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COMPETITION IN PROFESSIONAL SERVICES

United States

1. Regulation of professions in the U.S. occurs at the State governmental level in the form of occupational licensing laws and related business practice regulations. In addition, self-regulating professional associations promulgate recommended standards of practice or codes of ethics. Governmental and private regulations can serve the public interest by ensuring an acceptable standard of competence and integrity of professional services, which in turn promotes the health, safety and well-being of consumers. This is particularly beneficial when it would be difficult for consumers to evaluate the quality of professional services, and factors such as litigation, reputation and guarantees are inadequate to enable consumers to make an informed purchase decision. However, regulations may also restrict professionals' ability to compete effectively, resulting in consumer injury, without providing benefits that outweigh the harm to competition.[1]

2. The turning point for active application of the antitrust laws to the professions was the 1975 U.S. Supreme Court decision in *Goldfarb v. Virginia State Bar*.[2] Since then the Federal Trade Commission ("FTC" or "Commission") and the Antitrust Division of the Department of Justice ("DOJ") have undertaken a broad enforcement program designed to eliminate private restrictions on business practices of state-licensed professions that may adversely affect the competitive process and raise the prices or decrease the quality of professional services.[3] In addition, the agencies have submitted numerous comments on the benefits and costs of occupational regulation to state legislatures, regulatory commissions and others, filed *amicus curiae* briefs in private cases, issued advisory opinions concerning proposed ethical restrictions by professional associations and other agreements among professionals, adopted enforcement policy statements on certain cooperative activities of health care providers, and issued an industry-wide rule covering certain opthamalic services.[4]

3. The first section of this paper provides an overview of the agencies' enforcement actions; the second section sets out the principles articulated in our advocacies in regulatory and legislative proceedings and discusses a few recent advocacies.

I. Enforcement actions

4. The agencies have challenged successfully anticompetitive restrictions imposed by private self-regulatory associations or state boards, where the state board regulation extended beyond protected "state action"[5] and other agreements among competitors, including restraints on advertising and solicitation, price competition, and contract or commercial practice.

1) Restraints on advertising and solicitation

5. Private professional associations and State boards traditionally imposed restrictions on advertising and solicitation by professionals, claiming this was necessary to protect consumers from false or deceptive advertising or marketing practices. The agencies have examined whether these restrictions are so broad that they also unnecessarily restrict the provision of truthful information to consumers that could enhance competition.

6. Some of the most important cases that the Commission has brought challenging restrictions on the dissemination of truthful advertising of professional services have been in the health care area. In the seminal case of *American Medical Association* ("*AMA*"),[6] the Commission found, among other things, that the AMA, through its ethical guidelines, had illegally suppressed virtually all forms of truthful, non-deceptive advertising and similar means of solicitation by doctors and health care delivery organizations. The Commission ordered the AMA to cease and desist from prohibiting such advertising. However, it allowed the AMA to continue its use of ethical guidelines to prevent false or deceptive advertisements or oppressive forms of solicitation.

7. In the decade since the final decision in the *AMA* case, the Commission has challenged private dental,[7] medical,[8] and other professional associations [9] for various restrictions on the dissemination of truthful information, usually imposed through provisions in codes of ethics. In addition, the Commission has challenged and banned similar restrictive rules adopted by State boards responsible for regulating health care professionals that were not shielded from antitrust liability by the state action doctrine.[10]

8. In 1990, the Commission charged the American Institute of Certified Public Accountants, the dominant professional association in the accounting field, with restricting truthful, non-deceptive advertising by prohibiting members from making truthful claims in self-laudatory or comparative advertisements, or using truthful testimonials. It also alleged that the association restricted members' efforts to solicit clients directly and by referrals. The consent order bars the association from prohibiting its members from engaging in these practices.[11] Similarly, the Commission recently brought cases

... to suppress advertising that was misleading or deceptive or otherwise caused unavoidable and unreasonable harm to consumers."[17] The *CDA* order also permits the CDA to restrict solicitation of patients who may be particularly vulnerable to undue influence.[18]

ii) Restraints on price competition

13. An early DOJ case, *National Society of Professional Engineers v. U.S.*,[19] challenged a professional society's prohibition in its canon of ethics of competitive bidding by its members. In that case the Supreme Court held that the trial court was justified in refusing to consider the defense that the canon was justified "because it was adopted by members of a learned profession for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety." The Court held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement," and that "the Rule of Reason does not support a defense based on the assumption that competition itself is unreasonable."

