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The Stifling of Competition by the Antitrust Laws: The Irony of the Health Care Industry

John A. Powers

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THE STIFLING OF COMPETITION BY THE ANTITRUST LAWS:
THE IRONY OF THE HEALTH CARE INDUSTRY

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INTRODUCTION

In recent years, the health care system in the United States has come to be dominated almost entirely by large health maintenance organizations [hereinafter “HMOs”]¹ and insurance providers. This trend has proven to deprive physicians of their decision-making authority when it comes to the administration of care, with the ultimate result of reducing the quality of health care services provided to consumers. The market dominance enjoyed by these entities is primarily the product of the current state and federal antitrust laws, which have effectively tied the hands of independently practicing physicians by preventing them from banding together in their contract negotiations with these types of managed care providers [hereinafter “MCPs”].² As such, a substantive change in our national antitrust laws is required in

¹HMOs are essentially legal entities that provide comprehensive health care for private parties in return for scheduled advance payments at a predetermined fixed rate. See COMPTROLLER GENERAL, REPORT TO THE CONGRESS OF THE UNITED STATES: HEALTH MAINTENANCE ORGANIZATIONS CAN HELP CONTROL HEALTH CARE COSTS 1 (1980). HMOs are not to be confused with PPOs, or preferred provider organizations, which are organizations comprised of a select panel of health care providers that jointly market their services under such pretences as greater cost efficiency, quality, and accessibility. See PEAT MARWICK, DIMENSIONS IN HEALTH CARE 1 (1985).

²PEAT MARWICK, *supra* note 1, at 1.

order to equalize the imbalance of power between physicians and MCPs, and to ensure the availability of the highest quality of care.

The text to follow is intended to provide an overview of the legal basis for the imbalance of power currently inherent to the health care industry, suggesting several reasons for its development. It also provides an outline of the current basis for antitrust liability in this country and describes some possible solutions. The most practical and effective means through which to rectify this imbalance would be to enact new federal legislation that would amend the antitrust laws to allow for limited "unionization" of independently practicing physicians for collective bargaining purposes.

I. REASONS FOR THE IMBALANCE

A. *Lack of Enforcement of Antitrust Laws Against HMOs*

The bargaining position of independent physicians is substantially weakened by the lack of significant enforcement of the antitrust laws by the Federal Trade Commission [hereinafter "FTC"] and the Department of Justice [hereinafter "DOJ"] against managed care and insurance companies. Even in the face of the considerable market dominance in many localities by a single HMO, the federal enforcement agencies charged with the enforcement of the antitrust laws seem reluctant to interfere with their growth. In fact, Robert F. Liebenluft, former assistant director for health care in the FTC's Bureau of Competition, has reportedly stated that the federal agencies "had rarely, if ever, challenged an HMO merger."³ In some markets, MPCs have amassed more than fifty percent of the health care market, yet the FTC and the DOJ have done little more than rubber stamp the mergers and acquisitions of these large health plans.⁴ This apparent lack of enforcement of the antitrust laws against HMOs allows such entities to accumulate even greater dominance in health care and serves to undermine the limited bargaining power that independent physicians enjoy.

B. *Limited Exemption From Antitrust Liability For Insurance Companies*

Insurance companies are also treated in a more preferential light by the federal government in regards to antitrust matters, thereby further weakening the bargaining power of independent physicians and lessening their control over treatment of their patients. In the United States, the regulation and taxation of the insurance business is left primarily to the states.⁵ In 1945 the U.S. government enacted the McCarran-

³*Concern Rising About Health Plan Mergers*, N.Y. TIMES, Jan. 13, 1999, at 1C.

⁴E. Ratcliffe Anderson, Jr., M.D., Statement of the American Medical Association to the Committee on the Judiciary, U.S. House of Representatives (June 22, 1999), at 9 (stating Alpha Center review of HMO market shares in twenty-five states revealed that the largest five insurers control the care administered to more than 50% of the insured citizens of twenty-three states and more than 70% of the insured citizens in sixteen of those states). Smaller, "local" health plans have achieved similar market dominance in numerous localities. *Id.* at 5. For example, Blue Cross has attained a market share of 57% in Philadelphia, Highmark has a market share of 66.4% and controls 96% of the HMO market in Pittsburgh, and Blue Cross Blue Shield controls approximately 50% of the market in Rhode Island. *Id.*

⁵Francis Achampong, *The McCarran-Ferguson Act and the Limited Insurance Antitrust Exemption: An Indefensible Aberation?*, 15 SETON HALL LEGIS. J. 141 (1991); *see generally*

Ferguson Act.⁶ This legislation served to provide insurance companies with a limited exemption from federal antitrust laws, to the extent that their activity is covered by state law.⁷ However, this exemption does not shield insurance companies from federal prosecution for acts that traditionally constitute violations of federal antitrust law, such as boycotts, coercion, or intimidation.⁸

The Supreme Court has established a three-part test for determining whether the actions of an insurance company should be construed as part of the “business of insurance,” and, therefore, exempt from antitrust liability under the McCarran-Ferguson Act.⁹ This three-part standard requires the reviewing court to determine: first, whether the activity transfers or spreads the insured’s risk; second, whether the activity is an essential or integral part of the policy relationship between the insurer and insured; and third, whether the activity or practice is limited to members within the insurance field.¹⁰ Challenges to the states’ power to regulate and tax insurance companies under the Commerce Clause following the enactment of this statute were rejected and the right of the several states to regulate insurance was affirmed.¹¹

This industry friendly legislation has justifiably received some criticism. As previously stated, the McCarran-Ferguson Act only applies to the insurance business, providing insurance companies with statutory immunity under the federal antitrust laws not granted to any other major industry.¹² However, there does not seem to be any valid reason why the insurance industry should enjoy this unique preferential treatment.

It arguable that this exemption actually serves to restrict competition by allowing for data sharing and concerted rate determination. This legislation also opens the door to possible collective raising of rates or premiums. The added leverage that the McCarran-Ferguson Act provides insurance companies over individual health care providers and patients has also been noticed by many members of Congress, evidenced by the listing of this effect of the Act in the findings of Congress in the

SEC v. Nat’l Sec. Inc., 343 U.S. 453 (1980); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

⁶McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified at 15 U.S.C. §§ 1011-1015 (1988)).

⁷§ 1013(a). Section 1012(b) provides that “no Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance. . . .” § 1012(b).

⁸§ 1013(b). (providing that “(b) Nothing contained in this Act shall render said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate or act of boycott, coercion or intimidation. . .”).

⁹See *Group Life & Health Ins. Co.*, 440 U.S. at 229-30.

¹⁰*Id.*

¹¹See generally *FTC v. Travelers Health Ass’n*, 362 U.S. 293 (1960); *Wilburn Boat Co. v. Fireman’s Fund Ins. Co.*, 348 U.S. 310 (1955); *Maryland Cas. Co. v. Cushing*, 347 U.S. 409 (1954); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946).

¹²See Achampong, *supra* note 5, at 141.

recently proposed bill referred to as the Quality Health-Care Coalition Act of 1999.¹³ Essentially, the McCarran-Ferguson Act unnecessarily provides added bargaining power, though limited, to insurance companies, thereby further hampering physicians in contract negotiations.

II. OPPOSITION TO UNIONIZATION OF PHYSICIANS

A. Basis For Antitrust Liability

To date, attempts by independent physicians to pool together to lessen this imbalance of power within the health care industry have been met by strong resistance. A principle argument of those opposed to such efforts seems to be that such a unionization of doctors would serve to stifle competition within the health care arena, fattening the pockets of already overpaid physicians and yet not significantly improving the quality of care provided to patients. Fear of striking physicians and the resulting unavailability of medical services, particularly emergency care, undoubtedly to greatly fuel the opposition. Accordingly, physicians' efforts to unite for collective bargaining purposes have been viciously attacked as violations of the antitrust laws.

