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Bad Medicine: The Anti-Competitive Side-Effects of Physician Unionization

Thomas Segars
University of North Carolina at Chapel Hill

BAD MEDICINE: THE ANTICOMPETITIVE SIDE-EFFECTS OF PHYSICIAN UNIONIZATION

THOMAS HAMILTON SEGARS*

INTRODUCTION

This paper analyzes the recent trend toward physician unionization from an antitrust perspective. Section I chronicles significant developments in the physician unionization movement, and suggests underlying perceptions of the market as possible impetuses. Section II explores the relationship of antitrust law to unionization in general and to physician unionization more specifically. Section III examines House Bill 1304[1] as a model for physician unionization and criticizes various policy justifications of the bill. Section IV proposes physician network joint ventures and monopsony[2] regulation as two alternative antitrust strategies. Finally, the conclusion summarizes the various arguments against physician unionization.

I. THE RISE OF PHYSICIAN UNIONIZATION AND PERCEPTIONS OF AN UNLEVEL PLAYING FIELD

Although the phenomenon of physician unionization is by no means novel,[3] changes in the health care industry have rekindled interest in and debates over the legality, legitimacy, and consequences of this practice. Recent statistics indicate that about six percent of all U.S. physicians belong to a union.[4] In absolute numbers, this means

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1. H.R. 1304, 106th Cong. (1999). For more detailed discussion of H.R. 1304, see *infra* notes 70-86 and accompanying text.

2. A monopsony is a market situation in which one buyer exerts a disproportionate influence on the market. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 768, 822 (1983).

3. For a history of the physician unionization movement, see generally GRACE BUDRYS, WHEN DOCTORS JOIN UNIONS (1997).

4. *See* Ed Egger, *If Physician Unionization Trend Catches On, Hospitals Could Be Drastically Affected*, HEALTH CARE STRATEGIC MGMT., Sept. 1, 1999, at 10; *see also In the News: More Physicians Join Unions*, REHAB REP., Aug. 24, 1999 (predicting fifteen percent annual increases in physician union participation in the near future).

that between 45,000 and 50,000 of the 737,000 licensed physicians have signed a union card.[5] Furthermore, this number is steadily rising.[6]

This current trend toward physician unionization is most poignantly evidenced by the June 1999 reversal of the American Medical Association's (AMA's) long-standing position against unionization.[7] Despite a history of staunch union opposition,[8] on June 23, 1999, the AMA's Board of Trustees voted to establish its own union.[9] With the endorsement of an association as catholic and prestigious as the AMA, physician unionization has shed its image as an unorthodox practice[10] and emerged as a mainstream solution to perceived problems in the health care industry.

As this growing direction in health care has gained public attention, Congress has also taken notice. In 1998 and 1999, California Representative Thomas Campbell sponsored legislation that would immunize physician unionization from antitrust laws.[11] Specifically, House Bill 1304[12] proposes to exempt negotiations among health care professionals from antitrust law in the same way the collective bargaining of labor unions under the National Labor Relations Act (NLRA) is exempted.[13] Since the House Judiciary Committee recently approved the bill, its prospects of winning a vote on the House floor have grown.[14] Although similar success on the

5. *See* Tom Abate, *Doctors Examine Union Option: Physicians Are Beginning to Band Together—and HMOs Are Worried*, THE SAN FRANCISCO CHRON., Sept. 3, 1999, at C1; Elizabeth Neus, *Doctors Who Want to Unionize Face Legal, Logistical Obstacles*, GANNETT NEWS SERVICE, Oct. 1, 1999, *available at* 1999 WL 6975379.

6. *See* Egger, *supra* note 4, at 10.

7. *See AMA: Unprecedented Vote to Create Doctor's Union*, AM. HEALTH LINE, June 24, 1999, *available at* LEXIS, News Library, HLTLNE File [herinafter *AMA: Unprecedented Vote*]. Founded over 150 years ago, the AMA is an organization of nearly 300,000 physicians dedicated to the promotion of "the science and art of medicine and the betterment of public health." *AMA—Home* (visited Nov. 4, 1999) <http://www.ama-assn.org/about/purpose.htm>.

8. A self-proclaimed "voice and influential advocate for patients and physicians," the AMA historically opposed physician unionization, arguing that the economic agenda of a union would be detrimental to physicians' professional obligations to public welfare. *Id*; *see also* BUDRYS, *supra* note 3, at 87-88. Indeed, the AMA was so resolute in its antiunion position that in 1989 it solicited the Federal Trade Commission (FTC) to investigate the antitrust implications of one physician union's collective bargaining activity. *See id.* at 90.

9. *See AMA Backs Formation of Union*, MED. INDUSTRY TODAY, June 24, 1999, *available at* LEXIS, News Library, MEDTDY File. According to AMA Board of Trustees Chairman Dr. Randolph D. Smoak, Jr., the union will "give America's physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits." *Id.*

10. *See* BUDRYS, *supra* note 3, at 15-16.

11. *See* H.R. 1304, 106th Cong. (1999); H.R. 4277, 105th Cong. (1998).

12. H.R. 1304.

13. *See id.*

14. *See* 146 Cong. Rec. D292-01, 294 (Mar. 30, 2000). *Compare* Sarah A. Klein, *Physician*

Senate floor is unlikely,[15] a dramatic increase in congressional cosponsorship of the bill is a good indication that popularity for the bill is burgeoning.[16]

This recent wave of interest in unionization is fueled largely by changes in the way Americans receive their health care since the incipience of managed care organizations (MCOs).[17] MCOs are third-party payers that "attempt to achieve economic efficiencies by providing financial incentives for health care providers and implementing case control management and utilization review."[18] Before MCOs, patients received medical care paid for on a "fee-for-service" basis by employers or private insurers.[19] As such, third-party payers had little control over either the costs of care or the decisions regarding treatments.[20] To contain costs, however, MCOs implement highly regimented processes for determining the appropriate costs and courses of medical services.[21] This change in health care access and payment has also changed the way U.S. physicians do business, resulting in a sharp increase in the number of physician-MCO contracts.[22]

Antitrust Bill Pronounced Dead for Now, AM. MED. NEWS, Nov. 8, 1999, at 5; *Bill Number H.R. 1304 106th Cong. 1st Sess.*, LEXIS Congressional Bills Legislative Forecasts—Current Congress (1998) (projecting that H.R. 1304 has a sixteen percent and four percent chance of passing the House and Senate Committee level, respectively; and a fifteen percent and four percent chance of passing the House and Senate Floor, respectively), *with* Westlaw BILLCAST-106th Congress (Apr. 2000) (giving H.R. 1304 a ninety-four percent chance of passing a vote on the House floor).

15. *See* 146 Cong. Rec. D292-01, 294 (Mar. 30, 2000) (giving H.R. 1304 only a twenty-five percent chance of success should it reach the Senate floor).

16. While its 1998 predecessor could only accumulate the co-sponsorship of four representatives, H.R. 1304 has amassed a remarkably bipartisan cosponsorship of 212 representatives. *Compare Bill Summary & Status (H.R. 4277)* (visited Oct. 25, 1999) <http://thomas.loc.gov/>, *with Bill Tracking Report H.R. 1304*, 1999 LEXIS Bill Tracking H.R. 1304 (last updated Apr. 14, 2000) (listing the 122 Democrat and eighty-eight Republican cosponsors of H.R. 1304).

17. For the purposes of this Note, the term "managed care organization" refers to the many forms assumed by health care insurers, including HMOs, PPOs and other similar plans. *See, e.g.*, Ellen L. Luepke, *White Coat, Blue Collar: Physician Unionization and Managed Care*, 8 ANN. HEALTH L. 275, 276 n.5 (1999) (using "MCO" to refer generally to all types of managed care firms). Statistics indicate an increase in the presence of MCOs in recent years. For example, between 1976 and 1995, national MCO enrollment increased from 6 million to 51 million. *See* Mary Guptill Warren et al., *The Impact of Managed Care on Physicians*, HEALTH CARE MGMT. REV., Spring 1999, at 44 (citing GROUP HEALTH ASS'N OF AMERICA, NATIONAL DIRECTORY OF HMOS WASHINGTON, D.C.: GROUP HEALTH ASS'N OF AMERICA). During the same period, MCOs increased in number from 175 to 591 nationwide. *See id.*

18. Luepke, *supra* note 17, at 276.

19. *See id.* at 275

20. *See id.* at 275-76.

