

Proposed development of a relative value guide for physician services to be distributed to member internists would be likely to have anticompetitive effects that probably would not be outweighed by any countervailing efficiency justifications. [*American Society of Internal Medicine, P84 3532*]

April 19, 1985

Dear Mr. Kopit:

This letter responds to your request for an advisory opinion concerning the legality of the American Society of Internal Medicine's ("ASIM") proposal to develop and disseminate relative value guides ("RVGs"). The Commission has determined, on the basis of the information provided by ASIM and additional information gathered by Commission staff, that there is substantial danger the proposed conduct would lead to a combination or conspiracy that unreasonably restrains competition among physicians in violation of Section 5 of the Federal Trade Commission Act. The Commission, therefore, cannot give advance approval to ASIM's RVG proposal.

This advisory opinion begins with a brief summary of ASIM's proposal. It then discusses two central questions—first, whether there is substantial danger of an agreement in restraint of trade resulting from the proposed conduct, and second, whether, were such an agreement to result, it would restrain trade unreasonably. The letter then indicates alternative actions, unlikely to raise antitrust problems, that ASIM can pursue to redress the alleged reimbursement disparities about which it is concerned.

ASIM's Proposal

ASIM, a national professional society consisting of approximately 19,000 doctors of internal medicine, proposes to develop an RVG and distribute it to its member physicians and to private and governmental third-party payors on an advisory basis. ASIM plans to request that these parties consider using the RVG as a guide in developing reimbursement programs consistent with the approach contained in the RVG. The RVG would cover services that are provided by physicians who specialize in internal medicine ("internists"). ASIM proposes in the future to work with other physician organizations, including surgical societies, to develop RVGs for other medical and surgical services.

The proposed RVG would list medical services by descriptive codes. ASIM intends to assign numeric values to each coded service, relative to one another, determined on the basis of costs, time, complexity, and the level of training required to perform each service. The RVG would not in itself be a fee schedule, but could be converted to a fee schedule by physicians or third-party payors simply by multiplying the relative values by a dollar conversion factor. ASIM has indicated that it would

not provide conversion factors with its RVG; that the RVG and the other proposed aspects of ASIM's conduct would be voluntary and "advisory" in nature; and that there would be no explicit or implicit threats or coercion against physicians or third-party payors to induce them to use the RVG.

ASIM has stated that it wants to develop the RVG to redress an alleged disparity in reimbursement for "cognitive" and "procedural" services provided by physicians. According to ASIM, a high level of insurance reimbursement now encourages physicians to use and sometimes overuse costly "procedural" services such as surgery, electrocardiograms, x-rays, and other technology-intensive services. At the same time, ASIM submits, relatively low levels of reimbursement discourage physicians from using more time-consuming "cognitive" services such as the diagnosis of patient health care problems, preventative education, and life style evaluation. ASIM's members are internists, most of whom are chiefly engaged in primary care and the delivery of cognitive services. ASIM proposes to increase the relative value of cognitive services and decrease the relative value of procedural services to encourage use of more cognitive services and discourage overuse of procedural services. ASIM states that its RVG, if widely adopted, would reduce health care costs by creating incentives to substitute low-cost care for high-cost care. It further states that an increase in the relative amount at which cognitive services are reimbursed, as compared to procedural services, would encourage physicians to spend more time in personalized aspects of care and would provide new incentives for physicians to choose primary care specialties utilizing relatively large amounts of cognitive services.

ASIM plans to use the "Delphi technique" to reach consensus on the relative values to be assigned to each of the services commonly provided by internists. In separate mail surveys, representatives of internal medicine subspecialty¹ organizations and two ASIM state affiliates would be asked anonymously to assign relative values to medical services on the basis of time, complexity, costs, and training. Median and average figures computed by ASIM based on the first round of responses would then be submitted to the same physicians to use in making a second round of responses. The process would continue until a consensus or as much uniformity as possible was reached. ASIM's Resource Cost Committee would then review the product of each of these survey determinations and determine relative values using the Delphi consensus-building technique. The resulting RVG would then be submitted to ASIM's Board of Trustees for approval or disapproval without modification.

ASIM also plans to send a "white paper" to physicians and third-

¹ Internal medicine subspecialties include cardiology, gastroenterology, allergy, endocrinology, hematology.

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party payors that would explain the cognitive/procedural reimbursement disparity and use of its RVG to reduce the disparity. It would also illustrate how to use the RVG to "change the reimbursement structure from the current procedural service basis to a cost of resources basis." The stated purpose of the "white paper" would be to persuade and not to coerce.

Legal Analysis

The antitrust issue raised by ASIM's proposal is whether it presents a substantial danger of an agreement that unreasonably restrains trade.² The threshold question in resolving this issue is whether there is danger of an agreement in restraint of trade. If there is a substantial danger of such an agreement occurring, the second question is whether there is a substantial danger that it would unreasonably restrain trade. The antitrust laws prohibit, of course, only those agreements that restrain trade unreasonably.³

Danger of Agreement in Restraint of Trade

ASIM's adoption and dissemination of an RVG, as it proposes, could involve or facilitate two types of agreements in restraint of trade: (1) an agreement among ASIM, its members, and possibly other physicians to adhere to the RVG in determining charges for their services; and (2) an agreement between ASIM, acting on behalf of its members, and one or more third-party payors, possibly resulting from coercion, that the third-party payor(s) will adhere to the RVG in reimbursing physicians for covered services. The Commission concludes there is a substantial danger that the first type of agreement may occur; there does not appear to be a substantial danger of the second type of agreement.

With respect to the first type of agreement, if a professional association expressly or implicitly suggests or advises marketplace conduct on the part of its members or other competitors and the intent or likely consequence of the communication is that association members or others will concertedly or interdependently modify their behavior in the marketplace to restrain trade, both the professional association and the individuals so acting could properly be found to be parties to an agreement in restraint of trade.⁴ In contrast, when an association provides information or advice to its members or others that could be

² The Commission discusses the antitrust risks of ASIM's proposal in terms of "substantial danger" because this advisory opinion seeks approval for proposed future conduct, the precise nature and specific effects of which cannot now be determined.

³ *United States v. Standard Oil Co.*, 221 U.S. 1, 59-60 (1911).

