WHITE COATS AND UNION LABELS: PHYSICIANS AND COLLECTIVE BARGAINING

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I. INTRODUCTION

Healthcare is the focus of a sometimes bitter debate in the United States. The major participants—government, insurance companies, employers, hospitals, physicians, and patients—engage in the finger-pointing game of blaming others for healthcare delivery problems while defending their own actions and demands.[1] The only point upon which all might agree is that the U.S. healthcare system has markedly changed over the last twenty years.[2]

Tensions arise between the various healthcare participants as they act in their respective roles as purchasers, providers, and consumers.[3] Purchasers are primarily employers and government entities that purchase healthcare either indirectly through insurers or directly from providers.[4] Purchasers of healthcare demand lower costs while providers—e.g., physicians, hospitals, pharmaceutical companies, and medical equipment manufacturers—seek to maximize their profits.[5] Consumers, i.e., patients, demand increased services in the form of access, new technologies, and more effective treatments as they see healthcare costs absorb more of their income.[6] The dynamics become more complicated when single entities act in dual roles: a health maintenance organization ("HMO") may act as a purchaser of healthcare when contracting with providers and as a

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1. *See generally* Milo Geyelin, *AMA Alleges HMO Uses Faulty Data in Reimbursements*, WALL ST. J., Mar. 16, 2000, at B19; Julie A. Jacob, *How to Sue Your HMO*, AM. MED. NEWS, Apr. 3, 2000, at 13.

2. *See* Jeremy Lutsky, *Is Your Physician Becoming a Teamster: The Rising Trend of Physicians Joining Labor Unions in the Late 1990s*, 2 DEPAUL J. HEALTH CARE L. 55, 55 (1997).

3. *See* Thomas Bodenheimer, *The American Health Care System—Physicians and the Changing Medical Marketplace*, 340 NEW ENG. J. MED. 584, 584 (1999).

4. *See, e.g.*, John K. Iglehart, *The American Health Care System—Expenditures*, 340 NEW ENG. J. MED. 70 (1999) (identifying various purchasers of health care).

5. *See* Lutsky, *supra* note 2, at 57–59.

6. *See, e.g.*, Robert Kuttner, *The American Health Care System—Health Insurance Coverage*, 340 NEW ENG. J. MED. 163 (1999).

provider of healthcare, at least indirectly, when contracting with an employer purchasing insurance coverage for its employees. In that case, the HMO is squeezed by employers (purchasers) on one side and physicians (providers) on the other.[7]

Clearly, gains by any one group come at the expense of one or both of the other groups. Forty-four million Americans, including eleven million children, currently have no health insurance coverage, due in part, to costs.[8] Those individuals who are covered may feel trapped in health plans they did not select and which may not serve their particular needs.[9]

Employers are asked to provide ever more generous and expensive insurance coverage to their employees while facing economic competition from others in the global marketplace who need not provide health insurance to their employees. The government faces irreconcilable demands to increase healthcare under its programs, primarily Medicare[10] and Medicaid,[11] and, at the same time, to decrease the growth of expenditures for these same programs.

Radical changes have been advocated as a result of the competing interests inherent in the present health care system. Among the occasionally conflicting "solutions" proposed by varying groups to solve some cost and/or delivery problems have been the Patient Protection Act(s),[12] elimination of the ERISA (Employee Retirement Income Security Act) protections for HMOs,[13] increased state regulation of HMOs,[14] Medicare prescription plans,[15] nationalization of the entire healthcare system,[16] and the elimination of governmental involvement in healthcare.[17]

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7. *See generally* Robert Kuttner, *The American Health Care System—Wall Street and Health Care*, 340 NEW ENG. J. MED. 664 (1999) (describing the pressures on HMOs in the current market).

8. *See* Susan J. Landers, *Clinton Aims at Health Reform Legacy*, AM. MED. NEWS, Feb. 7, 2000, at 5.

9. *See* Iglehart, *supra* note 4, at 76; *see also Bush, Gore Plans Fail to Hit Right Balance for Uninsured*, USA TODAY, Apr. 13, 2000, at 16A.

10. 42 U.S.C. § 1395 (1994).

11. 42 U.S.C. § 1396 (1994).

12. *See, e.g.*, The Norwood-Dingell Bill, H.R. 2723, 106th Cong. (1999) (addressing patient rights and HMOs, along with approximately thirty other bills in the 106th Congress).

13. *See id.* (eliminating ERISA protections for HMOs to some degree in most of these bills).

14. *See, e.g.*, H.B. 2600, 44th Leg., 2nd Reg. Sess. (Ariz. 2000) (codified at A.R.S. § 20-118–119 (2000)).

15. *See* Susan J. Landers, *Delegates Back New Medicare Drug Benefit—with a Caveat*, AM. MED. NEWS, July 12, 1999, at 5; William M. Welch, *GOP Offers $40B Senior Drug Plan*, USA TODAY, April 13, 2000, at 1A.

16. Interview with Eve Shapiro, past president, Pima County Medical Society, in Tucson, Ariz. (Nov. 20, 1999) (advocating a single payer national health insurance plan).