21. *See id.* at 276-77.

22. *See* Warren et al., *supra* note 17, at 44. ("[B]etween 1988 and 1993, the percentage of physicians with any managed care contracts increased from 61 percent to 75 percent."); *see also* Bruce H. Drukker, M.D., *Envelopes: Presidential Address*, 179 AM. J. OBSTETRICS &

Despite increasing enrollment statistics,[23] consumers generally are dissatisfied with services that MCOs provide and perceive a deterioration in the overall quality of health care. A recent Kaiser-Harvard survey indicates that many patients believe that MCOs have reduced the amount of time doctors spend with patients, made it harder for sick patients to see specialists, and lowered the quality of health care.[24] A 1997 Louis Harris & Associates poll also found that consumers rated MCOs next to last (above only tobacco companies) in customer service.[25]

With the influx of managed care, physicians also have become increasingly frustrated by the resulting lack of professional autonomy and perceived hindrance on the quality of care. One study indicates that, as MCO participation increases, "physicians are less likely to believe that third-party payers don't affect treatment, and more likely to believe that they must sometimes ignore their clinical judgment, that managed care has increased their use of diagnostic tests, and that managed care has changed the individual physicians to whom they refer."[26] Specifically, MCOs threaten physician autonomy by influencing physician behavior. According to another study, MCOs influence physician behavior by implementing certain financial incentives; administrative or management strategies (including utilization review, referral requirements, and sanctioning); structural characteristics (including practice site, service availability, staffing patterns, and governance); and information or normative influences (including professional culture and institutional practices such as education and feedback).[27]

GYNECOLOGY 1400, 1400 (1998) ("With about 600 managed care operations in the United States, physicians can no longer afford to sit in the stands and just watch the play on the field. Participation is crucial and must be accompanied by additional learning, such as masters degrees in business administration or MBAs."); Jerome P. Kassirer, *Doctor Discontent*, 339 NEW ENG. J. MED. 1543, 1543-44 (1998) ("Some physicians are attempting to meet the challenge of the new economics of practice head-on. They have tried to master bookkeeping and accounting skills and, working in groups, have been aggressively negotiating contracts and fees with multiple insurers.").

23. *See supra* note 17 and accompanying text.

24. *See* Drukker, *supra* note 22, at 1402. Kaiser Family Foundation President Drew E. Altman, Ph.D., stated that, "[m]anaged care is winning in the marketplace but is in danger of losing in the battle of public opinion." *Id.*

25. *See id.*

26. Warren et al., *supra* note 17, at 55.

27. *See* Bruce E. Landon, M.D., M.B.A., et al., *A Conceptual Model of the Effects of Health Care Organizations on the Quality of Medical Care*, 279 JAMA 1377, 1379-80 (1998); *see also* Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1516 (Nov. 19, 1998) (analyzing a study on the prevalence MCO financial incentives and their influence on primary care practice).

Many physicians argue that MCOs restrict patient access to quality medical care in an effort to cut costs.[28] So upset are physicians that many condone lying to MCOs in order to obtain authorization for certain medical procedures, according to a recent study.[29] The study found a tension between a physician's "traditional ethic of patient advocacy and the new ethic of cost control that restricts patient and physician choice in the use of . . . resources."[30] This tension especially was demonstrated by an increased willingness to use deception among physicians who practiced in markets with high concentrations of MCOs.[31]

More cynical critics suggest that physician frustration with the managed care system may be rooted more in the self-interested desire for higher earnings than in the professional pursuit of autonomy or quality health care.[32] Statistics documenting a slowdown in the average earnings of U.S. physicians could give rise to such suspicions. A recent AMA survey indicates that the average earnings of U.S. physicians increased a meager 0.3% between 1996 and 1997.[33] In contrast, average earnings increased at about ten percent per year before the current managed care regime.[34]

Whether or not a recession in physician earnings is motivating

28. *See, e.g.*, John P. Little, D.M.D., *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1400-02 (1997).

> MCOs directly restrict care by retaining the final decision on whether to authorize benefits for medical care, such as hospital admissions, referrals to specialists, and access to medical tests. Many MCOs indirectly restrict access to care by imposing a system of financial penalties and bonuses on physicians in order to induce them to provide as little patient care as possible. The aggressive use of these policies has led to patient deaths and bitter disputes when MCOs [refuse] to authorize or have delayed approving benefits for necessary medical care.

Id.

29. *See* Victor G. Freeman, M.D., et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES INTERNAL MED. 2263 (Oct. 25, 1999) <http://archinte.ama-assn.org/issues/v159n19/full/ioi81370.html>.

30. *Id.*

31. *See id.* at 2269.

32. Edward O'Neill of the Center for the Health Professions at the University of California at San Francisco comments that although "[u]nionization is being positioned as a patient-care issue . . . . [i]t is motivated out of economic issues." Abate, *supra* note 5, at C1. Professor Howard Berliner of the New York School for Social Research adds, "I don't really think this is being done for patients. This is happening because doctors' incomes, doctors' sense of autonomy, are getting killed." *AMA: Unprecedented Vote*, *supra* note 7. Noting the AMA's estimation that physicians enjoy a median annual income of $164,000, critics in the insurance industry charge physician unions with merely attempting to pad "already cushy salaries." Jodie Morse, *Unionizing the E.R.: To Combat Managed Care, Doctors Want to Organize, but It's No Magic Elixir*, TIME, July 5, 1999, at 62.

33. *See AMA Backs Formation of Union*, *supra* note 9.

34. *See id.*

the physician unionization movement, the following is clear: many physicians attribute a deterioration in the quality of health care and an economic slump for physicians to an unequal bargaining power enjoyed by many consolidated MCOs. The AMA blames the high market concentration of such health plans for restraining the ability of physicians to negotiate health plan contract terms that adequately ensure quality care.[35] According to the AMA, MCOs use the leverage gained from monopsonizing the demand for medical services to dictate contractual terms.[36] The result, it argues, is a "take it or leave it" contract that forces physicians to provide lower quality care by narrowly defining "medical necessity,"[37] implementing patient quotas,[38] or reducing reimbursement rates.[39]

Still others suggest that any reduction in physician earnings (or attendant decline in the quality of care) may be attributable to an over supply of medical professionals. Between 1970 and 1990, the number of physicians in the U.S. whose primary activity was patient care increased from 115 to 182 per 100,000 population.[40] While the market absorbed this increase in supply without depressing physician incomes,[41] subsequent increases in the supply of physicians may have had a different effect. Indeed, studies project that in the year 2000 U.S. health care markets will have a physician surplus amounting to thirty percent of the 571,000 patient care physicians nationally.[42] With multiple applicants for every position in medical school, this glut in supply shows no signs of waning.[43] Basic economics suggests that, without any change in demand, this increase in the supply of health care professionals will result in lower prices for their services.[44]

35. *See Quality Health Care Coalition Act of 1999: Hearings on H.R. 1304 Before the House Comm. on the Jud.*, 106th Cong. (1999) [hereinafter *Hearings*] (statement of the AMA).

36. *See Hearings*, *supra* note 35, at 151 (statement of the AMA).

37. *Id.*

38. *See AMA Backs Formation of Union*, *supra* note 9.

39. *See infra* note 68 and accompanying text (describing the FTC response to physician attempts to collectively negotiate higher reimbursement rates).

40. *See* Uwe Reinhardt, Ph.D., *Impending Physician Surplus: Is It Time to Quit?*, 277 JAMA 69 (1997).

41. *See id.*

42. *See id.*

43. *See* Itzhak Jacoby, Ph.D., & Gregg Meyer, M.D., *Creating an Effective Physician Workforce Marketplace*, 280 JAMA 822 (1998).

44. Furthermore, Dr. Uwe Reinhardt of Princeton University reminds physicians that unionization efforts to raise reimbursement rates could actually exacerbate the effects of a high supply as "the number of professionals society wishes to employ in any given year . . . will decrease if they insist on higher annual incomes." *See* Reinhardt, *supra* note 40, at 69.