⁴ See generally *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226-27 (1939) ("It was enough [for a unlawful conspiracy] that, knowing that concerted action was contemplated and invited, the[y] gave their adherence to the scheme and participated in it. Each . . . was advised that the others were asked to participate; each knew that cooperation was essential to successful operation of the plan. They knew that the plan, if carried out, would result in a restraint of commerce, which . . . was unreasonable . . . and knowing it, all participated in the plan.").

used by its recipients unilaterally in the marketplace and it is neither intended nor likely that the communication will result in concerted, interdependent action to restrain trade, the association would probably not be found party to an agreement in restraint of trade.⁵ In this matter, the substance and market context of ASIM's communications and physician actions in response to them would be critical in determining the existence of an agreement in restraint of trade.

Although any action by ASIM, an association of individual practitioners many of whom compete with one another, to develop an RVG would reflect an agreement to take that action, ASIM's development of an RVG, standing alone, would not constitute an agreement *in restraint of trade*. No one would be party to an understanding by which he or she is committed to any particular course of conduct in the marketplace. However, antitrust analysis of ASIM's proposal must be focused on the entire course of conduct planned by ASIM to determine whether the proposal is intended to or could be expected to involve or facilitate an agreement in restraint of trade.

Several factors indicate there is substantial danger that ASIM's proposed conduct would be intended to or would result in concerted, interdependent action by physicians *to adhere to the RVG* in pricing their services. Despite the disclaimers it would make in its distribution of the RVG, ASIM appears to be proposing implicitly to invite physicians to adhere to the RVG in determining their charges. ASIM plans to send members the RVG on a "purely advisory" basis, leaving individual members "free to make independent fee decisions", with a "white paper" that would "illustrate 'how to' use the [RVG] to change the current reimbursement structure." The RVG would be prescriptive in nature, describing a set of pricing relationships that ASIM would be supporting as what *should* be. The RVG would be designed to *change* future market transactions with respect to physician charges and output. Such pricing information programs are more likely to result in agreements in restraint of trade than are exchanges of descriptive data, which merely describe or reflect historical or current market transactions.⁶ Indeed, there is a danger that use of the RVG could lead to an agreement among physicians on a single conversion factor to apply to each service on the RVG. Thus, the RVG could easily become the means for physicians in at least some communities to coordinate a collusive pricing scheme.

Further, for a number of reasons there appears to be a substantial

⁵ See generally *Monsanto v. Spray-Rite Service Corp.*, 104 S.Ct. 1464, 1471 (1984) (To find an agreement, "[t]here must be evidence that tends to exclude the possibility that the manufacturer and the nonterminated distributors are acting independently. . . . [T]he antitrust plaintiff should present direct or circumstantial evidence that reasonably tends to prove that the manufacturer and others 'had a conscious commitment to a common scheme designed to achieve an unlawful objective.'" (citation omitted)); *First Nat'l Bank v. Cities Service Co.*, 391 U.S. 253, 268 (1962) (the inference of a conspiracy does not logically follow in the absence of either direct conspiratorial intent or motive to enter a tacit agreement).

⁶ See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 781 (1975); *Maple Flooring Mfrs' Ass'n v. United States*, 268 U.S. 563, 585-86 (1925).

danger that concerted adherence to the RVG by physicians in response to ASIM's invitation would be widespread. The invitation to use the RVG would emanate from a leading national medical specialty association and would presumably have the support of the other medical organizations that would have helped to build the "consensus" the RVG reflects. Concerted adherence to an ASIM RVG would appear more likely than if an independent outside organization were to formulate an RVG. Moreover, ASIM's invitation to adhere to the RVG would be attractive to the many primary care physicians who would benefit financially from increased reimbursement for cognitive services. Also, the RVG would be circulated in a form easily used by individual physicians in setting their prices. It would require only that the physician identify the appropriate code for each medical service rendered and apply a conversion factor he or she selects to each listed relative value to determine his or her charge for every service.

Widespread adherence to the RVG by physicians in local communities would likely be interdependent because it would probably not be in the economic self-interest of individual physicians to charge on the basis of the RVG unless they believe most competing physicians would be doing likewise. Physicians choosing to price in conformance with the RVG would likely do so to effect increases in the absolute level of their charges for cognitive services.⁷ If only a few physicians were to increase their charges for cognitive services, insurers might refuse to pay the increased amounts on the ground that for each such physician, it reflected a fee exceeding the "usual and customary" charge of internists. In light of increasing competition at the primary care level, individual physicians considering adherence to the RVG would know that patients who were not fully reimbursed by insurance and who incurred higher out-of-pocket costs for cognitive services could over time go elsewhere for their medical care (e.g., to other private practice physicians or to health maintenance organizations). If most primary care physicians in an area adhered to the RVG, in contrast, insurers' "customary" screen levels would over time increase, likely resulting in higher reimbursement allowances. Patients would then have less incentive to seek, and could less easily find, a lower-cost provider. Thus, concerted or interdependent conduct by a very substantial number of physicians could succeed, and would probably be necessary to succeed, in raising the relative price level of cognitive services. If concerted conduct were not necessary, physicians concerned about the disparity identified by ASIM could address it unilaterally, and presumably already would have in their own

⁷ Adherence to the RVG would likely require physicians to depart from their current fee schedules. It would be unlikely that physicians would voluntarily elect to conform to the RVG and choose conversion factors that would keep their prices for cognitive services at roughly their current levels and would result in reduction of their charges for procedural services.

practices, by increasing charges for cognitive services. ASIM's likely knowledge that individual physicians probably could only effectively use the RVG interdependently, or concertedly, would help support a finding that ASIM contemplated a concerted response by physicians to its promulgation of the RVG.

Finally, to the extent third-party payor coverage "desensitizes" insured patients to price increases, concerted conformance to the RVG in an effort to raise charges for cognitive services would be more likely contemplated, attempted, and successful in the medical marketplace than restraints of trade in other market contexts in which consumers are more "price sensitive." If the RVG were adhered to by a substantial number of physicians, then "discounting" might not be as advantageous for physician competitors as it typically is for other competitors seeking to undercut higher charges resulting from collusion. As noted above, general adherence to the RVG would likely create a new range of "customary" charges, so that third-party payors would, as time passes, likely recognize and pay higher charges for cognitive services. In this event, even if some physicians did not adopt the RVG and charged lower prices for cognitive services, they might not be able to undercut effectively those adhering to the RVG because fees below those recognized as customary by insurers might not attract many insured patients away from other physicians. Patients with paid-in-full insurance coverage or only small co-payment obligations, who are treated by physicians whose fees are within the "customary" range, could have little, if any, monetary incentive to switch physicians.