17. Interview with Jane M. Orient, M.D., Executive Director, American Association of Physicians and Surgeons, in Tucson, Ariz. (Jan. 28, 2000) (advocating that government extricate itself from the health care system).

Physicians perceive themselves to be caught between the Scylla and Charybdis as powerful purchasers try to minimize their expenditures on one side and consumers demand greater services on the other.[18] Physicians feel a loss of control over their practices, including their ability to make medical decisions they believe are in the patients' best interests.[19] An increasing number of physicians advocate unionization, claiming that "[t]he dawning of physician discontent has provided the intellectual fodder for the revival and popularity of unionism as a proactive strategy to right the wrongs of this era."[20] The proponents of unionization assert that through collective bargaining and other union activities, physicians will be able to negotiate effectively with entities they perceive as having unfair advantages over the individual or small groups of physicians that make up the majority of practices.[21]

Calls for unionization, once advocated by only a handful of medical professionals, have increased to the point that they are influencing the policies of the American Medical Association ("AMA").[22] The AMA passed a resolution at its June 1999 meeting that authorized it to collectively bargain for physicians legally entitled to engage in such activities under current law and to seek exemptions allowing other physicians, heretofore barred from such activities, to participate in collective bargaining activities.[23] However, the AMA clearly opposes withholding care from patients in order to gain an advantage in collective bargaining activities.[24]

This Note will explore the antitrust and labor laws governing physician unionization. Part II of this Note discusses the fundamentals of antitrust law that, taken alone, prohibit concerted actions (such as collective bargaining) that attempt to control prices. Part III discusses two major exceptions to the antitrust laws, the labor exemption and state action immunity, that restrict the application of the antitrust laws under certain circumstances. Part IV discusses monopsony power, the mirror image of monopoly power. Part V discusses physicians as employees as opposed to independent contractors. Part VI discusses options available to physicians under current law, and Part VII discusses legislative efforts to expand these options. In Part VIII, this Note proposes to allow increased collective

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18. *See* Bodenheimer, *supra* note 3, at 584.

19. *See* Matthew K. Wynia, *Physician Manipulation of Reimbursement Rules for Patients—Between a Rock and a Hard Place*, 283 JAMA 1858, 1858 (2000).

20. Lutsky, *supra* note 2, at 55–56 (quoting Joseph L. Murphy, *Physician Unions: Bane or Balm?*, CHICAGO MED., Aug. 21, 1997, at 1–2).

21. *See, e.g.*, Aaron Bernstein, *The Amalgamated Doctors of America?*, BUS. WEEK, June 28, 1999, at 36; Sarah A. Klein, *Nontraditional Organizer*, AM. MED. NEWS, Feb. 28, 2000, at 10; Sarah A. Klein, *Opposing Sides Debate Physician Unions*, AM. MED. NEWS, Jan. 3–10, 2000, at 1.

22. *See* Edward B. Hirshfeld, *Physicians, Unions, and Antitrust*, 32 J. OF HEALTH L. 43, 44 (1999) (citing AMERICAN MEDICAL ASSOCIATION, POLICY COMPENDIUM, §§ H-385.971, 385.973, 385.976, 385.983 (1999)).

23. *See* Sarah A. Klein, *AMA to Establish National Collective Bargaining Unit*, AM. MED. NEWS, July 5, 1999, at 1.

24. *See* Hirshfeld, *supra* note 22, at 44 (citing AMERICAN MEDICAL ASSOCIATION, POLICY COMPENDIUM, § H-405.998 (1999)).

bargaining activities in certain markets, tying the level of such activities to the market power of purchasers in that market.

II. ANTITRUST FUNDAMENTALS

Two bodies of law—antitrust and labor—affect unionization and union activities. It has been noted that "there is a conflict between the goals of the antitrust laws and those of the labor laws."[25] The Supreme Court has referred to antitrust laws as a "consumer welfare prescription," since they protect consumers, not competitors.[26] Such laws are designed to prevent a single entity, or small group acting in concert, from asserting market power by raising prices or otherwise setting the terms of dealing.[27]

Labor unions seek to standardize, or fix, the price paid for labor through collective bargaining activities; therefore, serious antitrust violations would arise if unionization and collective bargaining were analyzed solely under the antitrust laws.[28] Labor laws shield such activities from the antitrust laws, permitting collective agreements and action among laborers to raise wages and improve working conditions.[29] The major antitrust laws, including Sections 1 and 2 of the Sherman Act[30] and Section 7 of the Clayton Act,[31] as well as the exemptions affecting physician unionization (the labor exemption[32] and state action exemption[33]) are discussed below. However, these statutes are merely a framework, like the Constitution, with the courts filling in the details through case law.[34] Understanding judicial interpretations of these laws is essential to applying antitrust theory to specific situations.