II. ANTITRUST BARRIERS TO PHYSICIAN UNIONIZATION

To fully appreciate the antitrust concerns raised by physician unionization in particular, an examination of the economic consequences of unionization in general is essential. In common parlance the terms "union" and "unionization" refer to *labor* unions and the process of organizing employees into unions under federal labor laws.[45] For the purposes of this Section, however, these terms refer to the collective organization of independent individuals, regardless of the applicability of labor law. As explained more fully below, an antitrust exemption immunizes many labor union practices from liability.[46] Where federal labor law does not govern a "union," however, no such immunity exists. In light of this framework, this Section begins by addressing the economic effects of unionization without regard to antitrust laws or exemptions. Next, this Section explains the nature of the labor exemption to the antitrust laws. Finally, this Section examines the particular antitrust law problems posed by physician unionization.

A. The Economic Effects of Unionization

A "union" is defined as "a confederation or league of independent individuals . . . for some common end or purpose."[47] Where unions are formed "horizontally" (that is, among parties who otherwise compete for limited resources such as market share, jobs, or contracts), the "common end or purpose" toward which union participants endeavor likely will be mutually favorable terms for procurement of economic resources. For example, a hypothetical labor union, though comprised of employees who would otherwise compete for jobs, may negotiate higher wages or more favorable working conditions for its members. In short, market competition is supplanted by cooperation among the members. Furthermore, if the union is successful in its use of cooperative bargaining power, future competition among the parties will be discouraged.[48]

In stark contrast to this milieu of cooperation, antitrust policy stands predicated on the assumption that competition produces the most efficient allocation of economic resources and facilitates

45. *See, e.g.*, NLRA, 29 U.S.C. §§ 151 et seq. (1994).

46. *See infra* notes 52-60 and accompanying text.

47. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2499 (1993).

48. *See* Jason E. Whitehead, *The Labor Exemption from Antitrust As an Ideological Antinomy*, 32 WILLAMETTE L. REV. 881, 901 (1996).

innovation in the development of products and services.[49] Under such a rubric of analysis, threats to a competitive model directly result in adverse effects for consumers. Accordingly, antitrust policy seeks to police actions that threaten competition like collusion among actors within a marketplace.[50] Therefore, the procompetitive goals of antitrust policy and the procooperative goals of unions set the stage for what one critic terms an "ideological impasse."[51]

B. *The Labor Exemption to Antitrust Law*

In the special case of *labor* unions, this "ideological impasse" has been resolved in favor of an antitrust exemption for organized labor. Labor unions derive their antitrust immunity from a number of different sources both nonstatutory and statutory.[52] The most patent statutory exemption is found in section 6 of the Clayton Act.[53] This section has been interpreted to exempt labor unions acting in their own self-interest from antitrust scrutiny.[54] *United Mine Workers v. Pennington*,[55] a case involving union collective bargaining attempts with coal mining firms, illustrated the nonstatutory exemption. Ostensibly, labor exemptions operate by removing human labor from the scope of commodities and articles of commerce to which antitrust laws apply.[56] Other critics, however, characterize these exemptions as a means of offsetting the employer's monopsony power[57] over the labor market with a countervailing monopoly power.[58]

Regardless of the theoretical roots of the labor exemption, however, certain practical limitations to the exemption exist. As interpreted, the labor exemptions have been restricted to unions acting in their own interest, unions using the least restrictive means available to achieve their objective, unions involving an employer-employee (rather than independent contractor) relationship, and

49. *See* 2A PHILLIP AREEDA, ANTITRUST LAW ¶ 401 (1995).
50. *See id.* ¶ 415.
51. *See* Whitehead, *supra* note 48, at 901.
52. *See* AREEDA, *supra* note 49, at ¶¶ 255-57.
53. *See* Clayton Act § 6, 15 U.S.C. § 17 (1994).
54. *See, e.g.*, United States v. Hutcheson, 312 U.S. 219, 234 (1941).
55. 381 U.S. 657 (1965).
56. *See* Clayton Act § 6.
57. For a discussion of monopsony power, see generally ROGER D. BLAIR & JEFFREY L. HARRISON, MONOPSONY: ANTITRUST LAW AND ECONOMICS (1993).
58. *See, e.g.*, Daniel J. Gifford, *Redefining the Antitrust Labor Exemption*, 72 MINN. L. REV. 1379, 1402-03 (1988). For an explanation of the countervailing power argument, see J.K. GALBRAITH, AMERICAN CAPITALISM: THE CONCEPT OF COUNTERVAILING POWER (1952).

unions acting in an official capacity.[59] To the extent that the statutory exemption applies to union activity, the NLRA further defines the statutory exemption and provides for the adjudication of applicable issues.[60]

C. *Problems with Physician Unionization under Antitrust Law*

These labor exemptions, however, do not apply to most unions of physicians. In fact, most physician unions fail to qualify because they are considered groups of independent contractors rather than employees.[61] This disqualification has frustrated many physicians in light of recent trends toward condoning the union activity of other, less traditional laborers including professional athletes, musicians, actors, and movie directors.[62]

Without an applicable exemption, the anticompetitive effects of a physician union may be scrutinized under specific antitrust laws. While a physician union's potential to engage in horizontal price-fixing would be the most blatant affront to antitrust law,[63] the potential to engage in refusals to deal with MCOs,[64] internal restraints on advertising or practice,[65] or information sharing[66] could also reduce competition by stabilizing prices. When horizontal unions collaborate to stabilize or even fix prices within a market (as many physician unions propose to do through the collective negotiation of MCO

59. *See* E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS 78-80 (3d ed. 1998).

60. *See* Luepke, *supra* note 17, at 282 (citing NLRA § 1, 29 U.S.C. § 151 (1935)).

61. *See* BUDRYS, *supra* note 3, at 116-18; *see also* Luepke, *supra* note 17, at 290. House Bill 1304 of 1999 expressly addresses this dilemma for physician unions. The bill states that a health care professional negotiating under the Act shall "be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor." H.R. 1304 § 3(a), 106th Cong. (2000).

62. *See* BUDRYS, *supra* note 3, at 117 (quoting Sanford Marcus, *A Proposal for the Defense of the American Medical Profession*, J. MIAMI MED., Feb. 1986, at 22); *Hearings*, *supra* note 35, at 428 (statement of Michael P. Connair, M.D., Vice-President, Federation of Physicians and Dentists).

63. *See, e.g.*, United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224 (1940) (holding that price is the "central nervous system of the economy" and that agreements interfering "with the setting of price by free market forces" are per se illegal).

64. *See, e.g.*, FTC v. Indiana Federation of Dentists, 476 U.S. 447, 449 (1986) (finding a section 1 violation where eighty-five percent of Indiana dentists refused to send x-rays with health insurance claim forms).

65. *See, e.g.*, California Dental Ass'n v. FTC, 526 U.S. 756 (1999) (finding a violation where a group of California dentists agreed to limit advertising on the basis of quality).

66. *See, e.g.*, American Column & Lumber Co. v. United States, 257 U.S. 377, 411-12 (1921) (holding that a plan among competing firms in the American Hardwood Manufacturers' Association to create a clearinghouse for sales, shipping, pricing, and production of product information was illegal).

reimbursement fees), union members violate section 1 of the Sherman Act, prohibiting "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . ."[67] Indeed, physician groups engaged in collective bargaining have formed the basis of successful antitrust litigation.[68]

III. THE DEBATE OVER AN ANTITRUST EXEMPTION FOR PHYSICIAN UNIONS: HOUSE BILL 1304 OF 1999

H.R. 1304 has provided a crucible in which policy debates over physician unionization have sparked. Proposing to provide physician unions with NLRA antitrust immunity, the bill clearly subscribes to the premise that physicians should be given a countervailing power with which to negotiate MCO contracts. Indeed, findings appended to the bill assert that the collective negotiation of physicians "will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care."[69] This Section will discuss two issues raised in the debate over this legislation: the very use of a countervailing force and the effect of physician unionization on health care quality.[70] Moreover, this Section will present arguments against H.R. 1304 on the basis of both.

67. 15 U.S.C. § 1 (1994).