14. The Commission has challenged various forms of price restraints by medical and other professional societies including the proscription of: i) underbidding for a contract or agreeing to accept compensation that was "inadequate" in light of the usual fees in the community;[20] ii) offering services at "discounted fees";[21] iii) low pricing and granting favorable credit terms;[22] and iv) requiring members to uphold the principle of "appropriate and adequate compensation."[23] Recently the FTC sued the International Association of Conference Interpreters ("AIIC") and its U.S. affiliate members, charging that the association published lists of fees that its members were required to charge. The complaint also challenged certain work rules facilitated price fixing and restrained price competition among AIIC members by requiring, among other things, that all interpreters on a team be paid the same rate, that fees be paid in day-long increments, that certain standards of lodging and transportation be provided, that payment be made for travel, rest and study days, and that services not be provided free of charge. The Commission's order requires AIIC to eliminate these rules and by laws regarding these challenged practices.[24]

15. Some cases have involved price-fixing agreements in the context of a joint arrangement. An important issue in these cases has been whether the agreement on price should be considered *per se* unlawful or ancillary to a legitimate joint venture and therefore analyzed under the rule of reason. In 1998, the Commission settled charges that three companies and two doctors illegally fixed prices for professional services for lithotripsy procedures -- a non-surgical treatment for kidney stones. The urologist-owners of the facilities in which the procedures were performed financially integrated by jointly investing in the purchase and operation of the machines used to perform the procedure. The complaint alleged, among other things, that the collective setting of fees for lithotripsy professional services was not reasonably necessary to achieve efficiencies from the legitimate joint ownership and operation of the lithotripsy machines nor were the urologists sufficiently integrated to justify the agreement to fix prices for lithotripsy services. There was a legitimate basis for establishing a set fee for use of the lithotripter but not for insisting that all doctors charge the same professional fee. The consent order prohibited the respondents from fixing prices and required them to terminate third-party payor contracts that include the challenged

insurer any information about a member's fees, pricing, bidding, or advertising, and stating that competitive bidding, low prices, or liberal credit terms affect any engineer's ability to obtain or keep insurance.

17. Collaboration by competing health care providers to thwart cost containment efforts also raises price fixing concerns. The Commission has brought numerous cases challenging health care providers' collective efforts to increase reimbursement levels through boycotts and other agreements to fix prices. In 1997, the Commission charged the College of Physicians and Surgeons of Puerto Rico and related medical groups with taking collective action to attempt to raise their reimbursement level under a program developed by the Commonwealth government to provide health care coverage for the 30% of the Puerto Rican population that is uninsured. The College called an eight-day strike, pursuant to which members closed their offices and, in some cases, canceled elective surgery without notice. With the cooperation of the Commonwealth government, the FTC reached a settlement that resulted in an injunction and a

system facilitated, rather than safeguarded against, collusion. The Federation encouraged the physicians to refuse to negotiate with Blue Cross except through the Federation. By the end of 1997, nearly all of the members of the Federation had rejected a Blue Cross fee proposal and terminated their contracts with Blue Cross. The case is currently in litigation.[29]

iii) Exclusion of Competitors

22. The Commission has a long record of challenging concerted efforts to exclude new competitors and forms of competition in the health care sector. The cases have addressed obstruction of entry by HMOs,[30] non-physician providers,[31] hospital-sponsored clinics,[32] and other "alternative" arrangements.[33]

23. In the early 1990s the Commission issued a series of orders against alleged threatened boycotts by physicians to prevent local hospitals from pursuing an affiliation with the Cleveland Clinic, a nationally-known provider of comprehensive health care services.[34] The Clinic, which operated as a multi-specialty group medical practice, offered a pre-determined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. The Commission's orders prevent such conduct from recurring.

24. In 1994, the Commission settled charges that the medical staff of Good Samaritan Regional Medical Center conspired to boycott the hospital in order to force it to end its dealings with a potentially cost-containing multi-specialty physicians clinic that would have competed with the staff.[35] The consent order prohibits the respondents from agreeing, or attempting to agree, to restrict services offered by the hospital, clinic, or any other health care provider by refusing to deal with others offering health care services or by withholding patient referrals.

25. In June 1995, the DOJ sued the American Bar Association ("ABA"), alleging that the ABA, in its accreditation of law schools, restrained competition among professional personnel at ABA-approved law schools, by fixing their compensation levels and working conditions. The complaint also alleged that the ABA allowed its law school accreditation process to be captured by those with a direct interest in its outcome. Consequently, rather than setting minimum standards for law school quality and thus providing valuable information to consumers, which are legitimate purposes of accreditation, the ABA at times acted as a guild that protected the interests of professional law school personnel. ABA approval was a valuable asset to law schools as over 40 states required graduation from an ABA-approved school to qualify to take the state bar exam, and the ABA is the only agency the U.S. Department of Education recognizes as a law school accrediting agency. In 1996, the U.S. District Court entered a modified consent decree which prohibits the ABA from misusing its powers as the law school accrediting agency to restrain competition among professional personnel at ABA-approved law schools. The decree bars the ABA from fixing faculty salaries, refusing to accredit schools simply because they are for-profit, and refusing to allow ABA-approved law schools to accept credits from schools that are state-accredited but not ABA-approved.