A. Section 1 of the Sherman Act

Section 1 of the Sherman Act provides that "[e]very contract, combination...or conspiracy, in restraint of trade or commerce...is hereby declared to be illegal."[35] The purpose of this section is to prevent collusion or

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25. *Id.* at 45.
26. Reiter v. Sonotone Corp., 442 U.S. 330, 343 (1979).
27. *See* Hirshfeld, *supra* note 22, at 45.
28. *See id.*
29. *See id.*
30. 15 U.S.C. §§ 1, 2 (1994).
31. 15 U.S.C. § 18 (1994).
32. The labor exemption consists of several statutes, including sections 6 and 20 of the Clayton Act (codified at 15 U.S.C. §§ 17, 52 (1994)); sections 1, 2, 4, 5, 7 and 13 of the Norris-LaGuardia Act (codified at 29 U.S.C. §§ 101, 102, 104, 105, 107, 113 (1994)); and the National Labor Relations Act (codified at 29 U.S.C. §§ 151–169 (1994)).
33. *See, e.g.*, Parker v. Brown, 317 U.S. 341 (1943) (holding that the Sherman Act does not prohibit anticompetitive state action).
34. *See* BCB Anesthesia Care, Ltd. v. Passavant Mem'l. Area Hosp. Ass'n, 36 F.3d 664, 666 (7th Cir. 1994) ("[T]he Sherman Act is perhaps the quintessential delegation by the Congress to the courts of the task of fashioning a legal structure to govern conduct.").
35. 15 U.S.C. § 1 (1994).

agreements among competitors that restrict competition.[36] Although the Act's language seems all-inclusive, the courts have taken the narrower view that only those agreements that unreasonably restrain competition are prohibited.[37] Congress did not define "restraint of trade," but left it to the courts to distinguish those activities that restrain trade from agreements that are relatively harmless, or maybe even beneficial, to consumers.[38] Importantly, it is the agreement itself that is illegal,[39] not just the results of the agreement. The agreement need not be implemented for a Section 1 violation to occur.[40]

The judiciary employs two different frameworks to analyze agreements under the antitrust laws: the per se rule and the rule of reason.[41] Those agreements that are inherently anticompetitive with no redeeming procompetitive effects are deemed "per se illegal," while agreements not so obviously damaging to competition, or that possess some procompetitive effects, are analyzed under the "rule of reason."[42] Under the per se rule, a plaintiff need not prove any actual damages; the presumption is that the agreement unreasonably restrains competition and is therefore illegal.[43]

The per se analysis is the exception; the presumption is that the rule of reason should apply to most agreements.[44] Under the rule of reason analysis, an agreement's anticompetitive and procompetitive effects are identified and balanced against one another.[45] If, on balance, the agreement results in substantial or significant anticompetitive effects, it is unlawful.[46]

A full rule of reason analysis consists of a three-part burden-shifting test.[47] A plaintiff[48] must make a prima facie showing that an agreement either has,

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36. *See, e.g.*, National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 690 (1978); United States v. Topco Assocs., 405 U.S. 596, 610 (1972).

37. *See* State Oil v. Khan, 522 U.S. 3, 10 (1997) (holding that "this Court has long recognized that Congress intended to outlaw only unreasonable restraints").

38. *See* WILLIAM R. ANDERSON & C. PAUL ROGERS III, ANTITRUST LAW: POLICY AND PRACTICE 171 (2d ed. 1992).

39. *See* 15 U.S.C. § 1 (1994) ("Every contract...is hereby declared to be illegal.").

40. *See, e.g.*, Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 330 (1991) ("[T]he essence of any violation of § 1 is the illegal agreement itself—rather than the overt acts performed in furtherance of it.").

41. *See* ANDERSON & ROGERS III, *supra* note 38, at 172.

42. *Id.*

43. *See, e.g.*, Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

44. *See, e.g.*, American Tobacco Co. v. United States, 221 U.S. 106 (1911) (establishing the rule of reason as the method of analyzing antitrust issues).

45. *See* State Oil v. Khan, 522 U.S. 3, 10 (1997) ("[T]he finder of fact must decide whether the questioned practice imposes an unreasonable restraint on competition, taking into account a variety of factors....").

46. *See* Bhan v. NME Hosps., 929 F.2d 1404, 1413 (9th Cir. 1991) ("[T]he factfinder must analyze the anti-competitive effects along with any pro-competitive effects to determine whether the practice is unreasonable....").

47. *See* JOHN J. MILES, ANTITRUST FUNDAMENTALS § IV(D), presented at NHLA/AAHA's Fundamentals of Health Law Seminar, Nov. 3, 1997.

or potentially has, a substantial anticompetitive effect.[49] If the plaintiff succeeds, the burden shifts to the defendant to show that the agreement has significant procompetitive benefits.[50] If the defendant is successful, the burden shifts back to the plaintiff to show that these procompetitive effects could be achieved with a less restrictive effect on competition.[51]

Market power is an essential element of the rule of reason analysis.[52] Market power is defined as the ability of a single firm (or a small group of firms acting in concert) to raise prices above the competitive price and/or to reduce output below competitive levels, without market forces causing that firm to lose enough sales that it is forced to lower those prices back to the competitive level.[53] Because an agreement cannot produce anticompetitive effects unless the defendant either already has market power or will obtain it as a result of the agreement, some courts have held that without market power, a Section 1 violation cannot occur under rule of reason analysis.[54]

Analysis under the full rule of reason requires the court to examine the relevant product and geographic markets to determine whether an agreement is anticompetitive.[55] In some cases, however, it may be possible for the court to determine that an activity, while not obviously a per se violation, is so anticompetitive that a full-blown analysis under the rule of reason is unnecessary. Such an analysis, the "quick look" rule of reason,[56] has been described as an "intermediate standard."[57] This analysis shifts the burden of proof to the defendant to justify the challenged activity.[58] If the Section 1 defendant cannot offer procompetitive reasons for the agreement, the agreement violates the antitrust

48. *See id.* at § V (plaintiffs include the Department of Justice, the Federal Trade Commission, state attorneys general, and private parties injured by the challenged conduct).