The Commission recognizes, notwithstanding the foregoing discussion, that substantial arguments can be made against the likelihood that concerted adherence to the RVG would result from ASIM's proposed conduct. For example, physicians' different cost structures and diversity across the country in practice patterns and pricing relationships among various medical subspecialties may make it unlikely that physicians would reach a common understanding to utilize any single RVG. Also, the cost-containment practices of third-party payors would pose a major obstacle. Nonetheless, although the Commission cannot, in this advisory opinion context, predict that widespread concerted conformance to the RVG would necessarily result from its dissemination by ASIM, the available information on this specific RVG proposal indicates that this type of agreement in restraint of trade is a substantial danger.

ASIM also proposes to disseminate its RVG to insurers and other third-party payors and encourage them to adopt the RVG as a basis for their reimbursement structures. This conduct raises the question of whether ASIM's proposal may lead to the second type of possible

tween ASIM, on behalf of its members, and third-party payors that such third-party payors will adhere to the RVG in their reimbursement systems. Such an agreement between ASIM and a third-party payor could lessen competition among ASIM's members over the terms of their dealings with the third-party payor. The Commission does not find a substantial danger that this type of an agreement would result from the proposed conduct.⁸

No agreement in restraint of trade involving ASIM occurs if a third-party payor decides to adopt an RVG as the basis for its reimbursement system, even if its decision results from discussions with ASIM, so long as the third-party payor's decision is a unilateral one, i.e., is not the result of coercion by ASIM or of an *agreement*, coerced or voluntary, between ASIM and the third-party payor.⁹

In this regard, ASIM's request letter states that its discussions with third-party payors would be advisory and not coercive in nature. ASIM also states that it would not be acting as a common agent or in a representative capacity for its members in its dealing with third-party payors; rather it would simply seek to persuade third-party payors of the efficacy of reimbursement systems based on the RVG. Based on these representations and the absence of factors indicating serious risk in this regard, the Commission does not believe there is a substantial danger that ASIM will negotiate an agreement with, or coerce, third-party payors to use the RVG, so as to constitute an agreement in restraint of trade.¹⁰

Reasonableness of Potential Agreement in Restraint of Trade

Because the Commission has concluded there is a substantial danger that ASIM's proposed conduct would involve an agreement in restraint of trade among ASIM and physicians to concertedly adhere to the RVG, the remaining issue is whether such an agreement would *unreasonably* restrain trade and therefore be illegal. The Commission concludes that such an agreement would be inherently suspect, in light of its purposes and likely anticompetitive effects. The Commission further concludes that the likely anticompetitive effects of such an agreement probably would not be outweighed by any countervail

⁸ Because of the conclusion reached in this advisory opinion, it is not necessary to reach the question of whether an agreement to adopt and promulgate an RVG by a medical society could result in an unreasonable restraint of trade, even absent a finding of concerted adherence to it by physicians or an agreement between the medical society and any third-party payors.

⁹ See *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 483 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981); *Michigan State Medical Soc'y*, 101 F.T.C. 191, 286 (1983) ("*MSMS*"); *Monsanto*, S.Ct. at 1471.

¹⁰ ASIM's development of an RVG for dissemination to third-party payors, although not raising an apparent substantial danger of agreement in restraint of trade between ASIM and third-party payors, could nonetheless result in an agreement between ASIM and its members to adhere to the RVG. If ASIM were to develop and support it in discussions with third-party payors, its members' knowledge of this action and the specific the RVG could result in concerted adherence to it for many of the same reasons stated above. Although evidentiary situations would be different, this conduct could raise antitrust risks like those resulting from dissemination of the RVG to ASIM's members with encouragement to use it.

ing efficiency justifications that may flow from ASIM's proposed conduct. As a result, as is discussed below, an agreement among physicians to adhere to the ASIM RVG would be likely to restrain trade unreasonably. The Commission, therefore, cannot approve ASIM's proposed actions.

Naked horizontal agreements to restrict output or tamper with price are *per se* illegal. No elaborate inquiry into market power or actual effects is required for condemnation of such agreements under the antitrust laws, and insistence on the "need" in the marketplace for such arrangements cannot provide a defense.¹¹ An agreement on precise fees is not required for a finding of illegality.¹² "Any combination which tampers with price structures is engaged in unlawful activity . . . [T]o the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces."¹³ As the Supreme Court has recognized, "An agreement to pay or charge rigid, uniform prices would be an illegal agreement under the Sherman Act. But so would agreements to raise or lower prices whatever machinery for price-fixing was used."¹⁴ Thus, an agreement to use a particular formula, like an RVG, could support a finding of illegal price-fixing,¹⁵ because "tampering with the means of setting prices is tantamount to tampering with reimbursement levels."¹⁶ Similarly, the Supreme Court has condemned as *per se* unlawful a horizontal agreement to fix only one element of price, such as credit terms.¹⁷

If an agreement encompassing promulgation and adherence to the ASIM RVG is found, the agreement would have purposes and likely effects that under the foregoing precedent would condemn the agreement as *per se* unlawful absent plausible efficiency justifications. The agreement would tamper with market pricing structures, and pose a serious danger of higher prices, at least with respect to some medical services, and other anticompetitive effects.

United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 218 (1940); *NCAA v. Board of Regents of University of Oklahoma*, 104 S.Ct. 2948, 2960, 2965 (1984).

Per se condemnation has been deemed appropriate even when 1) suggested prices were used by a trade association's members only as a "starting point" for individual negotiations and price competition continued, *Youth Dealers Ass'n of N. Cal. v. United States*, 279 F.2d 128, 132 (9th Cir. 1960), and 2) there were no sanctions against members not adhering to the suggested prices and suggested prices in fact were not strictly adhered to by members, *United States v. Nationwide Trailer Rental Sys., Inc.*, 156 F.Supp. 800, (D. Kan.), *aff'd per curiam*, 358 U.S. 10 (1957). In regard to "advisory" price schedules possibly supporting a finding of agreement in restraint of trade, *de compare dictum in Goldfarb*, 421 U.S. at 781 (1975) ("[a] purely advisory fee schedule issued to provide information . . . without a showing of an actual restraint on trade, would present us with a different question") *with dictum in United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 488-89 (1950) (in regard to a "non-mandatory" price schedule, "[s]ubtle influences may be just as effective as the threat or use of formal sanctions to hold people in line").

Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 346 (1982) (quoting *Socony-Vacuum*). See also *MSMS v. American Medical Ass'n*, 708 F.2d 1000, 1005 (9th Cir. 1983), *cert. denied*, 464 U.S. 1000 (1983), 101 F.T.C. at 291.

Socony-Vacuum, 310 U.S. at 222 (emphasis added).

Morrison v. Nissan Motor Co., 601 F.2d 139 (4th Cir. 1979) (regarding an automobile repair flat rate schedule).

101 F.T.C. at 291.

Illano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980).

First, the agreement would tamper with the market's pricing structures by locking competing physicians into use of a particular pricing formula, if not uniform prices. It would fix the relationships among each physician's prices for different services, so that ratio would not depend upon the production costs or quality of each physician's service, nor on the degree of demand he or she faces for various services.

Second, use by physicians of the proposed RVG would apparently be designed to achieve, and would likely result in, payment and reimbursement for cognitive services at higher absolute levels than prevail currently. It can be inferred from ASIM's own statements that ASIM's purpose in developing the RVG includes raising prices for cognitive services *on an absolute basis* as well as on a relative basis. Examples include an ASIM resolution in 1983 stating: "Resolved, that in ASIM's campaign to reduce the discrepancy in reimbursement between cognitive and procedural services, the Board of Trustees continues to actively promote *enhanced reimbursement* for cognitive services"¹⁸ In proposing in 1982 that the Department of Health and Human Services adopt an RVG demonstration project, ASIM stated, "A new schedule of allowance providing for *increased reimbursement* for internist's cognitive services would be created."¹⁹ Moreover, ASIM very likely knows that its members would have every incentive to use the RVG to increase the absolute level of their prices for cognitive services. As noted above, physicians who voluntarily convert their current fee schedules to the new ASIM RVG would be unlikely to adopt a conversion factor that would result in lower prices for procedural services and no increase in their cognitive services charges. The effect of widespread use of the ASIM RVG by physicians to bill higher fees for cognitive services, even without the RVG's explicit adoption by third-party payors, would likely be incorporated into third-party payors' physician fee profile data for computing usual, customary, and reasonable charges and raise third-party payors' reimbursement levels for cognitive services.

Third, a "fragmentation" phenomenon of new billing categories being created has apparently arisen with use of some other RVGs and could in the instant case result in increases in overall billing charges. For example, a study of the California Medical Association RVG concluded that more detailed and fractionalized RVG descriptive codes resulted in overall increases in payments to physicians.²⁰ Here, the is some danger, for example, of ASIM's RVG providing for no charges by procedure-oriented physicians for cognitive aspects of services, when patients were previously charged only for a procedu

¹⁸ ASIM, *Reference Committee B Report, 1983 House of Delegates* 4 (emphasis added).

¹⁹ ASIM, *Proposal for a Demonstration Project 3* (Oct. 1982) (emphasis added).

²⁰ Sobaski, *Health Ins. Statistics, USDHEW, Effects of the 1969 California Relative Value Studies on Certain Physician Services Under SMI*, Pub. No. (SSA) 75-11702 (June 20, 1975), at 5; see also Urban Institute, *Alter Methods of Developing a Relative Value Scale of Physicians' Services: Year End Report 7-8* (1983) ("Institute Study").

Such a tendency in the ASIM RVG could arise in the evolution of the "consensus" needed among both cognitive and procedure-oriented physicians for the RVG's contents.²¹

Fourth, widespread adherence to the RVG could also tend to stabilize prices artificially. Such a phenomenon could be in contrast to the stability of price one might expect in a competitive market in which homogeneous, fungible goods are sold. The price relationships of different services, and possibly absolute prices as well,²² would be stabilized to a degree not already effected by third-party payment and without regard to differences in the quality of each physician's services or his or her efficiency.

Fifth, the RVG may also facilitate direct price fixing. In the absence of an RVG the difficulties in forming a consensus among physicians on a fee schedule would involve deciding which services to include in a price-fixing agreement and agreeing on what value each service should have in relation to another. Agreement on a full-blown fee schedule would be facilitated by adherence to the RVG and would involve additional agreement only on a conversion factor. Although ASIM has disclaimed any intent to encourage such conduct, agreements among physicians to use a particular conversion factor with an RVG can arise. Agreement on conversion factors does not appear to be a part of ASIM's plan nor an inevitable result of it, but it is a possible result of ASIM's conduct, particularly in subspecialties at local levels.

Finally, in addition to affecting price, concerted adherence to ASIM's RVG would also appear to fix or restrict output of certain services, also a type of agreement that can be *per se* illegal.²³ ASIM's stated intent is to change the mix of cognitive and procedural services delivered by internists, if not all physicians, through change in reimbursement levels. ASIM's proposal apparently contemplates a reduction in the output of procedural services, and could, depending on the impact on demand of any significant price increases for cognitive services, reduce output of cognitive services.

Because of its apparent purpose to raise price levels for some services and the substantial danger of anticompetitive effects on price

²¹ *Am. Med. News*, Nov. 23/30, 1984, at 30, col. 3 (surgical society official quoted as stating there is "cognition OR [operating room] too"); see also *Am. Med. News*, Oct. 14, 1983, at 14, col. 1 (surgical society official quoted as stating "surgeons use cognition before, during and after surgery"; physician quoted as stating that "resistance" to concept of reducing cognitive and procedural services disparity began to "disappear" in state 1 society when internists explained to surgeons that, "because of the reimbursement bias," "surgeons do cognitive consultations that they have to consider throwaways" or "time lost").

²² Empirical study suggests that RVG use is associated with less fee dispersion, although not necessarily fees. B. Eisenberg, *Information Exchange Among Competitors: The Issue of Relative Value Scales for Physicians' Services*, 23 *J.L. & Econ.* 441, 457-58 (1980). The study's data were not sufficient to indicate whether reduction in dispersion reflected more efficient market performance, or a possibly unwarranted trend toward higher prices by physicians offering differing quality service. The study did find a positive association between RVG use and higher prices, but the association was not statistically significant.