68. *See* North Lake Tahoe Med. Group, Inc., No. C-3885, 1999 FTC LEXIS 134 (consent order issued July 21, 1999, prohibiting an IPA of 91 California physicians representing seventy percent of the physicians practicing in the Lake Tahoe area from engaging in collective bargaining with third party payers, collectively refusing to deal with Blue Shield of California, fixing prices, and restricting physician negotiations outside of the IPA); Mesa County Physicians Independent Practice Ass'n, Inc., D-9284, 1999 FTC LEXIS 67 (consent order issued May 4, 1999) (stopping a Mesa County, Colorado IPA comprising eighty-five percent of all physicians and ninety percent of primary care physicians in the relevant geographic market from fixing prices, refusing to deal with third party payers, and otherwise "hindering the development of alternative health care financing and delivery systems"); M.D. Physicians of Southwest Louisiana Inc., C-3824, 1998 FTC LEXIS 89 (consent order issued Aug. 31, 1998, prohibiting a Lake Charles, Louisiana physicians group from collective negotiations); Urological Stone Surgeons, Inc., C-3791, 1998 FTC LEXIS 36 (consent order issued Apr. 10, 1998 forbidding a group comprised of sixty-five percent of the urologists in the Chicago metropolitan area from using a common billing agent as a vehicle for collective bargaining).

69. H.R. 1304 § 2(4), 106th Cong. (2000).

70. House Bill 1304 is also objectionable to the extent that it allows for physician strikes. The prospect of an ill patient being refused treatment by striking physicians is certainly disconcerting. It can be argued that the people society entrusts with an intellectual monopoly on medical treatment have an ethical obligation to make their services available to those who need them. The stakes are especially high when human health hangs in the balance. Nevertheless, physician strikes are not unprecedented. On multiple occasions it has taken the enforcement power of the FTC to put striking physicians back to work. *See, e.g.*, Ernesto L. Ramirez Torres, D.M.D., et al., C-3851, 1999 FTC LEXIS 16 (consent order issued Feb. 5, 1999, prohibiting a group of Puerto Rican dentists from fixing prices and boycotting a government program for indigent dental care after the dentists boycotted the program); College of

A. *Addressing an Unlevel Playing Field with a Countervailing Force*

The very idea that implementation of a countervailing force is an appropriate way to respond to negotiating imbalances is itself a topic of much debate. In a sense, this debate is an extrapolation of the "ideological impasse" between labor law and antitrust law.[71] The very premise driving antitrust laws (that competition will yield the most efficient allocation of economic resources) is theoretically inconsistent with the legislative remedy proposed in H.R. 1304.

Most supporters of H.R. 1304 point to grossly disparate bargaining positions as *necessitating* a countervailing force. One physician claiming the necessity of a countervailing force justifies the AMA position by analogizing the physician-MCO relationship to the biblical story of David and Goliath.[72] Another argues that MCOs have forced physicians into working conditions best characterized as "medical sweatshops."[73] Ultimately, the arguments of these physician proponents of H.R. 1304 are self-defeating. While they complain of

Physicians-Surgeons of Puerto Rico, FTC File No. 9710011 (D.P.R. Oct. 2, 1997) (enjoining a group of 8,000 Puerto Rican physicians from continuing its eight day strike on nonemergency services, and ordering it to pay $300,000 in restitution to the Puerto Rico Department of Health); Trauma Assoc. of N. Broward, Inc., 118 F.T.C. 1130 (1994) (consent order compelling a group of ten Broward County, Florida surgeons to dissolve a corporation through which they collectively negotiated reimbursement fees and contract terms after the group went on strike, forcing a trauma center to close).

The bill ostensibly forecloses this possibility by expressly limiting its exemption so as not to confer upon any health care professional the "right to participate in any collective cessation of service to patients not otherwise permitted by law." H.R. 1304 § 3(c), 106th Cong. (2000). The effect of this limitation, added to the bill since its introduction in the House Judiciary Committee, is not certain. On one hand, this language appears to be clear in its proscription of physician strikes. Accordingly, the bill's limitation could be read as removing only one of myriad economic tools available to those who bargain collectively. On the other hand, the limitation could render the legislative exemption entirely meaningless by removing the shadow of a strike from MCO-physician union negotiations. Indeed, the ability of the NLRA to facilitate negotiation between labor and management has hinged, theoretically and empirically, on the underlying threat of a strike and its consequences to all parties involved. *See, e.g.*, JULIUS G. GETMAN ET AL., LABOR MANAGEMENT RELATIONS AND THE LAW 162-63 (2d ed. 1999).

Ultimately the threat of physician strikes may be mitigated from within the profession. Despite past physician strikes, the AMA has assured the public that its physician union and others like it will not strike. *See Physician Unionization: AMA Vows No Strikes*, Am. Health Line, Oct. 12, 1999, *available at* LEXIS, News Library, HLTLNE File. Furthermore, the findings introducing House Bill 1304 recognize that "[a]llowing health care professionals to negotiate collectively with health care plans will not change the professionals' ethical duty to continue to provide medically necessary care to their patients." H.R. 1304 § 2(5), 106th Cong. (2000).

71. *See supra* note 51 and accompanying text.

72. *See Hearings*, *supra* note 35, at 152 (statement of the AMA).

73. *Hearings*, *supra* note 35, at 183 (testimony of Robert L. Weinmann, M.D., President, Union of American Physicians and Dentists).

unfettered MCO power, they propose for themselves a vehicle for unchecked power as the best possible solution.[74]

FTC Chairman Robert Pitofsky acknowledges that bargaining imbalances certainly exist between solo practitioners and large insurance companies.[75] Such imbalances, he maintains, are common features of our economy.[76] Nevertheless, Pitofsky warns that "the suggestion that [H.R. 1304] would not impose higher costs on consumers and others—on the ground that the exemption would merely create a countervailing monopoly—is premised on theoretical arguments about market conditions that do not describe most health care markets."[77] Largely for this reason, the agencies have resisted physician attempts to create countervailing negotiating powers.[78]

B. The Effect of Physician Unionization on the Quality of Health Care

Many physicians attribute any perceived reduction in the overall quality of health care to MCO reimbursement, treatment, and referral policies. They argue that MCO contracts structurally discourage patient care through financial terms and incentives.[79] These arguments may be best understood as a response to the "cost containment" prerogative of managed care. MCOs have forfeited quality in an attempt to achieve the lowest possible costs, according to many physicians.[80] Managed care responds that by lowering the costs of health care, MCOs enable employers to insure more people.[81] Managed care further argues that MCO systems of selecting

74. The irony of this position is demonstrated in the statement of the AMA to the House Committee on the Judiciary. The AMA complains that "it is not healthy for any group to have virtually unlimited power over a matter as significant and sensitive as the kind of medical treatment needed by an individual with an illness or injury. When that unlimited power exists, it is inevitable that distortions will occur, and they are occurring." *Hearings*, *supra* note 35, at 151 (statement of the AMA). Although this statement beseeches heightened antitrust enforcement of the health care industry, it supports an antitrust exemption. In short, the legislative solution proposed by House Bill 1304 in fact facilitates unlimited bargaining power.

75. *See Hearings*, *supra* note 35, at 51 (statement of Robert Pitofsky, FTC Chairman).

76. *See id.*

77. *Id.*

78. *See* Robert Pitofsky, *Thoughts on "Leveling the Playing Field" in Health Care Markets* (visited Apr. 13, 2000) <http://www.ftc.gov/speeches/pitofsky/nhla.htm> ("To the extent . . . that the level playing field argument is about creating a countervailing force in order to neutralize a perceived imbalance in bargaining power, antitrust law will not be receptive.").

79. *See* Little, *supra* note 28, at 1411.

80. *See Hearings*, *supra* note 35, at 154 (statement of the AMA).

81. *See Quality Health-Care Coalition Act of 1998: Hearings on H.R. 4277 Before the House Comm. on the Jud.*, 105th Cong. (July 29, 1998) (testimony of Steven J. deMontmollin, Vice President, AvMed Health Plan, on behalf of the American Association of Health Plans, Inc.).

competent network providers, providing quality improvement interventions, and conducting clinical accountability studies achieve quality levels impossible under fee-for-service regimes.[82]

The question of professional service quality is particularly problematic. On one hand, professionals have a "monopoly" of knowledge and skill gained through professional training that would make them likely candidates to set standards of quality within their respective professions. Conversely, the promulgation of professional standards often results in higher prices for consumers and may, therefore, restrain free competition.[83] Antitrust law reconciles this dilemma by trusting the marketplace to insure professional quality.[84]

The assumption that competition in the market will insure quality is complicated by certain conditions specific to the health care financing industry. First of all, many managed care subscribers are "one step removed" from the market insofar as a large percentage of the insured population relies on employer-provided care.[85] An employer, as the surrogate purchaser on behalf of its employees, may

82. *See id.*

83. *See, e.g.*, California Dental Ass'n v. FTC, 526 U.S. 756 (1999) (finding a violation where a group of California dentists promulgated professional standards).