49. *See, e.g.*, Capital Imaging Assocs. v. Mohawk Valley Med. Assocs., Inc., 996 F.2d 537, 543 (2d Cir. 1993) (describing the three-part burden-shifting test).

50. *See id.*

51. *See id.*

52. *See, e.g.*, L.A.P.D. v. General Elec. Corp., 132 F.3d 402, 405 (7th Cir. 1997) ("A 5% or 10% or 15% share of a normal market...does not imply power to raise prices...."); Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc., 123 F.3d 301, 305, 310 (5th Cir. 1997) (stating a prerequisite to finding an antitrust violation is that the defendants "possessed market power" in a properly defined market).

53. *See, e.g.*, Eastman Kodak v. Image Technical Servs., Inc., 504 U.S. 451, 452 (1992).

54. *See, e.g.*, Digital Equip. Corp. v. Uniq Digital Techs., Inc., 73 F.3d 756, 761 (7th Cir. 1996) (holding that substantial market power is an ingredient of every claim under the rule of reason).

55. *See* WILLIAM C. HOLMES, ANTITRUST HANDBOOK § 1.04[2] (1999).

56. *Id.*

57. *See* United States v. Brown Univ., 5 F.3d 658, 669 (3rd Cir. 1993).

58. *See id.* at 669 ("If no legitimate justifications are set forth, the presumption of adverse competitive impact prevails and the 'court condemns the practice without ado.'").

laws.[59] If the defendant does proffer reasonable procompetitive justifications for the agreement, then the court will conduct a full rule of reason analysis.[60]

In *FTC v. Indiana Federation of Dentists*,[61] the Supreme Court used the rule of reason to assess the concerted practice of a group of dentists who refused to provide X-rays to dental insurers.[62] The Court refused to apply the per se rule, even though the agreement was a form of group boycott, which is usually a per se violation.[63] However, rather than conduct a full rule of reason analysis, the Court rejected the proffered procompetitive justification for the dentists' agreement.[64] The Court found that a conspiracy among a majority of dentists not to compete on the terms of a contract (supplying the insurer with the X-rays) had caused actual harm in the market (thwarting an attempt by the insurers to monitor the care provided by the dentists in order to lower costs of dental insurance).[65] Once actual harm is shown, it is unnecessary to conduct a full market analysis, since the harm itself is evidence of market power.[66]

Since Section 1 of the Sherman Act deals exclusively with agreements between individuals or firms, the actions of a single entity, no matter how anticompetitive, cannot be a violation of Section 1 of the Sherman Act[67] (but may violate Section 2 of the Sherman Act, *infra* Part II.B). Agreements come in many forms, and any type of agreement may be a violation of Section 1.[68] Certain types of agreements, however, are more likely to raise antitrust concerns than other types. The most common types of agreements that may violate Section 1 of the Sherman Act include: (1) horizontal price fixing[69] (agreements between firms at the same level of production concerning prices they will charge customers); (2) vertical price fixing[70] (firms at different levels of production agree on prices at one or more levels of the market); (3) horizontal market share allocation[71] (agreements

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59. *See* Law v. National Collegiate Athletic Ass'n., 134 F.3d 1010, 1024 (10th Cir. 1998) (holding that the salary cap on part-time basketball coaches was illegal under quick-look rule of reason analysis even without an in-depth market analysis, since it was not shown to be justified by offsetting procompetitive benefits).

60. *See Brown Univ.*, 5 F.3d at 669 ("If the defendant offers sound procompetitive justifications, however, the court must proceed to weigh the overall reasonableness of the restraint using a full-scale rule of reason analysis.").

61. 476 U.S. 447 (1986).

62. *See generally id.*

63. *See* MILES, *supra* note 47, § III(A)(1)(b)(3).

64. *See Indiana Fed'n of Dentists*, 476 U.S. at 460–461.

65. *See id.*

66. *See id.*

67. *See, e.g.*, Capital Imaging Assocs., P.C. v. Mohawk Valley Med. Assocs., Inc., 996 F.2d 537 (2d Cir. 1993).

68. *See* ANDERSON & ROGERS III, *supra* note 38, at 171.

69. *See, e.g.*, Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940).

70. *See, e.g.*, Dr. Miles Med. Co. v. John D. Parks and Sons, 220 U.S. 373 (1911).