²³ *A. 104 S.Ct. at 2948; National Macaroni Mfrs. v. FTC*, 65 F.T.C. 583 (1964), *aff'd*, 345 F.2d 421 (7th Cir.

and output, the agreement to adhere to the RVG that could result from ASIM's proposal would be inherently suspect or *prima facie* anticompetitive. Such an agreement would not be condemned outright under the *per se* rule as a naked restraint of trade if a plausible procompetitive efficiency rationale existed for it, but the burden would be on ASIM to establish justifications legitimizing the agreement.²⁴ If ASIM established procompetitive efficiency justifications, they would then be weighed against the anticompetitive effects of the conduct to determine net competitive effects. If such justifications were not shown to be valid, the *prima facie* anticompetitive or inherently suspect conduct in question would be condemned without further proof of anticompetitive effects.²⁵ This method of analysis can be deemed a truncated, quick-look, or limited rule of reason analysis.²⁶

Showing adequate justification for concerted promulgation and adherence to ASIM's RVG would be particularly critical given the power of ASIM and those physicians, both ASIM members and others, who might concertedly use the RVG to effect significant changes in the marketplace. ASIM membership includes 19,000 physicians, a significant portion of the nation's 63,000 internists. The Commission understands that ASIM also has the support of at least 12 other physician organizations in its effort to make cognitive services reimbursement more "equitable." Concerted action by physicians who are members of these organizations to adhere to the RVG would likely have a substantial effect on the marketplace. In addition, primary care physicians who are not members of these organizations might also be attracted to the ASIM RVG because use of it would be in their financial interest. Finally, future proposed ASIM RVG activity encompassing all physician services could command widespread, across-the-board adherence by physicians in all specialties.

²⁴ NCAA, 104 S.Ct. at 2967; cf. *MSMS*, 101 F.T.C. at 291; see generally Brunet, *Streamlining Antitrust Litigation By "Facial Examination" Of Restraints: The Burger Court And The Per Se - Rule Of Reason Distinction*, 60 Wash. L. Rev. 1 (1984).

²⁵ *United States v. American Soc'y of Anesthesiologists, Inc.*, 473 F.Supp. 147 (S.D.N.Y. 1979) ("ASA"), cited by ASIM, warrants discussion. In that case, the court rejected the Department of Justice's contention that ASA committed a *per se* violation of the Sherman Act through its dissemination of an RVG for anesthesia services and found no violation under the rule of reason. The ASA case was tried solely on a *per se* theory so there was no exposition of possible anticompetitive effects. The court, in fact, found no agreement to adhere to the RVG with the purpose or effect of raising or stabilizing price, ASA at 159, and instead found that ASA had not "encouraged anyone to use its RVG. No evidence was cited showing any intent on the part of ASA to achieve an increase in fee levels. ASA at 159-60. The court also emphasized that delivery of anesthesia services is somewhat unique medical practice—little or no contact with patients prior to surgery and virtually 100 percent insurance coverage of fees. *Id.* The present matter differs significantly in these respects.

²⁶ See, e.g., *General Leaseways v. National Truck Leasing Ass'n*, 744 F.2d 588, 595-96 (7th Cir. 1984) (preliminary injunction); Brief for the United States as *Amicus Curiae* in Support of Affirmance, *NCAA* at 9-12. In reference to the quick-look rule of reason, "[s]easoned antitrust lawyers recognize that the threshold facial examination is not that novel and is entirely consistent with older landmark cases. *United States v. Addyston Pipe and Steel* evidences the historical foundation underlying the quick look method." Brunet, *supra* note 24, at 22. Even full-blown rule of reason analysis were the appropriate mode of analysis for an agreement encompassing concerted adherence to ASIM's RVG, the apparently anticompetitive purposes and potential effects discussed above, and likelihood that ASIM members and other physicians collectively using the RVG could exercise market power discussed below, would very likely make out a *prima facie* case, once established in an evidentiary record. A would then, as in a truncated rule of reason analysis, have to proffer evidence showing procompetitive effect greater or at least equivalent weight.

ASIM's stated justification is essentially that imperfections in the insurance payment system for reimbursing physicians have created "wrong incentives," i.e., a high level of reimbursement for costly technological and procedural services, which encourages overuse and more expensive medical care, and a low level of reimbursement for cognitive services, which discourages their use. ASIM further claims that redressing the reimbursement disparity between procedural and cognitive services through its proposed RVG would encourage greater use of more personalized cognitive services and provide new incentives for more physicians to choose primary care specialties. ASIM claims that its proposed RVG, besides influencing physicians to better meet the public's overall health needs, would be designed to reduce health care costs.

ASIM's purported objective—a lower-cost medical services marketplace, with concomitant health benefits to patients—is laudable. However, that objective would not provide a cognizable justification or defense under the antitrust laws for an agreement to supplant determination of prices by market forces on the ground that prevailing prices were not at a level the parties to the agreement believed was optimal for them or society.²⁷ In *Professional Eng'rs*, the Supreme Court confirmed that activities of professional societies are subject to the traditional antitrust test of reasonableness—"whether the challenged agreement is one that promotes competition or one that suppresses competition"—and may not be defended on the ground that the special characteristics of professional services markets make competitively determined prices undesirable.

The difficulties in recognizing the availability of such a defense for an agreement to adhere to the ASIM RVG are illustrated by the issues that would have to be resolved to determine its validity. A principal actual issue would be determining the accuracy of ASIM's claim that pricing levels and output in the medical services marketplace are not appropriate levels. If such nonoptimal performance is proven, one would then have to determine whether the results of the conduct in question would be improvement or worsening of the market. A court might well have to assess the likely result of physicians forming and acting upon a subjective consensus judgment, based on cost and other factors, of what pricing relationships would prevail in the marketplace if the market were working properly. This inquiry would be akin to the regulatory determination of a public utility commission and would go beyond any inquiry undertaken in prior antitrust cases. Indeed, to attempt to resolve empirically whether competition and consumers would ultimately be served or harmed by concerted agreement on a pricing formula would require an inquiry that courts have long eschewed in antitrust cases—i.e., to "set sail on a sea of doubt" seeking

²⁷ *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679, 688, 692 (1978).

to decide "how much restraint of competition is in the public interest, and how much is not," with the court trying to assess the reasonableness of the prices charged.²⁸ Also, even if it were demonstrated that the market changes ASIM proposes would in fact produce prices and output at a more optimal level in the immediate short term, they could over time produce unreasonable prices and output, with it being virtually impossible to police the ongoing effects of such concerted use of ASIM's pricing formula.²⁹

Even if a defense by ASIM premised on the appropriateness of agreed-upon changes of industry pricing structures and output levels were legally cognizable as an efficiency-enhancing device, it is doubtful that ASIM could successfully establish, on the facts, that market performance would improve through its proposed conduct to a closer approximation of optimal market pricing. For example, ASIM's proposal may drive up those prices that are now close to or at a competitive level, while leaving largely undisturbed prices for procedural services that may be reimbursed excessively. It is possible that market forces may be permitting above-optimal prices for procedural services, while keeping the prices of cognitive services at approximately optimal levels.³⁰ If so, ASIM's efforts could raise cognitive service prices above competitive levels. Thus, if it enhanced reimbursement for cognitive services, concerted adherence to ASIM's proposed RVG could distort the market to a point even further from optimal competitive performance than now exists.