84. *See* Letter from Albert A. Foer, President of American Antitrust Institute & Matthew D. Siegel, Research Fellow, American Antitrust Institute, to U.S. Congressman Henry Hyde, Chairman, U.S. House of Representatives Committee on the Judiciary (Oct. 10, 1999), *available at* <http://www.antitrustinstitute.org/rec nt/45.cfm> ("[House Bill 1304] implicitly assumes that health-care professionals are the best arbiters of health-care utilization levels. They are not. Neither are insurers.... Only consumers themselves... can integrate information about quality with information about cost, to select the preferred cost/quality balance."). In *National Society of Professional Engineers v. United States*, the Supreme Court affirmed an injunction nullifying a "code of ethics" for professional engineers promulgated by the petitioner. 435 U.S. at 679 (1978). The facts of the case indicate that the code prohibited member engineers from competing on price when bidding for jobs. *See id.* at 684. Petitioner defended its code, arguing that competitive bidding would threaten public safety by tempting engineers to compromise quality for profit. *See id.* at 685. Applying a rule of reason analysis, the Supreme Court rejected this and any other defense "based on the assumption that competition itself is unreasonable." *Id.* at 696. In so holding, the Supreme Court definitively addressed the relationship of professional service quality to antitrust law:

> The Sherman Act reflects a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services.... The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers. Even assuming occasional exceptions to the presumed consequences of competition, the statutory policy precludes inquiry into the question of whether competition is good or bad.

Id. at 695 (citations omitted).

85. *See, e.g.*, Robert Kuttner, *The American Health Care System—Employer-Sponsored Health Coverage*, 340 NEW ENG. J. MED. 248, 248 (1999) ("Most Americans rely on their employers for health insurance."). *But see* Pitofsky, *supra* note 78, at 5 ("[S]ome employers are experimenting with new ways to increase the role of informed choice by their employees.").

have divergent interests with respect to cost and quality factors. While employees may exert some influence over their employers' decisions regarding health insurance, the employer-employee dynamic certainly restrains the patient's participation in the market. This effect is further exacerbated by the very nature of insurance. Quality will be a more important factor for the minority of patients with immediate medical needs than for those who merely pay a premium in hopes of never needing acute medical attention.

Despite these market-specific conditions, the hypothesis that competition will control the quality of health care applies nonetheless. As MCOs compete for employer contracts, employers also must compete for labor. Employers that offer workers low-quality health insurance will lose employees to firms providing superior insurance. In turn, employers will demand that MCOs compete on the basis of quality and offer a cost/quality balance that reflects consumer demand.[86]

The nature of MCOs as insurance providers should not distort the market's ability to regulate quality tremendously. While the quality demanded by different individual subscribers may vary, in the aggregate it should reflect not only the costs that subscribers are willing to bear but the probability of needing medical attention as well. The prospects of one day needing unexpected treatment is likely sufficient to spur healthy subscribers toward demanding quality. If, on the other hand, healthy subscribers choose not to bear the additional costs of higher quality, different MCO markets reflecting consumer preference regarding cost and quality will develop.

IV. ALTERNATIVE ANTITRUST POLICIES TO "LEVEL THE PLAYING FIELD"

Operating under the assumption that an unfettered antitrust exemption for physician unions may be an unsatisfactory resolution to the current provider-MCO crisis, this Section proposes two alternatives to such legislation. The first alternative proposes a *legal* countervailing force by which physicians might negotiate collectively with MCOs. The second alternative involves antitrust regulation of the potential monopsony power of MCOs.

86. This chain of events is further described in Pitofsky, *supra* note 78.

A. *Formation of Physician Network Joint Ventures (PNJVs) in Accordance with DOJ/FTC Guidelines*

The 1996 DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care[87] (the Statements) suggest an alternative to unionization for physicians wishing to bargain collectively for MCO contracts without running afoul of antitrust laws. The Statements define a PNJV[88] as a "physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services."[89] The PNJV, therefore, presents a vehicle by which physicians might legally join forces to negotiate price and other terms with MCOs. Absent extraordinary circumstances, the DOJ and FTC will not challenge PNJVs in which participants share substantial financial risk and do not exceed certain "antitrust safety zones" described below.[90] PNJV participants not in compliance with the risk sharing or safety zone requirements may be challenged by the FTC or DOJ under either a *per se* approach[91] or a rule of reason analysis.[92]

1. Framework for the Antitrust Analysis of PNJVs

Compliance with "antitrust safety zone" guidelines is a conservative, yet nearly certain method for PNJVs to avoid antitrust scrutiny. As a threshold matter, PNJV participants "must share substantial financial risk in providing all the services that are jointly priced through the network" to fall within the safety zone.[93] However, further prerequisites for "antitrust safety zone" qualification differ with respect to the exclusivity of a PNJV for its constituent members. To qualify for the safety zone, an exclusive PNJV must not constitute more than twenty percent of the "physicians in each physician specialty . . . who practice in the relevant geographic

87. *See* DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) [hereinafter STATEMENTS].

88. While many PNJVs are established to *compete directly* with MCOs (often referred to as preferred provider organizations ("PPOs")), this Note will not discuss such ventures. Indeed, PPOs compete horizontally with MCOs insofar as they offer an *alternative* health care financing option. Instead, this Note limits its focus to PNJVs organized for the purpose of collectively negotiating price terms in a vertical relationship vis-à-vis the MCOs.

89. STATEMENTS, *supra* note 87, at 20,814.

90. *Id.* at 20,815-16.

91. *See id.* at 20,821.

92. *See id.* at 20,818.

93. *Id.* at 20,815-16.

market."[94] A nonexclusive PNJV, however, must not constitute more than thirty percent of the same market group.[95]

PNJVs that either fail to share substantial financial risk or include a higher percentage of physicians than allowed by the "antitrust safety zone" may be lawful under a rule of reason analysis nonetheless.[96] Indeed, "if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any [agreements that would otherwise be per se illegal] are reasonably necessary to realize those efficiencies," then rule of reason analysis will be applied.[97] On the other hand, arrangements among physicians that merely seek to impede competitive forces in the market and do not create procompetitive efficiencies will be treated as "unlawful conspiracies or cartels" and considered per se illegal.[98] Although a case-by-case factual inquiry ultimately must determine whether the rule of reason analysis or per se approach applies, the Statements list several indicia of naked anticompetitive conduct.[99] To further facilitate the creation of compliant PNJVs, the DOJ and FTC each provide a service whereby physicians contemplating a PNJV may solicit an opinion regarding the legality of potential joint ventures.[100]

The rule of reason analysis, as applied to PNJVs, is basically a four step process. First, the relevant geographic and product market is defined by considering all reasonably available substitutes for a PNJV's services.[101] Second, the anticompetitive potential of a PNJV to raise prices or impede other networks is evaluated.[102] Third, the procompetitive efficiencies created by a PNJV are assessed and

94. *Id.* at 20,815.

95. *See id.*

96. For examples of PNJVs outside of the safety zone that have been approved by the DOJ and FTC, see *id.* at 20,814 n.24 (citing five agency letters approving nonexclusive PNJVs with physician participation in excess of the thirty percent safety zone threshold).

97. *Id.* at 20,817.

98. *Id.*

99. *See id.* at 20,817-18 (listing as factors justifying per se treatment: statements evidencing anticompetitive purpose; a recent history of collusion in the market; obvious anticompetitive structural characteristics; the absence of efficiency-creating mechanisms; the presence of anticompetitive collateral agreements; and the failure to provide mechanisms to mitigate anticompetitive "spillover" effects outside of the network).

100. *See* Pilot Business Review Program, 58 Fed. Reg. 6132 (1993) (outlining the DOJ's expedited business review procedure); FTC General Procedures, 16 C.F.R. §§ 1.1-1.4 (1993) (explaining the FTC's advisory opinion procedure).