The free trade and unrestrained competition are central to American capitalism, and have led to the development and staunch enforcement of the antitrust laws.¹⁴ The Supreme Court of the United States has maintained that faith in the value of competition is at the heart of our national economic policy¹⁵ and described the antitrust laws as the "Magna Carta of free enterprise."¹⁶ These laws reflect the widely accepted belief that competition generally serves to promote the efficient allocation of resources, enabling consumers to have access to the highest quality goods and services at the lowest possible prices.¹⁷ The antitrust laws are also generally thought to ensure greater freedom of choice in the market, promoting increased quality, service, safety, durability, and immediate cost.¹⁸ Consumer preferences, rather than a competitor's abuse of market power, are intended to control the success or failure of one's business.¹⁹

¹³See Suhail Khan, *H.R. 1304: Quality Health-Care Coalition Act of 1999*, at <<http://thomas.loc.gov/cgi-bin/query>>.

¹⁴See Nancy K. Whittemore, *Antitrust Enforcement and Health Care Reform*, 32 HOUS. L. REV. 1493 (1996). The United States Supreme Court has gone as far as to analogize the relationship between the antitrust laws and the preservation of economic freedom and the free-enterprise system to the Bill of Rights and the protection of personal freedom. *United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972).

¹⁵*Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951).

¹⁶*Topco Assocs., Inc.*, 405 U.S. 596.

¹⁷See David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169 (1994); see also *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679 (1978).

¹⁸*Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 695.

¹⁹See *Antitrust Issues in the Health Care Industry: Hearings Before the Subcomm. on Medicare and Long-Term Care of the Senate Comm. on Finance*, 103d Cong. 66 (1993) [hereinafter "Antitrust Hearings"].

Ironically, the antitrust laws were intended to help entrepreneurs compete on a level playing field by condemning anti-competitive behavior.²⁰ However, today they serve as ammunition against private practitioners within health care, actually preventing them from having the opportunity to compete on the same level as the insurance companies and HMOs, which have come to dominate the industry.

Antitrust liability was originally a common law concept but has since been codified and thereby incorporated into positive law.²¹ The principal federal antitrust statutes are the Sherman Act of 1890,²² the Clayton Act,²³ enacted in 1914 and substantially amended by the Robinson-Patman Act in 1936,²⁴ and the Federal Trade Commission Act of 1914.²⁵

The Sherman Act serves to make contracts, combinations or conspiracies in restraint of trade, void at common law, unlawful in the positive sense.²⁶ It also created a civil cause of action for damages in favor of those injured by the actions of another party that violate its provisions.²⁷ The act is commonly employed to prevent or estop agreements to fix prices,²⁸ conspiracies amongst competitors to boycott other parties,²⁹ and the use of coercion to restrain open competition.³⁰

²⁰*Id.* at 70.

²¹Combinations in restraint of trade or tending to create or maintain monopoly gave rise to actions at common law. *Rogers v. Douglas Tobacco Bd. of Trade, Inc.*, 244 F.2d 471 (D.C. Cir. 1957); *see also Mans v. Sunray DX Oil Co.*, 352 F. Supp. 1095 (N.D. Okla. 1971) (providing that federal statutory law on monopolies did not supplant common law but incorporated it).

²²15 U.S.C. §§ 1-7 (1994).

²³§§ 12-27.

²⁴The Robinson-Patman Act amended the Clayton Act and added §§ 13a, 13b, and 21a to title 15. *Paceco, Inc. v. Ishikawajima-Harima Heavy Indus. Co., Ltd.*, 468 F. Supp. 256 (N.D. Cal. 1979).

²⁵15 U.S.C. §§ 41-58 (1994).

²⁶*Denison Mattress Factory v. Spring-Air Co.*, 308 F.2d 403 (5th Cir. 1962). Section One of the Sherman Act provides in pertinent part that: "(e)very contract, combination the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is hereby declared to be illegal." 15 U.S.C. § 1 (1994). Section Two of the Act further provides that: "(e)very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce . . . shall be deemed guilty of a felony. . . ." § 2.

²⁷*See, e.g., United States v. U.S. Gypsum Co.*, 438 U.S. 422, 436 (1978).

²⁸*See, e.g., Ariz. v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982) (holding that agreements among doctors that established the maximum fees to be claimed as payment for particular services rendered amounted to an illegal price-fixing conspiracy prohibited by the Sherman Act); *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975) (finding that the establishment of a minimum fee schedule, published by the county bar association and enforced by the state bar, constituted illegal price-fixing).

²⁹*See, e.g., Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir.1984) (holding the denial of staff privileges to osteopathic physicians by the staff of Weiss Hospital constituted a per se violation of the Sherman Act); *Wilk v. Am. Med. Ass'n*, 895 F.2d 352 (7th Cir.), *cert. denied*, 496 U.S. 982 (1990) (finding that the boycott of chiropractic physicians by the American

The elements that must be proven to establish a claim under the Sherman Act are: a contract, combination or conspiracy; which unreasonably restrained trade under the per se rule of illegality or rule of reason analysis; and affected interstate commerce or injured competition.³¹ It is also necessary that the plaintiff be able to demonstrate that the injury to his business or property was the direct result of the defendants' actions in restraint of trade, and said damages must be reasonably ascertainable and not merely speculative.³²

The Clayton Act is geared more toward preventing the development of unfair market conditions that serve to foster monopolies or deter competition.³³ The United States Supreme Court has interpreted the congressional intent underlining this Act, stating that through enactment of this section, Congress

sought generally to obviate price discrimination practices threatening independent merchants and businessmen, presumably, from whatever source, and intended to assure, to the extent reasonably practicable, that businessmen at the same functional level would start on equal competitive footing so far as price was concerned.³⁴

The Act focuses upon several types of restraints of trade, including exclusive dealing arrangements and price discriminations, and provides a civil remedy for

Medical Association amounted to unreasonable restraint of trade forbidden under Section One of the Sherman Act).

³⁰*See, e.g.,* FTC v. Ind. Fed'n of Dentists, 476 U.S. 447 (1986) (finding that the policy adhered to by the members of the Indiana Federation of Dentists of refusing to relinquish x-rays to insurers established an unreasonable restraint of trade prohibited by the Sherman Act).

³¹*Spence v. S.E. Alaska Pilots' Ass'n*, 789 F. Supp. 1014 (D. Alaska 1992). *See also* Mowery v. Standard Oil Co. of Ohio, 463 F. Supp. 762 (N.D. Ohio 1976), *aff'd* 590 F.2d 335 (6th Cir. 1978); Unibrand Tire & Prod. Co., Inc. v. Armstrong Rubber Co., 429 F. Supp. 470 (W.D.N.Y. 1977); N. C. Elec. Membership Corp. v. Carolina Power & Light Co., 85 F.R.D. 249 (M.D.N.C. 1979); Vietnamese Fishermen's Ass'n v. Knights of Ku Klux Klan, 518 F. Supp. 993 (S.D. Tex. 1981).

³²*Wilder Enter., Inc. v. Allied Artists Pictures Corp.*, 632 F.2d 1135 (4th Cir. 1980). *See also* Ernest W. Hahn, Inc. v. Coddling, 615 F.2d 830 (9th Cir. 1980), *on remand* 501 F. Supp. 155 (E.D. Pa. 1981); Sun Dun, Inc. of Wash. v. Coca-Cola Co., 740 F. Supp. 381 (D. Md. 1990).

³³*FTC v. Sun Oil Co.*, 371 U.S. 505 (1963). *See also* *FTC v. Anheuser-Busch, Inc.*, 363 U.S. 536 (1960), *on remand* 289 F.2d 835 (7th Cir. 1961) (providing that the Clayton Act, which serves to forbid price discriminations where the effect may be to substantially lessen competition or tend to create a monopoly in any line of commerce, was originally enacted to curb use by financially powerful corporations of localized price-cutting tactics that impaired competitive position of other sellers). *See generally* 15 U.S.C. §§ 12-27 (1994). Section 13 of the Act provides in pertinent follows: "It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality. . . ." § 13(a). In addition, § 13(f) provides: "It shall be unlawful for any person engaged in commerce, in the course of such commerce, knowingly to induce or receive a discrimination in price which is prohibited by this section." § 13(f).