There is certainly no assurance that the price of procedural services will be reduced by the ASIM RVG in the long run. ASIM's efforts to reduce the reimbursement disparity between procedural and cognitive services have reportedly met with concern from representatives of some internal medicine subspecialty groups whose members engage more heavily in procedural services. These groups reportedly do not object to increasing reimbursement for cognitive services, but question a decrease in reimbursement for procedural services.³¹ It is very possible that, once consensus on the RVG is reached, use in the market of the relative values accorded different services would result in increases in reimbursement for cognitive services with little or no decrease in reimbursement for procedural services. Moreover, it is difficult to reach consensus among physician representatives with divergent i

²⁸ *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 283-84, 291 (6th Cir. 1898), *aff'd as modified*, 175 F. 211 (1899). See also *MSMS*, 101 F.T.C. at 293.

²⁹ See *United States v. Trenton Pottery Co.*, 273 U.S. 392, 397-98 (1927).

³⁰ Market forces that may be restraining the price of cognitive services to a greater degree than procedural services could include better consumer knowledge of what a "fair" price is for cognitive services; more active and effective consumer involvement in determining whether and when to seek primary care services; a greater proportion of out-of-pocket costs for patients receiving cognitive services because of the terms of insurance coverage; the growth of ambulatory care centers that have extended hours; and growing competition from non-physician health care providers. See, e.g., AMA Council on Med. Service, *Effects of Competition in Medicine* (J. A.M.A. 1864 (Apr. 1983)); ASIM, *Reimbursement for Physicians' Cognitive and Procedural Services: A Paper 1* (Jan. 1981).

³¹ See, e.g., *Am. Med. News*, Oct. 14, 1983, at 14, col. 1.

terests, compromises might result in identification of new cognitive services, not previously billed for, that procedural service oriented physicians can bill to insurers and patients.³²

In addition, ASIM's implicit prediction that physicians would switch to providing more cognitive instead of procedural services and thereby contain health care costs is speculative. Even if some switching did occur, would it be enough to offset any increase in the price of cognitive services so as to lower overall health care costs? Would the resulting output be more beneficial to consumers than the current one? These questions demonstrate the risk inherent in permitting price and output mix to be determined or redirected by private agreement among competitors who have a stake in the outcome.³³

Finally, the means ASIM plans to use to develop its RVG highlights some of the dangers. ASIM proposes to derive appropriate relative values through a "consensus" building process—polling physicians by means of the Delphi technique. A recent study on the pros and cons of various relative value guide alternatives prepared for the Department of Health and Human Services, noted that if the Delphi technique is used, the representational nature of the polled group is critically important.³⁴ Physicians "would have a financial stake in the outcome of the RVS determinations and thereby have a substantial conflict of interest if empanelled to determine an RVS."³⁵ The study explains:

To the extent that various goals of an RVS would be encouraged as part of a group decision process, e.g., [the goal of] more adequately reward[ing] cognitive services, the process becomes less that of finding a solution and more that of achieving the most politically acceptable choice. The findings of research on formal, group decision-making or problem solving tasks [showing the potential efficacy of such efforts] are unlikely to be valid for group choice tasks in which participants have a stake in the outcome and no objectively correct solution exists. *Id.*

For this and the other foregoing reasons it is not at all clear that concerted use of the ASIM RVG would achieve the cost reductions and beneficial public health policy results ASIM has projected. Other possible justifications are also unlikely to provide an adequate ground of defense. Widespread adherence to a single RVG could provide a common benchmark for physician pricing. Arguably, this would facilitate enhanced price competition and comparison shopping among physicians by consumers and health plans on the basis of the current conversion factors used by physicians. Some procompetitive fits of this sort could conceivably result from standard adherence to a single RVG, but it is entirely speculative how substantial those

³² *supra* p. 12.

³³ A, 104 S.Ct. at 2948.

³⁴ Johnson, *Group Decision-Making Methods*, in *Urban Institute Study*, *supra* note 20, at 123.

³⁵ 121.

benefits would be and they would likely not outweigh the anticompetitive impact of concerted use of the RVG. Although insurers could possibly have benefitted significantly some years ago from such pricing by physicians, most insurers now have or can obtain computer profiles on physician fees that provide data on pricing differentials among physicians.³⁶

RVGs in some contexts can serve the legitimate, unilateral business needs of third-party payors, promoting competition and efficiency. An RVG adopted for use by an insurer, self-insured employer, health maintenance organization, or the government for its own use as a third-party payor could well be valuable. Here, when a horizontal agreement among physicians to adhere to the ASIM RVG is a realistic possibility, it is also possible that some procompetitive efficiency benefits could be achieved from its unilateral use by individual third-party payors. It is, however, unclear how substantial such benefits would be. More important, if third-party payors have had a critical need for an RVG, it is not clear why private entrepreneurs, research centers, or the payors themselves would not have already satisfied that need, with whatever physician consultation was necessary, short of medical society promulgation of the proposed RVG with its attendant risks.³⁷

Finally, informational benefits could flow from the availability of the ASIM RVG for unilateral use by physicians in the marketplace. Such benefits, however, would not be present when physicians conspire to adhere to the RVG, and do not merely use it as an informational tool. Such efficiencies would not, therefore, appear to constitute a valid justification for the unreasonable pricing agreement that is a risk of ASIM's proposal.

The Commission concludes, on balance, that any procompetitive efficiency benefits flowing from ASIM's proposed conduct would not be likely to outweigh the anticompetitive dangers of the agreement to adhere to ASIM's RVG that is a serious risk of its proposal to develop an RVG raising the relative prices of cognitive services.