101. *See* STATEMENTS, *supra* note 87, at 20,818.

102. *See id.* at 20,818-19.

balanced against any anticompetitive effects.[103] Fourth, the effect on competition of any collateral agreements made among physician participants is determined.[104]

2. Advantages of PNJVs As an Alternative to Unionization

PNJVs present a more economically satisfying alternative to physician unions precisely because of the financial risk-sharing requirement. By sharing financial risk, PNJV participants achieve economic integration. Sufficient economic integration precludes a Sherman Act section 1 violation by virtue of the U.S. Supreme Court's rejection of the "intra-enterprise conspiracy doctrine" in *Copperweld Corp. v. Independence Tube Corp.*[105] and its progeny. Indeed, by forming "single entities" for the purposes of antitrust analysis, physicians escape section 1 scrutiny.

103. *See id.* at 20,819.

104. *See id.*

105. 467 U.S. 752 (1984). The facts of *Copperweld* indicate that in conjunction with Copperweld's purchase of wholly owned subsidiary, Regal Tube, from Lear Siegler, these three parties entered into an agreement not to compete. *See id.* at 756. After the acquisition, however, a former vice president/general manager of Regal set up respondent business in direct competition and began taking orders. *See id.* Despite the advice of counsel that respondent would not be bound by the covenant not to compete, petitioners Copperweld and Regal sent out letters to prospective purchasers, suppliers, financial institutions, and real estate firms indicating that respondent was conducting business in violation of the covenant not to compete. *See id.* at 756-57. When respondent lost a contract to supply a tubing mill, it sued, alleging that Copperweld and its subsidiary, Regal, had conspired to restrain trade in violation of section 1 of the Sherman Act. *See id.* at 757-58. Reversing the lower court decision for the respondent, the Supreme Court addressed the narrow question of "whether a parent and its wholly owned subsidiary are capable of conspiring in violation of § 1 of the Sherman Act." *See id.* at 767. The Court reasoned that a "basic distinction between concerted and independent action" existed within the Sherman Act. *Id.* (quoting Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 761 (1984)). Accordingly, section 1 "reaches unreasonable restraints of trade effected by a 'contract, combination . . . or conspiracy' between *separate* entities"; whereas section 2 governs the threats of single firm monopolization. *See id.* at 767-68. Viewing "the coordinated activity of a parent and its wholly owned subsidiary" as "that of a single enterprise for purposes of § 1 of the Sherman Act," the Court held that a section 1 conspiracy between Copperweld and its subsidiary, Regal was impossible. *See id.* at 771, 777.

While the parent-subsidiary relationship in *Copperweld* may be distinguishable from the associations typically formed by groups of physicians, the basic premise that constituents of economically integrated ventures cannot conspire in violation of section 1 is applicable. Since *Copperweld*, this rationale has been extended to protect the concerted actions of parent corporations and partially owned subsidiaries; hospital trustees and staff peer reviewers; and other parties of varying relationships. *See, e.g.*, Oksanen v. Page Mem'l Hosp., 945 F.2d 696 (4th Cir. 1991) (holding that physician peer reviews conducted by staff physicians were an integral part of hospital management and, as such, immune from section 1 inquiry); Novatel Comm. v. Cellular Tel. Supply, No. C85-2674A (N.D. Ga. Dec. 23, 1986) (holding parent corporation incapable of conspiring in violation of section 1 with subsidiary in which it had at least fifty-one percent ownership interest). For an overview of subsequent developments in the demise of the intra-enterprise conspiracy doctrine, see SULLIVAN & HARRISON, *supra* note 59, at 197-214. There is little doubt that a PNJV formed in accordance with the Statements would be sufficiently integrated to fall into the *Copperweld* rationale, as well.

In addition to reconciling potential conflicts with section 1 of the Sherman Act, the PNJV method of physician organization surpasses the unionization option by creating efficiencies. Certain procompetitive efficiencies created by economic integration provide incidental benefits to the PNJV option. By combining expertise, investment capital, and business assets, physicians may be able to provide medical services together that no single physician could provide independently.[106] Further, where physicians are highly competitive these advantages ultimately could afford consumers lower prices and higher quality care.[107]

3. Criticisms of PNJVs As an Alternative to Unionization

Three significant criticisms of PNJVs as an alternative to physician unionization include impracticality, ineffectiveness, and unfair treatment by the agencies. First, a PNJV may not be a practical solution for all physicians. The requirement of economic integration necessitates bureaucratic-like arrangements to ensure sufficient risk sharing.[108] The accompanying financial burdens of legal representation and infrastructure modification are too onerous according to some physicians.[109] Further, by sharing risk with partners physicians may lose the very autonomy they seek to preserve by unionizing. Specifically, physicians complain that PNJV incentives to reduce or limit care would place participating physicians in ethically compromising positions.[110] Upon more careful reflection, however, these practical criticisms lose force. Complaints regarding the financial burden of increased bureaucracy and infrastructure ignore the fact that MCOs must bear similar costs in expanding the breadth

106. For an explanation of the procompetitive advantages of joint ventures, see SULLIVAN & HARRISON, *supra* note 59, at 149 (citing *In re* Brunswick Corp., 94 F.T.C. 1174, 1265 (1979), *aff'd sub nom.* Yamaha Motor Co. v. FTC, 657 F.2d 971 (2d Cir. 1981)).

> By joining skills, spreading risks, achieving certain economies of scale, and reducing transaction costs, the joint firm may be more efficient and willing to undertake research or production. "The combined capital, assets, or know-how of two companies may facilitate entry into new markets and thereby enhance competition, or may create efficiencies or new productive capacity unachievable by either alone."

Id.

107. *See* STATEMENTS, *supra* note 87, at 28 (arguing that competition—as a motivation for firms to lower prices, reduce costs, and provide higher quality—facilitates pro-consumer efficiencies).

108. *See id.* at 24 (noting agreements that provide for "capitated" rates—a system of significant financial incentives for members, or a system of mixing services for complex treatments—as acceptable models for sharing financial risk).

109. *See Hearings*, *supra* note 35, at 168 (statement of the AMA).

110. *See id.*

of the services *they* offer. Indeed, such costs are the inevitable costs of expansion, and physicians' inability to bear them only demonstrates that they are not competitive vis-à-vis MCOs. Criticisms about incentives to limit care do not acknowledge the existence of similar incentives in the status quo. This perceived "disadvantage" of forming a PNJV would otherwise exist even if the physician were to contract directly with an MCO. In truth, such incentives may reflect a consumer plea for lower costs.

Second, PNJVs may be ineffective in addressing the specific concerns of physician unionization proponents. The effectiveness of PNJVs may be doubted simply because the option exists in the status quo, yet physician frustration over MCOs is rampant nonetheless. However, this argument prematurely assumes that PNJVs have been and are, in fact, utilized by physicians. Further, although many physicians argue that the DOJ and FTC are unfair in their enforcement of antitrust laws against physician mergers,[111] the agencies maintain that "it is not their intent to treat [PNJVs] either more strictly or more leniently than joint ventures in other industries."[112]

4. Summary of PNJVs As an Alternative to Unionization

Despite criticisms of PNJVs, the potential advantages created by joint ventures would outweigh any disadvantage. By forming new PNJVs, physicians could increase their bargaining power vis-à-vis managed care without implicating antitrust law and increase the quality of health care through procompetitive efficiencies. Accordingly, the Statements provide an acceptable alternative to unionization through the use of the PNJV.

B. Aggressively Police the Monopsony Power of MCOs

Another strategy for preventing unlevel playing fields in the health care provider-MCO relationship wholly abandons the premise that physicians need a countervailing negotiating force. An antitrust enforcement policy to address MCO monopsony power could foster negotiating parity without endorsing the forms of collusion that give rise to concerns of section 1 violations.

Monopsony is defined as "the structural condition of there being

111. *See id.* ("[T]he agencies' 1996 Statements of Antitrust Enforcement Policy in Health Care reflect a bias against physicians and in favor of payers.").

112. STATEMENTS, *supra* note 87, at 25.

a single buyer of a well-specified good or service."[113] Monopsony power refers to a buyer's ability or power to depress the price of a good or service below competitive levels.[114] While a monopolist may raise prices above its marginal cost by decreasing the supply of a product or service, a monopsonist may depress prices through its control over the demand for a product or service.