³⁴*FTC v. Henry Broch & Co.*, 363 U.S. 166, *reh'g denied* 364 U.S. 854 (1960). *See also* *Grand Union Co. v. FTC*, 300 F.2d 92 (2d Cir. 1962).

those injured by parties who violate it.³⁵ Essentially, this legislation was enacted to curb and prohibit all devices through which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power.³⁶

While not identical to the Sherman Act, the tests for illegality under these two Acts are complementary.³⁷ The principle distinction between the two is that the Sherman Act makes illegal monopolies and agreements in restraint of trade that have already manifested themselves fully, while the Clayton Act serves to strike down discriminatory and anti-competitive practices at their incipiency, before they have had the opportunity to reach the dimensions of Sherman Act violations.³⁸

In 1936, the Clayton Act was significantly altered by the Robinson-Patman Act.³⁹ The Robinson-Patman is generally thought to be a response to perceived increases in market power and coercive practices by large purchasers or buying groups over their smaller independent competitors.⁴⁰ The primary purpose of the Act seems to be to protect independent business persons by eliminating the competitive advantages of larger market entities that result from their superior purchasing power.⁴¹ Unlike actions under the Sherman Act, in which it need only be demonstrated that the transactions complained of have affected interstate commerce, to successfully bring a claim under the Robinson-Patman Act, it is necessary to allege and prove that the actions in restraint of trade complained of are actually in interstate commerce.⁴²

Although on its face the Robinson-Patman Act might appear to be the ideal mechanism through which independent physicians might be able to combat the market dominance and competitive advantages of HMOs and insurance companies, to date, it has not been an effective means to achieve that end.

Finally, the Federal Trade Commission Act serves as a catch-all enactment for antitrust regulation. It empowers the FTC to enforce the antitrust laws embodied in the aforementioned Acts and, essentially, fills the gaps left open by the seemingly

³⁵See *Henry Broch & Co.*, 363 U.S. 166.

³⁶*Id.*

³⁷See *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963) (providing that §§ 1-7 and 12-27 of this title do not embody inconsistent policy approaches and are not unrelated to each other, but tests of illegality under such sections are complementary).

³⁸See *United States v. General Dynamics Corp.*, 258 F. Supp. 36 (S.D.N.Y. 1966); see also *United States Besser Mfg. Co.*, 96 F. Supp. 304 (S.D. Mich. 1951), *aff'd* 343 U.S. 444 (1952) (maintaining that §§ 12-27 of this title aim to strike down a monopoly at its inception, when the first step is taken, and §§ 1-7 of this title aim to strike down a monopoly after it has become more virile).

³⁹See *FTC v. Fred Meyer, Inc.*, 390 U.S. 341 (1968); *Nat'l Dairy Prod. Corp. v. FTC*, 395 F.2d 517 (7th Cir.), *cert. denied* 393 U.S. 977 (1968); *Lago & Sons Dairy, Inc. v. H.P. Hood, Inc.*, 892 F. Supp. 325 (D.N.H. 1995), *reconsideration granted* 937 F. Supp. 107 (1996).

⁴⁰*Yeager's Fuel, Inc. v. Pa. Power & Light Co.*, 953 F. Supp. 617 (E.D. Pa. 1997).

⁴¹See *FTC v. Simplicity Pattern Co., Inc.*, 360 U.S. 55, *reh'g denied* 361 U.S. 855 (1959) (holding that the Robinson-Patman Act was enacted to eliminate inequities resulting from competitive advantages obtained by large purchasers from special services or facilities).

⁴²See *Lewis v. Shell Oil Co.*, 50 F. Supp. 547 (N.D. Ill. 1943); *Sears, Roebuck & Co. v. Blade*, 110 F. Supp. 96 (S.D. Cal. 1953), *appeal dismissed sub nom. Sears, Roebuck & Co. v. Metro. Engravers, Ltd.*, 245 F.2d 67 (9th Cir. 1956).

more explicit regulatory statutes described above.⁴³ The Act also makes it unlawful to engage in unfair methods of competition or deceptive practices in or affecting commerce.⁴⁴ Much like all of the aforementioned antitrust legislation, the Act seems to be directed primarily toward combating the evils thought to be associated with conspiracies in restraint of trade and monopolization.

B. Enforcement of Antitrust Laws

The federal antitrust laws are primarily enforced by the FTC and the antitrust division of the DOJ, though private parties can also bring actions under those provisions.⁴⁵ In applying these laws to the facts of a particular case, the actions of the entity in question are either determined to be per se violations or are analyzed under what is referred to as the "rule of reason."⁴⁶ Agreements among competitors that clearly serve to fix prices or allocate markets are generally deemed to be per se illegal.⁴⁷ This per se rule is enforced uniformly across all forms of industry⁴⁸ and is not rendered inapplicable simply because the alleged justification for the agreement in question is to promote competition.⁴⁹ Similarly, economic justifications for the fixing of prices or arguments that the established prices are reasonable, or even beneficial to consumers, will not serve to protect a given party from liability.⁵⁰ One might be surprised to learn that the per se rule has even served to invalidate price-

⁴³15 U.S.C. §§ 41-58 (1994). Section 41 of the this Act provides in pertinent part as follows: "A commission is created and established, to be known as the Federal Trade Commission. . . ." § 41.

⁴⁴§ 45(a)(1). See also Antitrust Hearings, *supra* note 19, at 66 (prepared statement of James C. Egan, Jr.).

⁴⁵See generally 15 U.S.C. §§ 1-7, 12-27, 41-58 (1994).

⁴⁶See generally ROBERT KLEIN, DEP'T OF JUSTICE AND FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

⁴⁷See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 213 (1940) (holding that any combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se under the Sherman Act); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980).

⁴⁸*Socony-Vacuum Oil Co.*, 310 U.S. at 222. See also *Ariz. v. Maricopa County Med'l Soc'y*, 643 F.2d 563, 564 (9th Cir. 1982) (expressing that there is nothing in the nature of the medical profession or the health care industry in general that would warrant their exemption from per se rules for price fixing); *Goldfarb v. Va. State Bar*, 421 U.S. 773, 778 (1975); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 696.

⁴⁹*Maricopa County Med. Soc'y*, 457 U.S. 332.

⁵⁰See *United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290 (1897); *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1890), *aff'd*, 175 U.S. 211 (1898); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 689 (rejecting the argument that competitors may lawfully agree to sell their goods at an established price so long as the agreed-upon price is reasonable); *Catalano, Inc.*, 446 U.S. at 647; *Socony-Vacuum Oil Co.*, 310 U.S. 150, at 226 (maintaining that all price-fixing agreements are banned, regardless of their justification, because of their actual or potential threat to the central nervous system of the economy).

fixing agreements that established the maximum fees to be charged for particular services.⁵¹

The per se rule has also been employed to invalidate agreements made between groups of physicians.⁵² A noteworthy example of this is *Arizona v. Maricopa County Medical Society*, a case involving alleged price-fixing agreements that was reviewed by the United States Supreme Court.⁵³ In *Maricopa County*, the member doctors of the Maricopa County Medical Society in Arizona made an agreement through which they established the maximum fees that could be charged for specific health services rendered to policy holders of specified insurance plans.⁵⁴ The Court found that this agreement violated the per se rule because it constituted a price restraint that provided for the same economic rewards for all practitioners, regardless of their relative skill, experience, training, or willingness to engage in novel medical procedures.⁵⁵ It also speculated that this type of agreement could serve to discourage entry of competitors into the market and might deter experimentation and new developments within the industry.⁵⁶ This case demonstrates the real potential that agreements made between physicians concerning the fees to be charged for particular services rendered will be found violative of the antitrust laws.