71. *See, e.g.*, General Leaseways, Inc. v. National Truck Leasing Ass'n, 744 F.2d 588 (7th Cir. 1984); United States v. Topco Assocs., 405 U.S. 596 (1972).

in which actual or potential competitors agree on a division of the market among themselves); (4) group boycotts or refusals to deal[72] (agreements among competitors not to deal with another marketplace participant as a way to gain some advantage for themselves); (5) tying agreements[73] (the sale or purchase of one product is conditioned on the purchase or refusal to purchase another product, and the seller has appreciable economic power in the tying market); and (6) exclusive contractual arrangements[74] (purchasers or sellers agree to deal only with an exclusive seller or purchaser).

B. Section 2 of the Sherman Act

Section 2 of the Sherman Act concerns monopolization, attempted monopolization, and conspiracies to monopolize, providing 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 among the several States, or with foreign nations, shall be deemed guilty of a felony...."[75]

Activities commonly contested under Section 2 of the Sherman Act include: (1) actual monopolization[76] (acquiring or maintaining monopoly power through anticompetitive activities); (2) attempted monopolization[77] (engaging in anticompetitive practices that, if unchecked, have a high probability of creating monopoly power); (3) joint monopolization[78] (two or more parties conspiring to either acquire or maintain actual monopoly power, and these parties actually attain or maintain monopoly power); and (4) conspiracy to monopolize[79] (two or more parties conspiring to acquire monopoly power, but who have not yet succeeded in establishing that power).

Under Section 2, monopolization and attempted monopolization claims are those that involve actions by single firms with significant market power (or monopoly power) that are designed to prevent other firms from interfering with that power.[80] The degree of market power required for a Section 2 violation must be greater than market power under a Section 1 claim.[81] Since the statute does not

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72. *See, e.g.*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

73. *See, e.g.*, Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451 (1992).

74. *See, e.g.*, Jefferson Parish Hosp. Dist. 2 v. Hyde, 466 U.S. 2 (1984).

75. 15 U.S.C. § 2 (1994).

76. *See, e.g.*, United States v. Grinnell Corp., 384 U.S. 563 (1966).

77. *See, e.g.*, Spectrum Sports, Inc. v. McQuillan, 506 U.S. 447 (1993); Lorain Journal Co. v. United States, 342 U.S. 143 (1951).

78. *See, e.g.*, American Tobacco Co. v. United States, 328 U.S. 781 (1946).

79. *See, e.g.*, United States Steel Corp. v. Fortner Enters., Inc. 429 U.S. 610 (1977); Aquatherm Indus., Inc. v. Florida Power and Light Co., 145 F.3d 1258 (11th Cir. 1998).

80. *See American Tobacco Co.*, 328 U.S. at 811 (defining monopoly power as the power to exclude actual or potential competitors from the field).

81. *See* Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 481 (1992) (finding monopoly power under § 2 requires something greater than market power under § 1).

specify what constitutes "monopolization," the courts have been faced with defining the elements of monopolization. According to the Supreme Court in *United States v. Grinnell Corporation*:

> The offense of monopoly under § 2 of the Sherman Act has two elements: (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.[82]

Although the Supreme Court defines a Section 2 monopoly claim as consisting of two elements,[83] plaintiffs must actually show three elements to prevail.[84] First, a Section 2 plaintiff must show that proper, relevant product and geographic markets exist.[85] Second, the plaintiff must prove that the defendant has monopoly power in that market. Monopoly power is defined as the power to "control prices or exclude competition."[86] Indicia of possible monopoly power include a high percentage of sales within the relevant market (a high market share), actual exercise of leadership control over the industry, and actions that tend to exclude actual or potential competitors.[87] Third, the plaintiff must show that the defendant "willfully" acquired or maintained that power.[88]

Willful or predatory conduct is usually defined as conduct that tends to exclude competitors *and* that does not have any legitimate business purpose.[89] However, there is no consensus as to what constitutes such conduct. Each federal circuit has a somewhat different definition of predatory conduct.[90] Whether a firm has monopoly power is an essential inquiry, because some conduct that is legal for a firm without monopoly power might be predatory when conducted by a firm with such power.[91]

Section 2 also bars attempted monopolization, defined as conduct by a single firm that already possesses significant market power with the specific

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82. United States v. Grinnell Corp., 384 U.S. 563, 570–71 (1966).
83. *See id.*
84. *See* HOLMES, *supra* note 55, § 2.03.
85. *See, e.g.*, Standard Oil Co. v. United States, 221 U.S. 1, 61 (1911).
86. United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956).
87. *See* HOLMES, *supra* note 55, § 2.03[2].
88. *Grinnell Corp.*, 384 U.S. at 570–71.
89. *See* Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 483 (1992).
90. For a circuit by circuit analysis of the definition of predatory conduct, see MILES, *supra* note 47, § III(A)(2)(a)(2) (citing JOHN J. MILES, HEALTH CARE & ANTITRUST LAW § 5:4, n.9 (Supp. 1997)).
91. *See Eastman Kodak*, 504 U.S. at 488 ("Behavior that might otherwise not be of concern to the antitrust laws—or that might even be viewed as procompetitive—can take on exclusionary connotations when practiced by a monopolist.").