Like monopoly power, monopsony power may develop as a result of either collusion among multiple firms (collusive monopsony) or the concentration of power in a single firm (monopsonization).[115] Furthermore, antitrust enforcement of these distinct monopsonistic circumstances differs. Collusive monopsonies, like collusion of multiple seller firms, may be regulated under section 1 of the Sherman Act. Single firm monopsonists debatably may be subject to scrutiny under section 2 of the Sherman Act. Finally, *potential* monopsonists may be prevented through the implementation of merger guidelines and pre-merger reporting requirements.

1. Framework for the Antitrust Analysis of MCO Monopsony

That collusive monopsonists may be subject to liability under Sherman Act section 1 is clearly precedented. Insofar as confederations of independent buyer firms stabilize or fix prices through their conduct, they are liable to the same extent as their seller firm counterparts. In *Mandeville Island Farms v. American Crystal Sugar Co.*,[116] the Supreme Court considered whether a group of California sugar refiners could agree among themselves on a uniform price to pay for California sugar beets.[117] Reversing the court of appeals' affirmation of a dismissal for failure to state a claim, the Court found that respondents' agreement was "the sort of combination condemned by the Act, even though the price-fixing was by *pur-*

113. *See* BLAIR & HARRISON, *supra* note 57, at 3.

114. *See id.* at 27.

115. *See id.* at 25-34.

116. 334 U.S. 219 (1947).

117. *See id.* at 221 (explaining that sugar refiners used beets as input for their refining process). The facts indicate that petitioner–sugar beet farmers operated their business in a relatively remote part of northern California. *See id.* at 222. This remote location, along with the special circumstances that beets may not be transported long distances or stored effectively, limited the universe of buyers to whom petitioners could sell their beets. *See id.* at 222 & n.2. In abuse of this monopsonistic condition, respondents (the only three sugar refiners to whom petitioners could profitably sell) entered into an agreement to fix prices on sugar beets. *See id.* at 223 (noting that respondents fixed prices by adopting identical form contracts and computing beet prices on the average net returns of all three rather than each individually).

chasers."[118] This language reflects the general principle that the section 1 prohibition on contracts, combinations, and conspiracies in restraint of trade applies equally to buyers and sellers.

While the regulation of collusive monopsonies is straightforward in its application of section 1 jurisprudence to purchaser firms, the regulation of existing single-firm monopsonists is more tenuous. As a structural condition alone, monopsony (like monopoly) is not forbidden by section 2 of the Sherman Act.[119] Indeed, natural monopsonies often form in markets where a single purchaser creates efficiencies due to economies of scale.[120] In the case of MCOs, for example, it is certainly more efficient for subscribers to purchase health care services jointly rather than individually. Destruction of these monopsonistic powers could lead to inefficiencies and cause "welfare losses."[121] Furthermore, much debate exists over whether or not the use of monopsony power by a single firm to lower prices *should* constitute an antitrust violation.[122]

Kartell v. Blue Shield of Massachusetts, Inc.,[123] stands for the proposition that monopsony pricing alone does not implicate antitrust liability. In *Kartell*, the Court of Appeals for the First Circuit reversed a district court finding that petitioner Blue Shield of Massachusetts (Blue Shield) had violated antitrust law by banning balance billing.[124] *Kartell* involved the complaints of a group of independent Massachusetts physicians alleging that Blue Shield's ban on balance billing illegally depressed health care service prices.[125] Analogizing Blue Shield's action to monopoly pricing, the court held that monopsony pricing alone did not violate antitrust law.[126]

Writing for the court, then-Judge Breyer suggested three policy considerations to bolster this result. First, he indicated that given the

118. *Id.* at 235 (emphasis added) (citations omitted).

119. *See* BLAIR & HARRISON, *supra* note 57, at 63.

120. *See id.*

121. *Id.*

122. *See* BLAIR & HARRISON, *supra* note 57, at 146 ("[T]he question of whether a seller to a monopsony [may] challenge a monopsonist buyer on the basis of the prices received is only of theoretical interest."); Roger D. Blair & Jeffrey L. Harrison, *Cooperative Buying, Monopsony Power, and Antitrust Policy*, 86 NW. U. L. REV. 331, 348 (1992) (referring to the inability of antitrust law to address single firm monopsony price setting as a structural dilemma).

123. 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985).

124. *See id.* at 922.

125. *See id.* at 929.

126. *See id.* at 927 (citing P. AREEDA, ANTITRUST LAW § 710 (Supp. 1982) and Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263, 297 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980)).

Sherman Act's consumer protection policy "courts at least should be cautious—reluctant to condemn too speedily—an arrangement that, on its face, appears to bring low price benefits to the consumer."[127] Second, he urged "judicial hesitancy" in considering the complex nature of medical costs.[128] Finally, he noted that antitrust scrutiny would be inappropriate, taking into account the regulatory role that states play in setting prices.[129]

In contrast to *Kartell*'s absolute refusal to condemn single-firm monopsony price-setting, *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*,[130] suggests that similar conduct may fall within the ambit of Sherman Act section 2 if accompanied by anticompetitive intent. In *Ball Memorial*, the Court of Appeals for the Seventh Circuit affirmed the district court's denial of an injunction proposed by a group of Indiana hospitals to stop Blue Cross & Blue Shield of Indiana ("BC&BS") from offering a PPO to its customers.[131] The hospitals argued that the PPO would exploit BC&BS's monopsony power to depress health care service prices.[132] Applying a rule of reason analysis, the court held that defendants lacked the requisite market power and anticompetitive intent to give rise to antitrust liability.[133] While *Ball Memorial* denied the specific injunction requested, critics suggest that by inquiring into the monopsonist's intent, the court left open a possibility of antitrust liability for single firm monopsonistic price setting.[134]

In addition to this legal development, *Kartell*'s policy assumptions have also been criticized. Then-Judge Breyer's emphasis on the importance of low prices for medical care is significantly undercut by the argument that lower prices may stifle development and innovation. Indeed, when health care prices are driven lower by MCO monopsony power, providers have less incentive to develop new and

127. *Id.* at 930-31 (citations omitted).
128. *Id.* at 931.
129. *See id.*
130. 784 F.2d 1325 (7th Cir. 1986).
131. *See id.* at 1346.
132. *See id.* at 1332.
133. *See id.* at 1337-40.
134. *See, e.g.*, Andrew Ruskin, *Unbridled Managed Care: When Consumers Experience Antitrust Welfare Loss from Exclusionary Contracts Between HMO Insurers and Health Care Providers*, 6 HEALTH MATRIX 391, 458 (1996) ("Although ultimately the [*Ball Memorial*] court found no antitrust violation, its situation-specific analysis of the elements that contribute to monopsonistic injury might guide other courts to be similarly thorough in their analyses when considering the effects of an exclusionary restraint on providers.").

efficient medical procedures.[135] Ostensibly, the district court recognized this argument in rendering its opinion of the case.[136] Further, critics suggest that MCOs similar to the one involved in *Kartell* may reduce the overall quality of health care by discouraging the provision of certain services on the basis of cost.[137]

Regardless of the legality of single-firm price control, much case law supports the proposition that a violation of antitrust law may be found where a monopsonist uses its power to acquire nonprice advantages. The seminal case in this arena is *United States v. Griffith*.[138] *Griffith* involved an action against four affiliated corporations that operated movie theaters in Oklahoma, Texas, and New Mexico.[139] The facts indicate that these corporations used a common agent to negotiate movie distributions.[140] Through the use of this agent, the corporations were able to control the demand for movie distributions in certain towns.[141] The complaint alleged that monopsony power in some towns was used to negotiate distribution contracts that favored the corporations' operations in other towns.[142] The Supreme Court reversed the lower court's dismissal, reasoning that the corporations attempted to use one monopoly power "to beget" another.[143]

Critics distinguish *Griffith* and cases like it from cases of pure monopsonistic *pricing* by noting that they involve procurement of "exclusive access to some input that would then result in an advantage for the firm *as a seller*."[144] Such criticism suggests that, to the extent MCO contracts seek to gain "exclusive access" to physician services, MCOs *may* fall within the confines of the *Griffith* decision. If exclusive access to physicians results in selling advantages, single-firm monopsonist MCOs may be subject to section 2 liability under a *Griffith* analysis.