Currently, most alleged agreements in restraint of trade seem to be analyzed under the rule of reason. Under this approach, it is possible for some agreements which actually do result in limited restraint of trade to still be found to be valid, even though they might justifiably be classified as per se violations of the antitrust laws.⁵⁷ In analyzing a particular agreement, the court first attempts to determine whether the formation and operation of the joint venture or network in question has a substantial anti-competitive effect.⁵⁸ If it is found to have such an effect, that potential impact is then weighed against any pro-competitive efficiencies which might result therefrom.⁵⁹ Legality, therefore, rests to a great extent upon whether the restraint imposed is such that it merely regulates and perhaps thereby promotes competition, or whether it serves to suppress or even destroy competition.

In making such a determination, the court ordinarily considers numerous factors. Among those factors most often reviewed are: the specific facts peculiar to the business in question, the condition of the relevant market before the alleged restraint was introduced, and the nature of the restraint in question and its actual or probable effect on the market.⁶⁰ Agreements, or express or implied contracts, that are found to

⁵¹*Trans-Missouri Freight Ass'n*, 166 U.S. at 345. See also *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968).

⁵²See, e.g., *Maricopa County Med. Soc'y*, 457 U.S. 332.

⁵³*Id.*

⁵⁴*Id.* at 335.

⁵⁵*Id.* at 348.

⁵⁶*Id.*

⁵⁷See *United States v. Joint Traffic Ass'n*, 171 U.S. 505 (1898).

⁵⁸See KLEIN, *supra* note 46, at 66.

⁵⁹*Id.*

⁶⁰*Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918).

be likely to produce significant efficiencies that benefit consumers and any pricing agreements determined to be reasonably necessary to realize those efficiencies, will most likely be found to be legal under the rule of reason.⁶¹ The key for physicians, therefore, is to persuasively demonstrate that their particular agreements or networks actually serve to create a benefit to the consumer that outweighs the detriment resulting from any restraint of competition.⁶² Therein lies another substantial obstacle to physician unionization.

C. Limited Labor Exemption

While the federal antitrust laws generally serve to prohibit agreements that are in restraint of trade, a limited exception has been established that enables employees to organize for contract bargaining purposes in a manner that would technically violate such laws. This was principally achieved through the enactment of the National Labor Relations Act [hereinafter "NLRA"] in 1935.⁶³ This legislation was enacted in response to the perceived inequality of bargaining power between employees and their employers.⁶⁴ It sought to level the playing field by conferring certain affirmative rights on employees and by placing certain enumerated restrictions on the activities of employers.⁶⁵

The fundamental purpose of the NLRA has been described as to promote industrial peace and stability by encouraging the practice and procedure of collective bargaining.⁶⁶ The manifest objective to be obtained through collective bargaining⁶⁷

⁶¹*Id.*

⁶²KLEIN, *supra* note 46, at 64.

⁶³29 U.S.C. §§ 151-169 (1994). The Act serves to create the National Labor Relations Board and empowers it to: "prevent any person from engaging in any unfair labor practice affecting consumers." § 160.

⁶⁴*See* *Fafnir Bearing Co. v. NLRB*, 362 F.2d 716 (2d Cir. 1966) (holding that this subchapter was designed to overcome the inequality of bargaining power between employees and employers).

⁶⁵*See* *Am. Ship Bldg. Co. v. NLRB*, 380 U.S. 300 (1965).

⁶⁶*See* *Carey v. Westinghouse Elec. Corp.*, 375 U.S. 261 (1964); *Bloom v. NLRB*, 603 F.2d 1015 (5th Cir. 1979) (maintaining that the intent of the Act is to minimize industrial strife and to promote industrial stability through collective bargaining); *NLRB v. Laney & Duke Storage Warehouse Co.*, 424 F.2d 109 (5th Cir. 1970) (stating that the purpose of this subchapter is to promote settlement of labor disputes through collective bargaining); *NLRB v. Air Control Prods. of St. Petersburg, Inc.*, 335 F.2d 245 (5th Cir. 1964) (maintaining that this subchapter is designed to facilitate industrial peace through encouraging collective bargaining); *NLRB v. Pincus Bros., Inc.-Maxwell*, 620 F.2d 367 (3d Cir. 1980) (finding that the fundamental policy of this subchapter is to encourage collective bargaining and the industrial stability flowing therefrom); *Int'l Bd. of Elec. Workers, AFL-CIO v. NLRB*, 487 F.2d 1143 (D.C. Cir. 1973); *Mobil Oil Corp. v. NLRB*, 482 F.2d 842 (7th Cir. 1973).

⁶⁷Collective bargaining is defined by the Act as:

the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment, or the negotiation of an agreement, or any question arising thereunder, and the execution of a written contract incorporating any agreement reached if requested by either party.

is the formation of binding contracts between employees and labor organizations.⁶⁸ To facilitate this collective bargaining, the NLRA allows for employees to unite and to select a union, by majority vote, that will serve as their bargaining representative.⁶⁹ However, by safeguarding the right of employees to engage in concerted activities for the purpose of collective bargaining, Congress did not intend to weaken the underlying contractual bonds and loyalties between employers and employees.⁷⁰ On the contrary, the underlying purpose of the Act is to strengthen, rather than weaken, the cooperation and functional relationship between the employer and the employed.⁷¹ In reviewing the purpose of the NLRA, the United States Supreme Court has stated that,

[this subchapter] is aimed at encouraging the practice and procedure of collective bargaining and at protecting the exercise by workers of full freedom of association, of self-organization, and of negotiating the terms and conditions of their employment or other mutual aid or protection through their freely chosen representatives.⁷²

Section 157 of the NLRA specifically defines the right of employees to organize and bargain collectively, stating in pertinent part:

Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all of such activities except to the extent that such right may be affected by an agreement requiring membership in a labor organization as a condition of employment as authorized in section 158(a)(3) of this title.⁷³

29 U.S.C. § 158 (1994).

⁶⁸NLRB v. Sands Mfg. Co., 306 U.S. 332 (1939). *See also* NLRB v. Scullin Steel Co., 161 F.2d 143 (8th Cir. 1947); NLRB v. Montgomery Ward & Co., 133 F.2d 676 (9th Cir. 1943); Consol. Edison Co. of N.Y. v. NLRB, 305 U.S. 197 (1938). *See also* H.K. Porter Co. v. NLRB, 397 U.S. 99 (1970) (stating that one of the fundamental policies of the NLRA is freedom of contract).

⁶⁹Cox v. C.H. Masland & Sons, Inc., 607 F.2d 138 (1979). *See also* NLRB v. Milk Drivers and Dairy Employees, Local 338, 531 F.2d 1162 (2d Cir. 1976) (maintaining that this subchapter was designed to permit workers to freely exercise the right to join unions, to be active or passive members, or to abstain from joining any union at all without imperiling their right to a livelihood).

⁷⁰NLRB v. Knuth Bros., Inc., 537 F.2d 950 (7th Cir. 1976).

⁷¹*Id.*

⁷²NLRB v. Newark Morning Ledger Co., 120 F.2d 262, *cert. denied* 314 U.S. 693 (1941). *See also* S.S. Pennock Co. v. Ferretti, 201 Misc. 563 (N.Y. 1951), *rev'd* 128 N.Y.S.2d 749 (1954), 283 A.D. 527 (1954), *motion dismissed* 286 A.D. 964 (1955) (arising in New York in which the purpose of this subchapter was identified as to encourage the practice and procedure of collective bargaining, and to protect the exercise by employees of full freedom of association, organization and designation of representatives of their own choosing).

⁷³29 U.S.C. § 157 (1994).

This statute was essentially meant to level the playing field within the labor market by granting employees whatever advantage they would get from collective pressure upon their employer.⁷⁴ It was hoped that the Act would serve to eliminate the ability of employers to use brute force to dominate labor disputes.⁷⁵

In light of the underlying philosophy of the NLRA and its express purpose of facilitating collective bargaining, one might logically assume that the Act would serve to insulate independent physicians from antitrust liability when they attempt to unite for the purposes of collective bargaining. However, the myriad of instances arising throughout the United States in which this issue has been addressed seem to demonstrate that this is simply not the case. The principle obstacle for physicians has been their inability to be classified as an appropriate bargaining unit by the National Labor Relations Board [hereinafter "Board" or "NLRB"], and thus afforded protection under the NLRA.