intent[92] to gain monopoly power through predatory conduct.[93] By definition the attempt is not yet successful, but there must be a "dangerous probability" that the activities, if left unchecked, might be successful.[94]

C. Section 7 of the Clayton Act

Section 7 of the Clayton Act is primarily concerned with mergers, acquisitions, and consolidations among businesses, prohibiting combinations that "substantially lessen competition, or tend to create a monopoly."[95] Although Section 7 is extremely broad, it does not apply to every acquisition, but only to those consolidations that may decrease competition. In order to determine whether the effects of a particular merger will, in fact, lessen competition, it is necessary to conduct a complex analysis of the product and geographic markets. The Department of Justice ("DOJ") has published several guidelines that assist in this analysis.[96] The application of Section 7 and the DOJ guidelines to physician activities will be addressed in Section VI.B, *infra.*

III. EXCEPTIONS TO THE ANTITRUST LAWS

Congress and the courts have exempted certain industries or economic activities from antitrust liability.[97] Two major exemptions that either impact or potentially impact physicians are the labor exemption and state action immunity.[98] Each is discussed separately below, including their impact on physicians and physician unions.

A. The Labor Exemption

The antitrust laws, if taken alone, prohibit concerted action by employees, or labor organizations acting on their behalf, undertaken with the intent to raise or fix the price of labor.[99] However, under certain circumstances such labor activities are statutorily exempt from the antitrust laws. Statutory exemptions for labor

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92. *See* Times-Picayune Pub. Co. v. United States, 345 U.S. 594, 626 (1953) (finding a "specific intent to destroy competition or build [a] monopoly is essential to guilt").

93. *See, e.g.*, Rebel Oil Co. v. Atlantic Richfield Co., 51 F.3d 1421, 1433 (9th Cir. 1995) (defining the elements of attempted monopolization under Section 2 of the Sherman Act).

94. *Id.*

95. 15 U.S.C. § 18 (1994).

96. *See, e.g.*, UNITED STATES DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES (1997); UNITED STATES DEPARTMENT OF JUSTICE, MERGER GUIDELINES (1984).

97. *See, e.g.*, McCarran-Ferguson Act, 15 U.S.C. §§ 1011–15 (1994) (exempting the "business of insurance"); ANDERSON & ROGERS III, *supra* note 38, at 823 (finding exemptions include regulated industries, labor, state action, and state regulated industries).

98. *See* MILES, *supra* note 47, §§ IV(D), (F).

99. *See* Hirshfeld, *supra* note 22, at 45.

activities are covered under various sections of the Clayton Act,[100] the Norris-LaGuardia Act,[101] and the National Labor Relations Act ("NLRA").[102] Section 6 of the Clayton Act states:

> The labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor...organizations...or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws.[103]

The NLRA[104] created the National Labor Relations Board ("NLRB"). This Act protects the activities of labor unions and those participating in them.[105] It "created a legally enforceable right for employees to organize, required employers to bargain with employees through employee elected representatives, and gave employees the right to engage in concerted activities for collective bargaining purposes or other mutual aid or protection."[106]

There are also non-statutory, judicially created exemptions to the antitrust laws, most applying to agreements between authorized labor unions and employers.[107] In *Brown v. Pro Football, Inc.*,[108] the Supreme Court observed that "[a]s a matter of logic, it would be difficult, if not impossible, to require groups of employers and employees to bargain together, but at the same time to forbid them to make...agreements potentially necessary to make the process work or its results mutually acceptable."[109]

B. State Action Immunity

Actions by state legislatures or regulatory systems may clash with the federal antitrust laws,[110] but it was never the intent of Congress to prevent the states from exercising their police power, even if such activity has anticompetitive effects.[111] State action may be the result of lobbying by private parties, which is

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100. 15 U.S.C. § 17 (1994).
101. 29 U.S.C. §§ 101, 102, 104, 105, 107, 113 (1994).
102. 29 U.S.C. §§ 151–169 (1994).
103. 15 U.S.C. § 17 (1994).
104. 29 U.S.C. §§ 151–169 (1994).
105. *See* Hirshfeld, *supra* note 22, at 46.
106. *Id.*
107. *See, e.g.*, Brown v. Pro Football, Inc., 518 U.S. 231, 237 (1996) (discussing how the non-statutory exemptions for employers are necessary to avoid the inconsistent results of allowing labor to act in concert but prohibiting the joint actions of employers in accepting the results of such collective bargaining).
108. *Id.*
109. *Id.* at 237.
110. *See* ANDERSON & ROGERS III, *supra* note 38, at 854.
111. *See* MILES, *supra* note 47, § IV(D).

protected from antitrust action by the *Noerr-Pennington* doctrine.[112] Petitioning the government is a protected activity under this doctrine, even though the resulting legislation or regulation could produce anticompetitive results.