Alternative Actions to Address the Cognitive/Procedural Disparity

There are actions ASIM can take to further its goal of reducing the alleged reimbursement disparity between cognitive and procedural services that would not appear to raise antitrust problems and that may be helpful to public and private third-party payors. To aid third-party payors in developing sound reimbursement programs and criteria, ASIM has available a range of actions that do not require incurring antitrust risk through development of a comprehensive

³⁶ This information is based upon staff interviews with representatives of large and small insurers and third-party payor administrators.

³⁷ Commission staff interviews of representatives of insurers generally indicated a lack of enthusiasm for the medical society developed RVG.

RVG and its dissemination to both third-party payors and all its member physicians. For example, ASIM can seek to persuade third-party payors to change their reimbursement methods or amounts without running afoul of the antitrust laws so long as there is no coercive conduct engaged in or threatened, nor any price agreement entered into between ASIM and any third-party payor lessening competition among ASIM's members. ASIM can lobby Congress or the Department of Health and Human Services for changes it desires in physician reimbursement. Expressions of opinion on the policy question of reducing the reimbursement disparity between cognitive and procedural services as would be contained in an ASIM "white paper" do not constitute a restraint of trade and also fall within the ambit of protected free speech. Finally, ASIM can conduct research and analyses that could be used with other information by the Department of Health and Human Services or other third-party payors in constructing an RVG. ASIM could, for example, study, analyze and report on the time, complexity, or costs of specific services performed by internists without developing a formal RVG mechanism and disseminating it to ASIM's member physicians.

Conclusion

The Commission has determined that the danger of an anticompetitive agreement in restraint of trade is sufficiently great that it cannot give approval to ASIM's proposed course of conduct. ASIM can, though, legitimately engage in alternative actions to redress the reimbursement inequities that it perceives. This advisory opinion does not reflect a determination by the Commission that ASIM's proposed conduct would necessarily violate the antitrust laws if undertaken, nor does it denigrate ASIM's concerns about the public health and the implications of current third-party payor reimbursement patterns. Rather, the Commission has determined only that advance approval cannot be given for the specific actions ASIM has proposed. This advisory opinion, like all those the Commission issues, is limited to the proposed conduct about which advice has been requested, and in the direction of the Commission.

Letter of Request

March 1, 1984

Mr. Muris:

On behalf of our client the American Society of Internal Medicine ("ASIM"), we hereby request an advisory opinion pursuant to 16 C.F.R. §§ 1.1 to 1.4, concerning the development and dissemination of

a relative value guide designed to reduce the disparity in reimbursement between cognitive and procedural physician services.

I. *Background*

The American Society of Internal Medicine is the national association of physicians specializing in internal medicine. ASIM believes that current reimbursement policy provides the wrong incentives for utilizing physician services and that these incentives need to be reevaluated. For example, under present insurance payment systems physicians are encouraged, by the high level of reimbursement, to use costly technological and procedural services—EKGs, X-rays and surgical and diagnostic procedures. At the same time, physicians are discouraged, by the low level of reimbursement, from utilizing more time consuming cognitive services—diagnosing patient health problems, providing preventive education, and evaluating lifestyle effects on health.

ASIM believes that the physician reimbursement system should be revalued to increase the relative value of cognitive services and decrease the relative value of procedural services, in order to encourage the use of more personal services and discourage the overuse of procedural services. It is further believed that an increase in the relative amount at which cognitive services are reimbursed, as compared to procedural services, would encourage physicians to spend more time and effort in personalized aspects of care. The increased value of cognitive services should also provide new incentives for more physicians to choose primary care specialties utilizing relatively large amounts of cognitive services.

II. *Activities in Question*

ASIM wishes to promote the concept of changing the physician reimbursement incentives, away from costly technical services and toward less costly personal care services—the cognitive services. In this effort, ASIM will develop and disseminate its evaluation as to how cognitive services can be valued when compared to procedural services to supply an alternative to the current reimbursement system. ASIM will also propose relative value guides for listed medical and surgical services based on factors designed to reduce the discrepancy between cognitive and procedural services.

Initially, ASIM proposes to develop relative value guides only for those cognitive and procedural services provided by physicians who specialize in internal medicine. ASIM intends in the future to work with other physician organizations—including the surgical society—to develop relative value guides for all listed medical and surgical services, also based on factors designed to reflect relative differences in the cognitive skills and costs required to provide each service.

These relative value guides ("RVG proposal") will contain no conversion factors or pricing information of any kind and will in no way constitute a fee schedule but, instead, will merely list medical services against which relative values will be assigned based on a listed set of relevant factors. As a result, the RVG proposal will merely describe the relative cost and difficulty of certain cognitive services in relation to other services. In this regard, many third party payors agree with the need to reduce the disparity in payment incentive but point to the unavailability of any RVG that accomplishes the desired result.

The development of such a relative value guide for internists' services will necessitate that ASIM consult with various other physician organizations representing the subspecialties of internal medicine (cardiology, gastroenterology, infectious disease, allergy, et al). Each organization will be asked to share with ASIM its assessment of the relative time, complexity, training, and overhead costs involved in each service commonly provided by internists in its subspecialty, and the recommended relative value for each based on these factors. ASIM will then take these recommendations, develop a draft RVG, and attempt to build a consensus among the various internal medicine organizations in support of the new RVG as a valid basis for reducing the disparity between cognitive and procedural services.

The RVG proposal will be developed in a "white paper" which will explain the problems caused by the cognitive-procedural service reimbursement disparity and will provide written examples, by way of relative value guides, as a method to reduce such disparity. The "white paper" will illustrate "how to" use the relative value guides to change the reimbursement structure from the current procedural service basis to a cost of resources basis. The purpose of the "white paper" will be to persuade and it will itself emphasize its voluntary and advisory nature. It will contain no explicit or implicit threats of any kind against physicians, payors or purchasers. Nor will ASIM issue any such threats in connection with its dissemination or otherwise.

ASIM intends to send the RVG proposal to its members, third party payors, and preferred provider organizations ("PPOs") and request that they consider using the RVG proposal as a guide to develop a reimbursement program consistent with the approach contained in the proposal. ASIM also intends to hold follow up discussions and meetings with interested payors. ASIM will further advise each of its physician members to evaluate the proposal and will recommend that physicians supportive of the concept request a reevaluation of the relative values of physician services in existing or proposed PPO arrangements, and to participate in any such reevaluation. ASIM will, however, engage in coercive conduct of any kind in this connection, nor will it serve as common agent for any of its members which

may be negotiating payments, pricing and reimbursement issues with PPOs, third party payors or purchasers, or other persons or organizations.

