee.

8. A minority of members of local medical societies refuse to participate in fee mediation processes. The ability to discipline members in this situation would increase the effectiveness of mediation, and would add to the public's confidence that the profession is committed to acting in the public interest. Patients have no reasonable alternative when told by a medical society that it cannot process a complaint because the physician refuses to participate. Not only is this result frustrating, but it also erodes the patient's trust of physicians.

The inability of medical societies to discipline physicians for egregious conduct prevents the profession from taking corrective action against its most unethical members. After all, a physician who is willing to defraud, mislead, or fleece patients, often repeatedly, is unlikely to agree to participate in mediation and voluntarily disgorge the proceeds. Fortunately, behavior of this type rarely occurs, but when it does the profession must be able to respond decisively. For example, the patients of the CMS physician referred to at pages 2-3 of whom sixteen complaints were filed in nine years would certainly have benefitted had CMS been able to take stronger measures. Cases of this kind take on a high profile, and thus a greater importance than

their numbers would suggest. Medicine must be able to publicly announce to patients and physicians alike that fee gougers will not be welcome.

9. Enclosed is a copy of the AMA's Model Guidebook for Medical Society Grievance and Disciplinary Committees.

I hope that this letter and the enclosed documents add to your understanding of our request for an advisory opinion, as well as the reasons which underlie it. Please call me if you would like any further information. Thank you for your careful consideration of this matter.

Sincerely,

Michael L. Ile

Re: Petition to Quash and Limit Civil Investigative Demand, Motion for Continuance, and Memorandum in Support Thereof; Diamond Rug and Carpet Mills, Inc. File No. 912-3409.

April 8, 1994

Dear Messrs. Coppedge and Citronberg:

This is to advise you of the Federal Trade Commission's ruling on the Petition to Quash and Limit Civil Investigative Demand, Motion for Continuance, and Memorandum in Support Thereof ("Petition") which you filed on behalf of your client, Emmett Parsons, in the above-captioned matter.

The ruling set forth herein has been made by Commissioner Deborah Owen pursuant to authority delegated under Commission Rule of Practice 2.7(d)(3). *See* 49 Fed. Reg. 6089 (Feb. 17, 1984). Pursuant to Rule 2.7(f), within three days after service of this ruling, Petitioner may file with the Secretary of the Commission a request that the full Commission review the ruling. The timely filing of such a request shall not stay the return date in this ruling, unless the Commission otherwise specifies.

The Petition is rejected because it was not timely filed in accordance with the Commission's Rules of Practice. Under Commission Rule of Practice 2.7 (d)(1), the Petition was due to have been filed with the Secretary of the Federal Trade Commission by 5:00 p.m. (EST) on March 14, 1994, twenty days after service of the civil investigative demand.[1] Petitioner was served with the civil investigative demand for oral testimony, now challenged, on February 22, 1994. The civil investigative demand specified that Petitioner should appear for an investigational hearing on March 14, 1994. By March 1, 1994 letter to Petitioner's then-counsel, Bruce Allen Kling, from Mr. Steven E. Weart, Assistant Director of the Dallas Regional Office

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[1] Commission Rule 2.7(d)(1) requires the filing of any petition to limit or quash any investigational subpoena or civil investigative demand within twenty days after service of the compulsory process, or, if the return date is less than twenty days after service, prior to the return date. In this instance, March 14 was the twentieth day after service of the civil investigative demand upon Petitioner, while March 13 was the day immediately prior to the original return date. As March 13 fell on a Sunday, Commission Rule 4.3(a) provides that the period for filing the petition shall run until the end of the next following business day, March 14. Thus, as a practical matter, the original return date coincided with the twenty-day deadline for filing a petition.

of the Federal Trade Commission, Petitioner was notified that he had been granted an extension of the time within which to appear for the investigational hearing. No extension of time for filing a Petition to Limit or Quash was granted by Commission staff pursuant to Commission Rule 2.7(d)(3). Pursuant to the March 1 extension, Petitioner was scheduled to appear for a hearing on March 21, 1994 at 1:00 p.m. Petitioner failed to appear at the scheduled investigational hearing and the pending Petition was filed on March 25, 1994. Petitioner expressly states that his Petition was not submitted within the statutory period. *See* Petition to Quash and Limit Civil Investigative Demand, Motion for Continuance, and Memorandum in Support Thereof at paragraph 3.

Given Petitioner's untimely filing of his Petition and his failure to appear at the investigational hearing as scheduled, Petitioner is hereby directed to appear at such time and place as staff in the Dallas Regional Office of the Federal Trade Commission may require, upon one week's notice.

Re: Diamond Rug and Carpet Mills, Inc. Petition for Commission Review Pursuant to Rule 2.7(f). File No. 912-3409.

April 20, 1994

Dear Messrs. Coppedge and Citronberg:

The Commission has considered (a) the Petition to Quash and Limit Civil Investigative Demand, Motion for Continuance, and Memorandum in Support Thereof ("Petition") filed by Emmett Parsons ("Petitioner") on March 25, 1994; (b) the April 8, 1994 letter ruling, denying the Petition; and (c) the Petition for Commission Review filed by Petitioner on April 13, 1994 ("Review Petition").

The letter ruling denied the Petition because it was not filed within the time permitted by the Commission's Rules. 16 CFR 2.7(d). The untimely filing is not excused because the Petitioner had not obtained his current counsel within the time permitted for filing such petitions. The Commission has determined that the request for full review does not provide grounds for accepting the Petition to Quash out of time. Therefore, the Petition was properly denied for the reasons stated in the April 8 ruling.[1] The Commission denies the request for a stay of the return date for the civil investigative demand for oral testimony.[2] Accordingly, the full Commission concurs with, and hereby adopts, the April 8, 1994 letter ruling in this matter, and Petitioner is directed to comply with the civil investigative demand in accordance with the terms specified in that ruling.

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[1] The Review Petition cites a passage from the Commission's letter ruling on Diamond's Petition to Quash and Limit Civil Investigative Demands. This excerpt, however, does not afford Petitioner an opportunity to avoid appearance at an investigational hearing and, thereby, allow him to circumvent raising his constitutional privileges on the record. As courts have consistently held, individuals wishing to raise a constitutional privilege against self-incrimination must properly do so, under oath, and on the record. *See e.g., SEC v. First Financial Group*, 659 F.2d 660, 668 (5th Cir. 1981) (blanket refusal to answer questions was improper invocation of the Fifth Amendment and insufficient to relieve party of duty to respond to questions and raise the constitutional defense as to each question; further noting that requiring party to object with specificity to information sought permits court to rule on validity of claims of privilege); *SEC v. Thomas*, 116 F.R.D. 230, 234 (D. Utah 1987); *see also* Letter Ruling to James B. Gurley (FTC File No. 752-3207) (May 3, 1976).

[2] The Commission notes that Petitioner requested, in the alternative of quashing compulsory process, that the return date of the civil investigative demand for oral testimony be no earlier than April 5, 1994. Petitioner has had well beyond that date to prepare with present counsel for his response to the civil investigative demand.

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