Under the NLRA, once a specific group has been certified by the Board as an appropriate bargaining unit, the group's employer becomes obligated to negotiate with unit representatives in good faith.⁷⁶ These bargaining units are referred to in the statutory language as "labor organizations."⁷⁷ In establishing the appropriateness of such a unit, the Board seems to focus primarily upon whether or not the employees of the unit can establish a discernable "community-of-interests."⁷⁸ This "community-of-interests" can be demonstrated by similarities amongst members of the group in regards to such things as the extent of interaction with other employees, wages, working hours, and the extent of common supervision.⁷⁹ Although the language of the Act and relevant case law has helped to identify the characteristics of bargaining groups required by the Board for certification as an appropriate bargaining unit, analysis must still be made on a case-by-case-basis.

⁷⁴Art Metals Constr. Co. v. NLRB, 110 F.2d 148 (2d Cir. 1940).

⁷⁵NLRB v. Del.-N.J. Ferry Co., 90 F.2d 520 (3d Cir.), cert. denied 302 U.S. 738 (1937).

⁷⁶See 29 U.S.C. § 158 (1994); see also NLRB v. Westinghouse Air Brake Co., 120 F.2d 1004 (3d Cir. 1941) (providing that this subchapter manifests intent that employer bargain collectively in respect to rates of pay, wages, hours of employment, or other conditions of employment, and "good faith" essential to the bargaining function is rendered impossible where employer has foreclosed in advance any possibility of agreement); E.I. Du Pont De Nemours & Co. v. NLRB, 116 F.2d 388 (4th Cir. 1940), cert. denied 313 U.S. 571 (1941) (finding that the Act's fundamental purpose is fulfilled when it is established that the employer acted in genuine good faith).

⁷⁷See 29 U.S.C. § 152(5) (1994) ("The term 'labor organization' means any organization of any kind, or any agency or employee representation committee or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work.").

⁷⁸John Robert Shelton, *NLRB Guidelines for Determining Health Care Indus. Bargaining Units: Judicial Acceptance or Back to the Drawing Board*, 78 KY. L.J. 143, 150 (1990). See also Leigh Anne Flavin, *The Thomas-Davis Cases: The Appropriateness of Physicians as Bargaining Units and the Possible Implications for Insurance Companies Under the National Labor Relations Act*, 30 ARIZ. ST. L.J. 811 (1998).

⁷⁹*Id.* See also *Allegheny Gen. Hosp.*, 239 NLRB 872, 873 (1978); Shelton, *supra* note 78, at 150-51.

In 1989, the NLRB greatly clarified this issue by exercising its substantial rule-making authority and actually listed the types of bargaining units within the health care industry that it deemed to be appropriate.⁸⁰ The validity of this rule, and the Board's authority to create it, have been upheld by the United States Supreme Court.⁸¹ While physicians are listed among the eight enumerated combinations of appropriate bargaining units under this rule, groups of independent practitioners are not necessarily protected.

To be insulated from antitrust liability by the NLRA, independent physicians must be classified as members of the class intended to be protected by the Act, specifically that of the employee.⁸² This protected class has been described as working men in crafts and unskilled labor.⁸³ It was hoped that the enactment of this legislation would enable employees to bargain collectively, so that they might be able to attain adequate wages for services rendered, fair working conditions, and job security.⁸⁴

The express language of the NLRA confirms that it was designed primarily to protect "employees" and "professional employees."⁸⁵ It also specifically excludes

⁸⁰See 29 C.F.R. § 103.30 (1998). Section 103.30 provides in pertinent part as follows: Except in extraordinary circumstances and in circumstances where there are existing non-conforming units, the following shall be the appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may be appropriate:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. Provided that a unit of five or fewer employees shall constitute an extraordinary circumstance.

(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.

Id. (emphasis added)

⁸¹See *Evans v. Am. Fed'n of Television and Radio Artists*, 354 F. Supp. 823, 847 (S.D.N.Y. 1973), *rev'd on other grounds* 496 F.2d 305 (2d Cir. 1974), *cert. denied* 419 U.S. 1093 (1974), *reh'g denied* 420 U.S. 956 (1975).

⁸²*Id.*

⁸³*Id.*

⁸⁴*Id.*

⁸⁵See 29 U.S.C. § 152 (1994). Section 152(3) provides:

The term "employee" shall include any employee, and shall not be limited to the employees of a particular employer, unless this subchapter explicitly states otherwise, and shall include any individual whose work has ceased as a consequence of, or in connection with, any current labor dispute or because of any unfair labor practice, and who has not obtained any other regular and substantially equivalent employment, but shall not include any individual employed as an agricultural laborer, or in the domestic

several enumerated classes of individuals, including independent contractors and supervisors.⁸⁶ Unfortunately for private practitioners, the nature of their profession is such that they are often classified as either independent contractors or supervisors.⁸⁷ As a result, they are often not included within the protected class of the “employee.”⁸⁸

Although independently practicing physicians have traditionally been classified as independent contractors, such a determination is not automatic.⁸⁹ Case law in this area demonstrates that physicians can, in some instances, be deemed to be employees, warranting of antitrust protection.⁹⁰ The Board, as well as reviewing courts, consider a variety of factors in determining whether an individual should be classified as an employee or an independent contractor, including common law agency principles and the decision-making authority and relative autonomy of the individual in question.⁹¹ As such, employee status must be determined on a case-by-case basis.

While the employee requirement of the NLRA has proved to be a prohibitive barrier for most physicians seeking to unite for collective bargaining purposes, proponents of physicians unions have attempted to challenge the traditional classification of physicians as independent contractors.⁹² For example, in 1998, representatives of the United Food and Commercial Workers Union successfully convinced the Board to reconsider the employment status of several hundred

service of any family or person at his home, or any individual employed by his parent or spouse, or *any individual having the status of an independent contractor, or any individual employed as a supervisor*, or any individual employed by an employer subject to the Railway Labor Act [§ 45 U.S.C. 151 *et seq.*], as amended from time to time, or by any other person who is not an employer as herein defined.

§ 152(3) (emphasis added). Section 152(12) provides:

The term “professional employee” means—

- (a) any employee engaged in work (i) predominantly intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work;
- (ii) involving the consistent exercise of discretion and judgment in its performance;
- (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental, manual, or physical processes.

§ 152(12)(a).

⁸⁶See generally, *Vizciano v. Microsoft Corp.*, 97 F.3d 1187 (9th Cir. 1996).

⁸⁷See Shelton, *supra* note 78.

⁸⁸*Id.*

⁸⁹*Id.* (finding that freelancing professionals who though they were independent contractors were actually employees).

⁹⁰See Flavin, *supra* note 78, at 828.

⁹¹*Id.*

⁹²*Id.*

independent physicians in New Jersey.⁹³ The Board Chairman ordered a full hearing to determine the employee or independent contractor status of the physicians, stressing that every aspect of the relationship between the alleged employee and the alleged employer should be considered.⁹⁴ The Board looked beyond the mere contractual relationship between the parties and seemed to place significant emphasis upon the amount of control exercised over access to patients.⁹⁵ The rationale employed by the Board in this case seems to suggest that the barrier to collective bargaining by independent physicians, embodied in the employee requirement of the NLRA, might be beginning to deteriorate.

The NLRA, as it was originally enacted, did not exclude supervisors⁹⁶ from the class of individuals potentially deserving of protection under the Act.⁹⁷ Accordingly, the Board initially allowed for supervisors to be counted in the class of employees.⁹⁸ However, the Board soon developed a realization of the substantial differences between the interests, roles, and duties of supervisors and those of employees.⁹⁹ In 1947, Congress amended the Act to expressly exclude “supervisors” from its protection.¹⁰⁰ As such, even those physicians who manage to escape classification as an independent contractor, could be, and quite often are, determined to be “supervisors” for purposes of the NLRA, and therefore barred from its antitrust protection.