State actions are immune from antitrust liability.[113] This allows states to engage in such anticompetitive activities as establishing monopolies (e.g., utilities), creating entry barriers (such as requiring licensure for certain occupations and professions, e.g., physicians), or price fixing (e.g., regulating rates).[114] If the state action is by a state legislature or court, the antitrust exemption is total.[115] In contrast, conduct by a state agency or local government requires further critical analysis to decide whether the immunity applies.[116]

IV. MONOPSONY POWER

Monopsony has been described as the mirror image of monopoly—the ability of a buyer to reduce the price of a purchased item below its competitive price.[117] While technically correct, this analogy is overly simplistic since monopsonists rarely cause the same effects on the market as monopolists.[118] Generally, monopoly power exercised by sellers results in higher prices and lower output.[119] In contrast, the exercise of monopsony power by purchasers (most commonly through joint purchasing agreements) results in lower prices and greater output for consumers.[120] The U.S. Supreme Court has recognized that purchasing cooperatives "are not a form of concerted activity characteristically likely to result in predominantly anticompetitive effects" and are not illegal per se.[121] The Court did not characterize how a lawful joint purchasing agreement could be distinguished from a per se illegal buyer cartel.[122] At least one court has

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112. *See* United Mine Workers v. Pennington, 381 U.S. 657, 670 (1965) (establishing an antitrust exemption protecting private-party solicitation of government); Eastern R.R. Presidents Conf. v. Noerr Motor Freight, Inc., 365 U.S. 127, 145 (1961) (holding that activities to influence legislation do not violate the antitrust laws).

113. *See* Parker v. Brown, 317 U.S. 341, 352 (1943) (holding that the Sherman Act is a "prohibition of individual and not state action").

114. *See* ANDERSON & ROGERS III, *supra* note 38, at 854.

115. *See, e.g.*, Hoover v. Ronwin, 466 U.S. 558, 559 (1984) (finding antitrust immunity for state bar testing program administered through state courts, making the conduct that of the state itself).

116. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 791 (1975) (holding that an attorney minimum fee schedule established by the local bar association and enforced by the state bar association violated the Sherman Act because it was neither required nor compelled by statute or the courts, but merely left to the discretion of the bar association).

117. *See* Jonathan Jacobson & Gary Dorman, *Joint Purchasing, Monopsony and Antitrust*, THE ANTITRUST BULL., Spring 1991, at 5.

118. *See id.* at 4.

119. *See id.*

120. *See id.*

121. Northwest Wholesale Stationers v. Pacific Stationery & Printing Co., 472 U.S. 284, 295 (1985).

122. *See* Jacobson & Dorman, *supra* note 117, at 2.

recognized that price fixing agreements by buyers are illegal, just as seller price fixing agreements are illegal.[123]

There are several necessary conditions for the exertion of monopsony power, including: (1) the buyer (or a small group of buyers) must control a significant percentage of the purchases in the market and (2) there must be some barriers to entry into that buyer's market.[124] The first requirement is necessary because only a buyer that controls a significant portion of the market can force a seller to lower its prices below the competitive level.[125] Entry barriers are necessary, or new buyers would enter that market to take advantage of the below-market costs. These new-buyer purchases would decrease the monopsonist's power, allowing the seller to raise its prices to the competitive price.[126]

Although concerns about monopsony power have not figured prominently in antitrust enforcement actions, the DOJ recently made it clear that it "takes concerns with buyer market power" seriously[127] and that economic thinking plays a major role in its analysis and enforcement decisions.[128] Monopsony power was an important consideration in the DOJ's recent decision to oppose the merger of Aetna and Prudential's health insurance assets.[129] The DOJ recognized that whether lower input prices translate into lower prices for consumers depends on the reasons for those lower input prices.[130] If these lower prices result from increased efficiencies on the part of the sellers, the lower input price may result in a lower price to consumers.[131] However, if lower prices result from the monopsony power of the purchasing firm, it is much less likely to result in these lower costs being passed on to the consumer.[132] Just as a monopolist does not often share its monopoly profits with its suppliers, a monopsonist does not usually share its decreased costs in the downstream market.[133]

The effects on the consumer market are particularly severe when the firm with monopsony power also has monopoly power in the downstream market.[134] The monopsonist creates decreased input because of the price reductions, which results in reduced quantity and increased prices in the downstream market when

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123. *See* United States v. Portac, 869 F.2d 1288, 1291 (9th Cir. 1989) (affirming that a conspiracy among buyers to rig bidding for lumber violates Section 1 of the Sherman Act).

124. *See* Jacobson & Dorman, *supra* note 117, at 10.

125. *See id.*

126. *See id.* at 11.

127. Marius Schwartz, Buyer Power Concerns and the *Aetna-Prudential* Merger, Remarks at 5th Annual Antitrust Forum, Northwestern University School of Law (Oct. 20, 1999) (text released Nov. 30, 1999), at § IV.

128. *See id.*

129. United States v. Aetna, Inc., 1999-2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999).

130. *See* Schwartz, *supra* note 127, § II.B.