135. *See* H.E. Frech III, *Monopoly in Health Insurance: The Economics of Kartell v. Blue Shield of Massachusetts*, *in* HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE 317-18 (H.E. Frech III ed., 1988).

136. *See* Kartell v. Blue Shield of Massachusetts, Inc., 582 F. Supp. 734, 752-53 (D. Mass. 1984) (noting that the ban on billing hindered the use of a safer, innovative colonoscopy procedure).

137. *See* Frech, *supra* note 135, at 318-19.

138. 334 U.S. 100 (1948).

139. *See id.* at 101-02.

140. *See id.* at 102.

141. *See id.*

142. *See id.* at 102-04.

143. *Id.* at 108.

144. BLAIR & HARRISON, *supra* note 57, at 32 (emphasis added).

Finally, as suggested above, potential monopsony may be avoided through the application of laws restricting mergers. Mergers of purchasing firms present an antitrust threat by consolidating market power.[145] Critics suggest that section 7 of the Clayton Act would apply equally to both sellers and buyers.[146] Presumably, by promulgating guidelines that specifically addressed the merger of MCOs, the agencies could adequately prevent future monopsonies.

2. The Current Monopsony Threat of MCOs

Many proponents of physician unionization complain that MCOs enjoy a monopsony power because of their high market concentration.[147] Indeed, one study indicates that the five largest insurers had at least fifty percent share of the relevant market in twenty-three of twenty-five states examined and over seventy percent share of the relevant market in sixteen of those states.[148] Furthermore, in eleven of the twenty-five states examined, the Herfindahl/Hirschman index of market concentration for health plans exceeded 1800[149] (the level at which FTC/DOJ Horizontal Merger Guidelines consider a market "highly concentrated"[150]). As physicians thus market their services to fewer and fewer MCO "buyers,"[151] the potential for either collusive monopsony or outright monopsonization increases. To make matters worse, physician unionization proponents allege that their complaints to the agencies about MCO mergers and the potential for monopsonization have fallen on deaf ears.[152]

Opponents of physician unionization respond that health plans lack monopsony power for two reasons. First, they assert that since MCO reimbursements account for a minority of average physician income,[153] it is "virtually impossible" for a single firm to represent a

145. *See id.* at 23.

146. *See id.*

147. In fact, the findings preceding House Bill 1304 take note of changes in the health care industry that have raised MCO market concentration. *See* H.R. 1304, 106th Cong. § 2(2) (2000).

148. *See Hearings*, *supra* note 35, at 155 (statement of the AMA).

149. *See id.*

150. DEP'T OF JUSTICE & FED. TRADE COMM'N, 1997 MERGER GUIDELINES (1997).

151. *See* Abate, *supra* note 5, at C1 (noting that eighteen major California HMOs have consolidated into six firms since 1990).

152. *See Hearings*, *supra* note 35, at 159 (statement of the AMA) ("[T]he agencies' 1996 Statements of Antitrust Enforcement Policy in Health Care reflect a bias against physicians and in favor of payers. None of the statements address the market power of managed care companies, collusion among managed care companies, or anticompetitive mergers among managed care companies. All nine Statements address [the] activities of physicians and other health care providers.").

153. *See Written Testimony of the Antitrust Coalition for Consumer Choice in Health Care*

monopsonist's share of physician revenues.[154] Second, opponents claim that health care markets are not as highly concentrated as others suggest. Indeed, Interstudy's *MSA Profiles*, 1998 suggests that in most areas enrollees in any one HMO account for a small portion of total populations.[155]

Allegations of MCO monopsony may also be deflated in light of the current glut of physicians in practice. In recent years, the number of physicians per capita has increased substantially.[156] Simple economics suggests that as this supply has increased, the respective demand for services has declined. If statistics showing an over supply of physicians are accurate, a depression in prices may be the result of basic economics rather than a monopsonistic MCO force.

Weighing the legitimacy of competing statistics on MCO monopsony power would be a moot point. Were the FTC or DOJ to pursue the regulation of any monopsony power, information about MCO concentration in a particularly relevant market would need to be determined before a tribunal on a case-by-case basis.[157] Nevertheless, some conclusions may be drawn from the nature of the data presented. Principally, the statistics offered by opponents of physician unionization focus only on the probability of monopsony by single firms, thereby ignoring the possibility of a collusive monopsony among MCOs. On the other hand, the proponents of physician unionization point to no *evidence* of collusion among MCOs that would give rise to a violation of section 1 of the Sherman Act.

3. Summary of Policing MCO Monopsony Power As an Alternative to Physician Unionization

Monopsony powers can create serious market distortions by controlling the demand for a product or service. Whether or not monopsony powers currently exist within the MCO industry has been a topic of intense debate. However, to the extent that such power

Opposing H.R. 1304 (visited June 22, 2000) <http://www.healthantitrust.org/writtentestimony.htm> (noting that average physician incomes in 1998 were comprised of 42.8% private insurance, 12% Medicaid, 28.6% Medicare, and 12.2% paying patients).

154. *Id.*

155. *See id.*

156. *See supra* notes 40-44 and accompanying text.

157. For a framework for analyzing the monopsonistic power of MCOs, see Ruskin, *supra* note 134, at 444-51. Ruskin cites three aspects of MCO monopsony: MCOs consume a significant amount of a provider's service, few non-MCO health care financing options exist in the relevant market, and barriers to entry for such non-MCO financing arrangements exist. *See id.* at 449.

does exist, Sherman Act sections 1 and 2 and pre-merger scrutiny may provide adequate mechanisms for regulation. An agency enforcement policy implementing these provisions could correct any existing market distortions and deter potential abuses of monopsony power. At a minimum, such an express policy could quell tension among physicians criticizing the agencies of bias.

The chief difficulty with pursuing such a plan is summarized in the policy considerations of *Kartell*.[158] Practically speaking, if MCOs are using monopsony power to depress prices, there are facially beneficial consequences for consumers. Although resulting threats to the quality of health care services would not be in the consumers' best interest, increased prices might very well be the "welfare losses" against which MCO monopsony powers protect. Establishing the *Griffith* nonprice advantages procured by MCO monopsonists might be difficult. Accordingly, increased antitrust scrutiny might be met with the "judicial hesitancy" exhibited in *Kartell*.

CONCLUSION

The growth of managed care in the U.S. has changed not only the way patients receive and pay for their health care, but also the way physicians conduct their practices. Third party payers now present physicians with an organized purchasing front that forces them to compete not only on the basis of quality but on price as well. At the same time, physician earnings have slowed substantially. While physicians argue that the MCO prerogative of "cost containment" has gutted their professional autonomy and threatened the quality of their services, MCOs respond that such frustrations, in fact, are rooted in physicians' financial self-interest. Physicians argue that MCO negotiating power bullies them into veritable "contracts of adhesion"[159] vis-à-vis managed care. MCOs respond that by consolidating buying power they actually create systems that improve the quality of health care. Drops in physician earnings, they maintain, are attributable to freer competition in the market and an over supply of physicians per capita.

As this debate has garnered public attention, many theories of resolution have been suggested. The latest proposal, though not unprecedented, is a system of physician unions to negotiate col-

158. *See supra* notes 127-29 and accompanying text.
159. Little, *supra* note 28, at 1397.

lectively with MCOs. Acquiring the support of the AMA and numerous legislators, the physician unionization movement has conceived a specific legislative remedy to exempt physician unions from antitrust liability. H.R. 1304, though surely well intentioned, furthers bad antitrust policy for two reasons. First, the premise that a negotiating disparity must be offset with a countervailing force is flawed. The old adage that "two wrongs do not make a right" explains why government should not answer one alleged restraint on free competition by endorsing another. Second, the suggestion that the quality of health care hangs in the balance of the legislation is misguided. In fact, antitrust jurisprudence has long recognized that competition (not its prevention) yields the highest quality goods and services.

Two more palatable alternatives include the increased use of legal PNJVs and an agency enforcement policy aimed at monitoring and regulating MCO monopsonies. These alternatives may provide physicians with the "level playing field" they have demanded while remaining true to the antitrust premise that competition is the best form of resource allocation in a free market.

STUDENT NOTES