III. WHAT SHOULD BE DONE?

It should be clear from the analysis of the federal antitrust laws above, that the cards are substantially stacked against independently practicing physicians who wish to unite to collectively bargain with insurance providers and managed care organizations. Our emphasis must now turn to what must be done to remedy this situation without running afoul of the antitrust laws.

Several options seem to present themselves. Doctors could simply resign to being labeled as independent contractors or supervisors and continue to be bullied by

⁹³*Id.*

⁹⁴See *NLRB: Divided NLRB Orders Full Hearing on UFCW Petition for HMO Physicians*, 174 Daily Lab. Rep. (BNA), Sept. 9, 1998.

⁹⁵See *id.*; see also *AmeriHealth Inc.*, 362 NLRB No. 55 (1998).

⁹⁶The term “supervisor” as defined by the NLRA includes: “. . . any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.” 29 U.S.C. § 152(11) (1994).

⁹⁷See Christopher J. Lawhorn, *NLRB v. Health Care & Retirement Corp.: One Less Hurdle to Finding “Supervisor” Status*, 39 ST. LOUIS U. L.J. 619 (1995).

⁹⁸See *In re Codchaux Sugars*, 44 NLRB 874 (1942); *In re Unio Colliers Coal Co.*, 41 NLRB 961 (1942).

⁹⁹See *In re Colonial Press*, 50 NLRB 823 (1943); *In re Maryland Drydock Co.*, 49 NLRB 733 (1943).

¹⁰⁰29 U.S.C. § 152(3) (1994).

insurance companies and HMOs. They might alternatively pray for Big Brother to step in and establish a national health care system fully regulated by the federal government. However, neither of these options seem very desirable.

Instead, physicians could adopt a more proactive approach. One possible option would be to attempt to structure their bargaining alliances in such a way that they comport to the limited latitude afforded by the antitrust laws and the enforcement policy of the FTC and DOJ. Alternatively, relief for physicians might be provided through the enactment of new legislation, either at the state or federal level, which expressly provides for antitrust exemptions for groups of independently practicing physicians. Among three viable options, the interests of all affected parties would best be served through the enactment of federal legislation, as the federal preemption over state law will prove to establish relative uniformity of enforcement throughout the country.

A. Viable Option 1: Attempt to Comply With Current Antitrust Laws

Simple solutions quite often turn out to be the best ones. Accordingly, a very logical and reasonable means through which physicians might legally improve their bargaining positions would be to simply design their particular bargaining alliances in accordance with the limited leeway allotted by the antitrust laws and their primary enforcers. Considerable guidance for such efforts can be found in the Statement of Antitrust Enforcement Policy issued by the DOJ and FTC in August of 1996.¹⁰¹

The 1996 Policy Statement specifically addresses physician organizations, referred to therein as “physician network joint ventures,” and identifies the characteristics of the types of groups with which the DOJ and FTC will likely not interfere.¹⁰² The statement provides that, in the absence of extraordinary circumstances, neither agency will interfere with exclusive physician network joint ventures¹⁰³ whose physician participants share substantial financial risk, and comprise no more than twenty percent of the physicians within each specialty having active staff privileges and practicing within a given geographic market.¹⁰⁴ Similarly, in the absence of extraordinary circumstances, both agencies will refrain from challenging non-exclusive physician network joint ventures¹⁰⁵ where the physician participants share substantial financial risk and constitute no more than thirty percent of the physicians from each specialty with active staff privileges practicing within a given geographic market.¹⁰⁶ These types of physicians groups are described by the agencies as functioning within antitrust “safety zones.”¹⁰⁷

The Policy Statement justifies the risk-sharing requirement common to both of the aforementioned antitrust “safety zones” by maintaining that such a requirement provides physicians with an incentive to cooperate in controlling costs and

¹⁰¹KLEIN, *supra* note 46.

¹⁰²*Id.*

¹⁰³*Id.*

¹⁰⁴*Id.*

¹⁰⁵*Id.*

¹⁰⁶KLEIN, *supra* note 46.

¹⁰⁷*Id.*

improving the quality of care that they provide.¹⁰⁸ These “safety zones” are not absolute, however, and physician groups that do not conform perfectly to their basic requirements might yet be found to be unlawful.¹⁰⁹ Physicians intending to form these types of organizations can actually obtain advisory opinions from the FTC, or business reviews from the DOJ, prior to establishing their proposed union, by submitting specified information to those agencies.¹¹⁰ As such, not only do physicians have the agencies’ Policy Statement to serve as a guide, but they also have the option of submitting proposals to the agencies in advance so that they might be able to rectify any potential problems prior to any legal proceeding.

The most recent case law dealing with this issue demonstrates that the two most readily available means through which physicians groups can engage in some degree of collaborative negotiating without violating the antitrust laws are either to obtain approval from the DOJ to operate a “Qualified Managed Care Plan” [hereinafter “QMPC”] or to adopt what is referred to as a “messenger model” approach.¹¹¹ To receive approval to operate as a QMPC, a physicians group must essentially comply with the DOJ Policy Statement discussed above.¹¹² While there seems to be some variance in the particular requirements from case to case, the essential characteristics of acceptable physicians groups include the sharing of substantial risk by the member physicians and comprising a small proportion of the relevant market, typically no more than thirty percent.

The term “messenger model” refers to a means through which groups of independent physicians can jointly market their services to managed care providers.¹¹³ This approach basically involves employing a third party to act as a sort of go-between, facilitating the exchange of information between individual physicians and those who purchase their services.¹¹⁴ This approach does not, however, allow for collective negotiations or any other collusive behavior of that sort.¹¹⁵ It simply provides a means through which managed care providers can gain access, through the third party “messenger,” to the fees which individual doctors are willing to accept for the performance of a particular service, without having to deal directly with each individual physician.¹¹⁶ The third party serves to benefit the

¹⁰⁸*Id.*

¹⁰⁹*Id.*

¹¹⁰*Id.*

¹¹¹KLEIN, *supra* note 46.

¹¹²*Id.*

¹¹³*Id.*

¹¹⁴*See generally* Dep’t of Justice Notice *in re* United States v. Woman’s Hosp. Found., 61 Fed. Reg. 43380-02 (Aug. 22, 1996); Dep’t of Justice Notice *in re* United States v. Health Care Partners, Inc., 60 Fed.Reg. 52014-01 (Oct. 4, 1995); Dep’t of Justice Notice *in re* United States v. Health Choice of Mo., Inc., 60 Fed. Reg. 51808-02 (Oct. 3, 1995) [hereinafter, collectively “Dep’t of Justice Notices”].

¹¹⁵*See* Dep’t of Justice Notices, *supra* note 114.

¹¹⁶*Id.*

physicians, in turn, by marketing their services and accepting offers from MCPs on their behalf that fall within a predetermined range of acceptable fees.¹¹⁷

While designing physicians organizations in accordance with the leeway allotted by the antitrust laws is a viable option, legislative intervention would be preferable. The guidance provided by the language of the antitrust statutes, relevant case law, and the Policy Statement of the DOJ and FTC, while helpful, is not clear or definite enough for physicians to be able to decipher and rely upon when creating collective bargaining units. There is still room in the law for subjective interpretation and analysis of factual considerations, both of which tend to lead to litigation. The enactment of a clear and definitive statutory provision, on the other hand, would greatly simplify this area of the law, providing physicians with the requisite guidance to establish legal bargaining groups and potentially reducing the amount of litigation in this area.

B. Viable Option 2: Let the Individual States Handle the Problem

It is arguable that the evils currently inherent to the health care industry could best be remedied through state action, rather than through federal intervention. Many state legislatures have already taken the initiative and begun to propose, and in some cases to enact, new legislation geared toward bridging the gap among physicians and managed care providers and insurance companies.¹¹⁸ Such efforts are undoubtedly motivated in no small part by the lobbying efforts of local medical associations.