26. Claims of exclusion from professional associations, provider-sponsored health plans, and the like or denial of accreditation or certification require careful analysis. Membership organizations perform valuable functions and cannot exist without membership rules, which can be procompetitive.[36] But exclusion can harm competition if excluded professionals are unable to compete effectively without access to the group.[37]

iv) Restrictions on contract and commercial practice

27. In a number of cases the Commission successfully challenged ethical guidelines and membership requirements of professional associations that restricted their members' contractual or commercial practices. In the *AMA* case, the Commission found that the AMA's "contract practice" rules adversely affected competition by preventing the development of potentially more efficient forms of business format

II. Advocacies

31. The goal of the agencies' competition advocacy programs is to prevent or reduce possible consumer injury caused by federal, state or local laws and regulations, or self-regulatory standards that

other terms of dealing. He testified that in addition to potentially harming consumers and raising health care costs, the immunity is unnecessary to protect legitimate collaboration among competing health care providers, would immunize anticompetitive activities that could diminish the effective functioning of health care markets, and would likely encourage those in other industries to seek similar exemptions.[44] He also noted that the proposed exemption would be a radical departure from existing labor law standards that protect the right to bargain collectively only in the employer-employee context but not to independent contractors like self-employed physicians. The bill did not pass, but a similar bill has been introduced in the current Congress.

III. Conclusion

38. In the twenty-four years since the U.S. Supreme Court paved the way for the application of antitrust law to professional services, the Federal Trade Commission and the Department of Justice have pursued an active policy, through law enforcement actions and advocacy, of opposing anticompetitive restraints on the provision of such services. Although neither the FTC nor the DOJ has conducted a formal empirical study of the effects of their efforts, we note that the markets for the provision of many professional services have been substantially liberalized and deregulated during this period. We believe that the elimination of restraints on conduct, such as advertising, discount pricing, and contractual and commercial practices, has resulted in increased competition, providing substantial welfare gains for consumers.

NOTES

1. A 1990 report by Federal Trade Commission economists concluded that occupational regulations frequently increase prices and impose substantial costs on consumers without increasing the quality of professional services. Cox and Foster, The Costs and Benefits of Occupational Regulation, Federal Trade Commission Bureau of Economics Staff Report, October 1990. The report recommended that the costs and benefits of any regulatory proposal be weighed on a case-by-case basis.

   421 U.S. 773 (1975). In this case, the Supreme Court struck down a minimum fee schedule adopted and enforced through disciplinary action by a state bar association, finding that the conduct was essentially private anticompetitive activity not shielded by the state action doctrine. Prior to this case, some courts believed that the "learned professions" should be treated differently, reasoning that because their goal is to provide services necessary to the community rather than to generate profits, their activities did not fall within the terms "trade and commerce" in Section 1 of the Sherman Act. The *Goldfarb* case also established that professional activities have a sufficient effect on interstate commerce to support Sherman Act jurisdiction.

3. Press releases and information about FTC and DOJ enforcement actions and competition advocacies are available on the FTC (http://www.ftc.gov) and DOJ (http://www.usdoj.gov/atr) home pages. There is a separate description of enforcement actions in the health care sector since the 1970s under "FTC Antitrust Actions in Health Care Services and Products." Summaries of 54 DOJ business review letters since the 1993 issuance of the DOJ/FTC Health Care Antitrust Statements of Enforcement Policy and of 32 DOJ health care cases since August 25, 1983 are available at http://www.usdoj.gov/atr/public/health_care/health_care.htm.

4. Advisory opinions and amicus briefs filed in health care cases can be found on the FTC home page, *id.* U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (August 18, 1996). The Opthamalic Practice Rule, 16 C.F.R. § 456 (1996), issued under the FTC's consumer protection authority, requires opthamalic service providers to provide consumers without charge a copy of their prescriptions and prohibits conditioning the availability of an eye examination on a requirement that the patient agree to purchase any opthamalic goods.

5. This judicial doctrine provides generally that the antitrust laws do not apply to action by a state in its sovereign capacity or to private conduct directed or compelled by the state. Direct action by a state legislature or court is automatically exempt, without further inquiry. *See, e.g.*, Hoover v. Ronwin, 466 U.S. 558 (1984); Bates v. State Bar, 433 U.S. 350 (1977); Parker v. Brown, 317 U.S. 341 (1943). Where the challenged conduct is undertaken by a state agency, local government, or private party, further inquiry is required into whether the conduct followed "clearly articulated and affirmatively expressed state policy" to displace competition and, in the

7. *See, e.g,* Association of Independent Dentists, 100 F.T.C. 518 (1982)(general restriction on truthful advertising without Board of Director's prior approval).

20. *E.g.*, AMA, *supra* note 6.

21. *E.g.*, Connecticut Chiropractor Association, *supra* note 8.

41. A summary of these advocacies is available in the United States' annual reports on developments in competition policy and enforcement to the Committee on Competition Law and Policy.

42. *See, e.g.,* Cox and Foster, *supra* note 1.

43. *See* DOJ press release at http://www.usdoj.gov/atr/public/press releases/1997/1210.htm.

44. Chairman Pitofsky's testimony is available on the FTC home page at http://www.ftc.gov/os/1998/9807/camptest.htm.