Finally, to facilitate the critical discussion of the issues involved and to promote the concept of RVG within the medical profession, ASIM will exchange information regarding the relative value of various services with the American Academy of Family Physicians, the American Academy of Pediatrics or other primary care organizations. However, no price information of any kind will be considered, discussed, or transmitted in any such communication, nor will any explicit or implicit threat or coercive conduct of any kind be undertaken.

III. Statutory Provision

The foregoing activities raise questions under Section 1 of the Sherman Act¹ and Section 5 of the Federal Trade Commission Act.²

IV. Present Law

It is clear that agreements to fix prices or to set fee schedules, or other arrangements which produce anticompetitive effects, violate the antitrust laws. *Arizona v. Maricopa County Medical Society*, 102 S.Ct. 2466 (1982) ("*Maricopa*").

The Supreme Court has recently determined that an agreement to establish a fee schedule constitutes *per se* price fixing. *See Maricopa*. Although the Federal Trade Commission ("FTC") has not litigated that issue, it has obtained consent orders by which certain professional associations agreed to withdraw and to refrain from developing in the future any RVG which also contained conversion factors. *In re California Medical Association*, 93 F.T.C. 519 (1979); *In re Minnesota State Medical Association*, 90 F.T.C. 337 (1977).³

Nevertheless, the mere development and circulation of an RVG, without conversion factors, is price neutral and does not necessarily have an anticompetitive purpose or effect. Moreover, activities proposed herein would not involve the implementation of any particular RVG. Indeed individual physicians, third party programs and purchasers of health care all would be explicitly advised to make independent decisions regarding the implementation of any such proposal. Finally, it is significant that the ASIM proposed RVG is designed to reduce total health care costs by creating incentives to

¹ 15 U.S.C. 1

² 15 U.S.C. 45

³ Although the complete facts are not known, the FTC has also made agreements and obtained consent orders wherein certain professional societies have agreed, among other things, to refrain from developing relative value studies where no mention of conversion factor was made. *In re American College of Radiology*, 89 F.T.C. 144 (1977); *In re American College of Orthopaedic Surgeons*, 88 F.T.C. 968 (1976); *In re American College of Obstetricians and Gynecologists*, 88 F.T.C. 955 (1976).

substitute low cost care for high cost care. Many of the existing physician reimbursement systems create precisely the opposite incentive.

Judicial precedent has determined that without conversion factors the circulation of relative value guides among association members, individual physicians, component societies, agencies of federal and local government and third party payors, does not violate the anti-trust prohibitions against price fixing when the RVG is intended only as suggested methodology for arriving at appropriate fees. *United States v. American Society of Anesthesiologist*, 473 F. Supp. 147 (1979). ("ASA"). In ASA the court found that the publication and circulation of RVG did not amount to an agreement to use the RVG in pricing services and that the circulation of RVG did not curtail competition or interfere with the setting of prices in the marketplace. *Id.*

Indeed, the FTC has recently addressed the issue of whether the mere circulation of even price related information amounted to price fixing and concluded that merely providing information, opinions or advice does not violate Section 5 of the Federal Trade Commission Act ("FTCA"). *In re Michigan State Medical Society*, Dkt No. 9129, 3 Trade Reg. Rep. (CCH) ¶ 21,991 (Feb. 17, 1983). ("Michigan"). Although the Commission in *Michigan* determined that the medical society's agreement to fix prices and to boycott third party payors violated Section 5 of the FTCA, the Commission exempted exchanges of information which did not amount to an imposition of a price related agreement. Accordingly, price related communications that do not involve an explicit or implicit agreement or an attempt to reach an agreement were held not to violate Section 5.

The Supreme Court has also recognized that even the mere sharing of price related information does not in itself violate the antitrust laws. *United States v. United States Gypsum Co.*, 428 U.S. 422 (1979). ("Gypsum"). In this regard the Court has stated that:

[t]he exchange of price data and other information among competitors does not invariably have anticompetitive effects; indeed such practices in certain circumstances increase economic efficiency and render markets more, rather than less, competitive.

438 U.S. 422, 440 n. 16 (1978). Thus, the Supreme Court refused to mandate the conclusion that a price fixing violation automatically follows from a finding that the exchange of price information has an impact on prices.

With regard to discussions with third party payors, an association may send information and may express the views of its membership. *Michigan* at 22,469 (where the Commission determined that the order to cease and desist did not reach noncoercive expressions of the medical society's views or the views of its members when made to third parties).⁴ Moreover, advocating physician participation in decision

⁴ Although binding joint negotiation with third party payors may amount to price fixing. Section 5.2.

making, does not create anticompetitive effects, as long as such advocacy is noncoercive. *Michigan* at 22,470; *Maricopa*, 102 S.Ct. at 2477-78.

V. Conclusion

ASIM believes that its activities with regard to the development and circulation of the RVG proposal will not have a probable or foreseeable anticompetitive effect on physician's fees and should not be precluded by the antitrust laws. *ASA; Michigan* at 22,469. Indeed, we believe that our proposal, if adopted, will be procompetitive and reduce medical care costs. As previously indicated, ASIM's efforts will be purely advisory in nature and are intended only as a suggested methodology to reduce the disparity in relative values between cognitive and procedural physician services. In addition, no conversion factors will be developed, proposed or disseminated so that the proposal is price neutral.

The circulation of the RVG proposal among individual physicians, PPOs and third party payors will not interfere with the PPO's or third party payor's ability to establish whatever pricing strategy they so desire. Moreover, ASIM will not bind nor attempt to bind or coerce its members in any way. Each member will continue to be free to make independent fee decisions.

We will be happy to supply additional information and to discuss this proposal with you in person. We appreciate your prompt attention to this matter.

Respectfully submitted,

/s/ William G. Kopit
Epstein Becker Borsody & Green,
P.C.

preclude third party payor discussions where each member reserves and exercises independence in pricing. *Virginia Excelsior Mills Inc. v. FTC* ("Virginia") 256 F.2d 538, 541 (where the court noted that the a common agent is not illegal when each member reserves and exercises independence in pricing and material matters). Here, of course, ASIM has stated explicitly that it would not act as a bargaining agent members or any other person or organization attempting to implement the RVG.



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