Texas has recently adopted legislation that enables individual physicians to join to negotiate with managed care providers under the supervision of the State.¹¹⁹ On June 20, 1999, Texas Governor George W. Bush signed Senate Bill 1468, often referred to as the "Physician Negotiation Bill," stating that it would serve to level the playing field between independent physicians and managed care organizations when it comes to determining the quality of care for patients.¹²⁰ Proponents of this Bill

¹¹⁷*Id.*

¹¹⁸*See generally* TIM MAGLIONE, MEMORANDUM TO OSMA COUNCIL: TEXAS "STATE ACTION" LEGISLATION (1999).

¹¹⁹*Id.*

¹²⁰1999 *Legislative Compendium: Market Fairness/Managed Care Reform*, at <<http://www.texmed.org>> [hereinafter "1999 *Legislative Compendium*"]. TEX. INS. CODE ANN. § 29.01 provides as follows:

The legislature finds that joint negotiation by competing physicians of certain terms and conditions of contracts with health plans will result in pro-competitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians. Although the legislature finds that joint negotiations over fee-related terms may in some circumstances yield anticompetitive effects, it also recognizes that there are instances in which health plans dominate the market to such a degree that fair negotiations between physicians and the plan are unobtainable absent any joint action on behalf of physicians. In these instances, health plans have the ability to virtually dictate the terms of the contracts they offer physicians. Consequently, the legislature finds it appropriate and necessary to authorize joint negotiations on fee-related and other issues where it determines that such imbalances exist.

§ 29.01.

maintain that it will allow physicians to better protect their own rights, as well as those of their patients.¹²¹ Since this new legislation was only recently enacted, no significant conclusions can yet be made concerning its effects upon the health care community within that state or the quality of care received by its citizens. However, it is likely that this novel legislation will have a considerable impact upon not only Texas, but upon other states that might now attempt to pursue similar legislation in hopes of restoring fairness health care.

This newly enacted statute is codified in Chapter 29 of the Texas Insurance Code, as “Joint Negotiations by Physicians with Health Benefit Plans.”¹²² It permits individual, competing physicians to collectively negotiate with managed care organizations so long as the group of physicians does not comprise more than ten percent of the physicians in the health plan’s service area or dominate a particular medical specialty.¹²³ The physicians are to designate a third party to represent their interests in the negotiations, during which time the health benefit plans maintain the right to make offers to, or even enter into contracts with other competing individual physicians.¹²⁴ However, before the negotiations can even commence, the parties must receive the approval of the state attorney general, who must review the request for joint negotiations to ensure that it is reasonable and that the likely benefits of such negotiations will not be outweighed by any harm caused by the reduction of competition.¹²⁵ Physicians are also somewhat limited as to with whom they are permitted to negotiate.¹²⁶ Public managed care plans, such as Medicaid, for example, are outside of the scope of parties subject to this statute.¹²⁷

Perhaps one of the most attractive aspects of this Texas statute is its inherent safeguards, which should prove to prevent physicians from abusing their newly granted power to jointly negotiate contract terms. Initially, the attorney general must determine that the health benefit plan with which the group of physicians intends to negotiate maintains substantial market power in a service area and has the capacity to adversely affect the quality and availability of patient care.¹²⁸ Further, physician groups are prohibited from negotiating certain contract terms, such as the fees or prices for services, the amount of any discounts to be granted on services rendered, and the dollar amount of capitation¹²⁹ or fixed payment for health services rendered

¹²¹See David Koenig, *Texas Takes the Lead on Doctor Bargaining*, HOUS. CHRON., June 22, 1999, at 1C.

¹²²See TEX. INS. CODE ANN. §§ 29.01-29.14 (West 1999).

¹²³§ 29.09; see also *1999 Legislative Compendium*, supra note 120.

¹²⁴TEX. INS. CODE ANN. § 29.07 (West 1999); see also *1999 Legislative Compendium*, supra note 120.

¹²⁵TEX. INS. CODE ANN. § 29.09 (West 1999); see also *1999 Legislative Compendium*, supra note 120.

¹²⁶TEX. INS. CODE ANN. § 29.03 (West 1999).

¹²⁷*Id.*

¹²⁸§ 29.06.

¹²⁹§ 29.05.

by physicians to health benefit plan enrollees.¹³⁰ Perhaps most importantly, this Texas statute expressly prohibits physicians from engaging in strikes, boycotts, or reductions in the provision of health care services.¹³¹ It thereby lays to rest what is perhaps the greatest fear of those who are against collective negotiating by physicians, namely that of hospitals being completely devoid of physicians when they or their loved ones are in need of medical treatment.

While the true merits of Texas's answer to the great imbalance of bargaining power between independent physicians and insurance companies or HMOs has yet to undergo the test of time, it seems on its face to be a reasonable and potentially effective solution. This statute enables physicians, who might traditionally be referred to as independent contractors, to unite to increase their bargaining power in contract negotiations.¹³² Yet, at the same time, it limits the percentage of physicians in a specialty who can legally unite to jointly negotiate with HMOs and expressly forbids walk-outs or strikes.¹³³ Thus, the statute seems to be a fairly effective compromise, enabling physicians to gain additional bargaining power and control over the treatment of their patients, while preventing them from amassing too much power or threatening accessibility to health care services.

While arguably preferable to a total lack of legislative action on any level, it seems apparent that the current evils inherent to the antitrust laws could more efficiently be combated through the enactment of federal legislation. While anti-competitive agreements and restraints of trade within the health care industry are likely to have their greatest impact on the local level, the federal antitrust laws are likely to be their principal sources of opposition. State laws in this area can essentially be viewed as supplementary, as they can impose greater restrictions upon state citizens but not grant immunity from liability under the federal laws.¹³⁴ For example, the requirements under the Texas statute are actually more restrictive than those provided in the Policy Statement of the FTC and DOJ. As such, logic dictates that any substantial changes in the antitrust laws, such as providing an exemption for independently practicing physicians, should properly be made at the federal level.

C. Viable Option 3: Amend the Federal Antitrust Laws

The most effective way to combat the imbalance of power within the health care industry would undoubtedly be to simply amend the current federal antitrust laws. Representative Tom Campbell from California has recently sponsored a Bill, commonly referred to as the "Quality Health-Care Coalition Act of 1999," [hereinafter "QHCCA"] intended to:

ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of health care

¹³⁰*Id.*

¹³¹§ 29.10 (providing in pertinent part: "[n]othing contained in this chapter shall be construed to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care services").

¹³²*See* §§ 29.01-29.14.

¹³³*Id.*

¹³⁴*Id.*

professionals and health plans and health insurance issuers in the same manner as such laws apply to collective bargaining by labor organizations under the National Labor Relations Act.¹³⁵

Essentially, this Bill, if enacted, would allow independent physicians who unite for contract negotiation purposes to be treated as employees, rather than as independent contractors, employers, managerial employees, or supervisors, thereby permitting them to evade antitrust liability.¹³⁶ This proposed exemption from federal antitrust law seems to be intended to allow physicians to match the bargaining power of HMOs in contract negotiations and to have a greater say in the proper course of treatment for their patients.¹³⁷ The bill, also referred to as H.R. 1304, was cosponsored by 137 members of Congress¹³⁸ and has already been presented to the House Judiciary Committee.¹³⁹

This legislation has been described as a response to the heavy handed negotiating tactics of health insurers, that already benefit from preferential treatment under the McCarran-Ferguson Act, which has come to characterize the American health care industry.¹⁴⁰ This imbalance of bargaining power leads to health care providers being forced to succumb to restrictive contractual terms, which are often proffered on a “take-it-or-leave-it” basis, under the threat of being removed from the health plan’s physician list or being denied access to its patients.¹⁴¹ Proponents of H.R. 1304 maintain that medical professionals should be permitted to unite to collectively bargain with insurers to obtain the best possible contract terms, allowing market

¹³⁵Suhail Khan, *Thamas*, at <<http://thomas.loc.gov/cgi-bin/query/D?c106:1:/temp?~c1065MELER>>.

¹³⁶*Id.* The Quality Health-Care Coalition Act of 1999 entitles any health care professional negotiating with a health plan regarding contract terms under which they provide health care items or services for which plan benefits are provided to the same treatment under antitrust laws as that accorded to a collective bargaining unit recognized under the National Labor Relations Act. Suhail Khan, *at Thamas*, <<http://thomas.loc.gov/cgi-bin/bdquery/z?d106:HR01304:@@D&summ2=m&>>.

¹³⁷*See* Suhail Khan, *Thamas*, at <<http://www.house.gov/campbell>>. The purpose of H.R. 1304 is to improve the health care industry by allowing medical professionals, such as doctors, pharmacists, and nurses, to collectively bargain in contract negotiations with HMO’s and other health care issuers. Suhail Khan, *Thamas*, at <<http://www.house.gov/campbell/leg.htm>>. In describing the desired effect of this legislation on the health care system, Congressman Campbell has stated, “(i)t is my strong belief that patients will be better served when fair and equitable contracts are negotiated by professionals, acting together, who are closest to the needs of their patients. First on the list of contractual terms that healthcare professionals will demand in these negotiations is a greater right to prescribe and care for patients as they see fit.” *Id.*

¹³⁸*See* Suhail Khan, *Thamas*, at <<http://thomas.loc.gov/cgi-bin/bdquery/z?d106:HR01304:@@P>> (providing a complete listing of the cosponsors of H.R. 1304).

¹³⁹Suhail Khan, *Thamas*, at <<http://thomas.loc.gov/cgi-bin/query>>.

¹⁴⁰Suhail Khan, *Thamas*, at <<http://www.house.gov/campbell/990325.htm>>.

¹⁴¹*Id.*

forces, rather than the federal government, to specify the parameters of the health care provider-insurer relationship.¹⁴²

In describing this proposed legislation, Congressman Campbell has stated:

this legislation is the best way to let the market deal with the complaints so many health care professionals have raised with HMOs. Health care professionals, including physicians, nurses, pharmacists, dentists and midwives, should be given the option to form their own professional associations and bargain with the HMOs in their service area. This will ensure that all health care professionals will be able to secure contracts of a fair and equitable nature, and the patients will be better served.¹⁴³

He maintains that allowing medical professionals, including physicians, pharmacists and nurses, to bargain together in contract negotiations with health care issuers such as HMOs, will serve to improve our nation's health care system by returning a greater right to control the course of treatment to the medical professionals who the needs of their patients.¹⁴⁴

While this proposed legislation has received substantial support, it has also been met by considerable opposition. Among those opposed to its enactment is the Antitrust Division of the DOJ, which has expressed its collective belief that its enactment would serve to harm consumers of health care in the long run.¹⁴⁵ In his statement concerning H.R. 1304 before the House Judiciary Committee, Joel Klein, Assistant Attorney General of the Antitrust Division of the DOJ, maintained that this legislation would serve to destroy the free-market competition that is essential to our nation's economic vitality and has yielded the benefits of innovation, increased choice, and the lessening of prices for services.¹⁴⁶ He also argued that the chief arguments of the supporters of this Bill are unfounded and inadequate to justify its enactment.¹⁴⁷ Specifically, he maintained that: the McCarran-Ferguson Act does not provide insurers with unfair market leverage or exempt their activities from antitrust scrutiny; the relative bargaining power of HMOs varies significantly across markets and does not stifle competition to the extent that Bill supporters maintain; and that the Bill provides no assurances that the collective bargaining efforts of health care professionals will yield a higher quality of care, rather than simply fattening their own pockets.¹⁴⁸

It seems that the position of the DOJ is that this proposed Bill would have a drastically adverse economic effect upon consumers. It maintains that medical

¹⁴²*Id.*

¹⁴³*Id.*

¹⁴⁴Suhail Khan, *Thomas*, at <<http://www.house.gov/campbell/leg.htm>>.

¹⁴⁵*The Quality Health-Care Coalition Act of 1999: Hearings on H.R. 1304 Before the House Judiciary Comm.*, 106th Cong. 1 (1999) (statement of Joel I. Klein).

¹⁴⁶*Id.* at 1.

¹⁴⁷*Id.* at 4.

¹⁴⁸*Id.* at 1 (referring to recently decided cases in which the DOJ and FTC challenged concerted actions by health care professionals, which the agencies determined would result in higher costs and diminished choices for health care consumers).

professionals will undoubtedly increase their fees significantly, should they be granted the ability to unite to jointly negotiate with insurers without regard to the antitrust laws.¹⁴⁹ It further speculates that this would produce a sort of snowball effect, driving up insurance prices, increasing costs for Medicare and Medicaid, and ultimately harming the consumer.¹⁵⁰ It also maintains that the resulting higher premiums will cause the percentage of citizens without insurance to greatly increase and lead many employers to either stop offering health insurance coverage to their employees or to decrease their benefits.¹⁵¹ The DOJ argument seems to be primarily financial, and dependent upon the warrantless assumption that health care professionals would use the increased bargaining power that the Bill would provide to substantially increase their incomes at the ultimate expense of their patients.

One of the most adamant supporters of H.R. 1304 is the American Medical Association [hereinafter "AMA"].¹⁵² In his statement before the House Judiciary Committee in support of this Bill, E. Ratcliffe Anderson, Jr., M.D., Executive V.P. and C.E.O. of the AMA, expressed that this legislation was critically necessary to rectify the myriad of problems currently inherent to the health care system in this country.¹⁵³ In particular, it was proposed that the current antitrust laws, coupled with the enforcement policy of the DOJ and FTC, are too restrictive on physicians, actually deterring them from engaging in pro-competitive behavior and unreasonably restraining their ability to stand up to health plans.¹⁵⁴ Dr. Anderson maintains that the enactment of this Bill would serve to restore the balance of power in health care contract negotiations in favor of adequate representation and appropriate treatment of patients.¹⁵⁵ In addition, he opined that the uniqueness of the health care industry, which is already substantially regulated by the government, justifies this limited modification of the antitrust laws reserved solely for that industry.¹⁵⁶

The crux of the AMA argument seems to be that it is actually the patients, or health care consumers, who would be the ultimate beneficiaries of the enactment of this Bill. It is proposed that the increased bargaining power that it would grant to physicians would enable them to resume greater control over the treatment administered to their patients.¹⁵⁷ Since treating physicians are naturally in a better position to determine which types of treatment are most appropriate for their patients, the quality of care which could be provided would be substantially improved.

¹⁴⁹*Id.* at 4 (stating DOJ investigations purportedly demonstrate that when health care professionals jointly negotiate with insurers they typically seek substantial increases in their fees, sometimes by as much as twenty to forty percent).

¹⁵⁰KLEIN, *supra* note 46, at 5.

¹⁵¹*Id.*

¹⁵²*The Quality Health-Care Coalition Act of 1999*, *supra* note 145 (statement of E. Ratcliffe Anderson, Jr., M.D., on behalf of the AMA).

¹⁵³*Id.*

¹⁵⁴*Id.* at 17.

¹⁵⁵*Id.* at 23.

¹⁵⁶*Id.*

¹⁵⁷*The Quality Health-Care Coalition Act of 1999*, *supra* note 145.

IV. CONCLUSION

Definitive action is needed to clarify the scope of antitrust liability as it applies to independently practicing physicians and to level the playing field between physicians and MCPs. Under the current antitrust laws, physicians are bullied by massive health care providers that dominate health care markets. They have lost affirmative control over the ultimate administration of care of their patients. While there may be no perfect solution to the imbalance of power that has come to characterize health care in America, the QHCCA is most attractive proposal to date. In any event, federal legislation must be enacted to amend the current antitrust laws to allow for limited scale unionization or collusion between independent practitioners to collectively negotiate contract terms with MCPs.

JOHN A. POWERS