131. *See id.*

132. *See id.*

133. *See id.*

134. *See* Jacobson & Dorman, *supra* note 117, at 17.

compared to a simple output monopolist who is not also an input monopsonist.[135] In its analysis of the Aetna-Prudential merger, the DOJ analyzed both the monopoly power of the merged firm and its monopsony power over the physicians the firm contracts with for services.[136] A major focus of its analysis centered on the likely effects of lower prices paid to physicians due to the merged firm's monopsony power.[137] It concluded that the effects of the merged firm on the physicians in certain geographic markets (particularly Dallas and Houston) would not only be severe, but the physicians in those areas would have few options due to the size of that merged firm.[138] In addition, the exercise of monopsony power by Aetna would have severe effects on the purchasers of HMO products in those markets, "likely leading to a reduction in quantity or degradation in the quality of physicians' services" to patients.[139] Due to these findings, Aetna entered into a consent decree with the DOJ that allowed it to proceed with the acquisition subject to the divestiture of HMO businesses in the Houston and Dallas markets.[140]

V. PHYSICIANS—EMPLOYEES OR INDEPENDENT CONTRACTORS?

Generally, only employees are allowed to collectively bargain under the NLRA.[141] However, what constitutes an employee, as opposed to an independent contractor, is not precisely defined within the Act. The NLRA gives parties only broad guidelines on this issue.[142] This leaves the determination of whether specific individuals are employees one of interpretation.[143] The NLRA states that "[t]he term employee shall include any employee...but shall not include any individual having the status of an independent contractor, or any individual employed as a supervisor."[144] Whether any particular group of physicians can unionize depends on whether they are employees under the NLRA.[145] It is convenient to divide physicians into three distinct categories for purposes of analyzing their ability to form collective bargaining groups under the labor exemption to the antitrust laws: (1) employee physicians (and those claiming to be employees); (2) post-graduate interns, residents, and fellows; and (3) self-employed physicians (independent contractors).[146]

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135. *See id.*
136. *See* United States v. Aetna, Inc., 1999-2 Trade Cas. (CCH) ¶¶ 72,730, 86,369 (N.D. Texas 1999) (consent decree and competitive statement).
137. *See id.* ¶ 86,379.
138. *See id.* ¶ 86,380.
139. *Id.*
140. *See id.* ¶ 86,369.
141. *See* 29 U.S.C. §§ 151–169 (1994).
142. *See* Lutsky, *supra* note 2, at 65.
143. *See id.*
144. 29 U.S.C. § 152(3) (1994).
145. *See* Lutsky, *supra* note 2, at 64.
146. *See id.* at 66.

A. Employee Physicians

Groups of physicians that meet the NLRB's criteria as employees are protected by the labor exemption and may engage in collective bargaining with their employers.[147] However, it is difficult for physicians to show that they meet those criteria, and they are most often regarded as independent contractors or supervisors, who are not protected under the NLRA.[148]

At one time, many states enacted statutes or adopted policies that prevented corporate entities from employing physicians to provide medical care to patients.[149] These statutes embodied a so-called "corporate practice of medicine doctrine."[150] But this doctrine is outdated in an era when many insured patients receive their health care through a managed care organization.[151] Recently, Congress heard testimony that "seventy-five percent of Americans with employer-based health insurance are enrolled in an HMO, preferred provider organization, or some other form of managed care."[152] Many states have abandoned the doctrine,[153] lending credence to the argument of union advocates that "physicians working for hospitals are either actual or constructive employees and should be allowed to collectively bargain."[154]

Recent NLRB action supports this proposition.[155] In Tucson, Arizona, physician-owners of Thomas-Davis Medical Clinic ("TDMC") built a large multi-specialty clinic.[156] By the mid-1980s, TDMC not only owned the clinic and the physician practices, but also operated Intergroup, the largest HMO in Arizona, which insured approximately 380,000 members.[157] The physicians sold the entire corporation to Foundation Health Corporation ("Foundation").[158] Shortly afterward, Foundation sold the clinical practice to FPA Medical Management ("FPA"), retaining the insurance operations and other assets.[159] Prior to the sale, Foundation began several cost-saving measures at the clinic, including firing

147. *See id.* at 67.
148. *See* 29 U.S.C. § 152(3) (1994).
149. *See* Lutsky, *supra* note 2, at 67–68.
150. *Id.* at 68.
151. *See id.*
152. *The Quality Health-Care Coalition Act, H.R. 1304: Hearings Before the House Committee on the Judiciary*, 106th Cong., June 22, 1999 (testimony of Robert L. Weinmann, M.D.), (visited June 25, 1999) <http://www.house.gov/judiciary/wein0622.htm>.
153. *See, e.g.*, Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 114 (Ill. 1997) (holding that the corporate practice of medicine doctrine does not apply to hospitals, clearing the way for hospitals, and other entities, to employ physicians).
154. Lutsky, *supra* note 2, at 68.
155. *See* Thomas-Davis Med. Ctrs., 324 N.L.R.B. 29 (1997) (finding former physician-owners of a medical clinic to be employees after selling clinic to an independent corporation).
156. *See* Lutsky, *supra* note 2, at 68 (citing *Medical Center Physicians Fight to Form Union*, PHYSICIAN PRACTICE OPTIONS, Aug. 1997, at 1).
157. *See id.*
158. *See id.* at 69.
159. *See id.*

twenty-six physicians, increasing the workloads of the remaining physicians, and eliminating much of the clerical staff.[160] The physicians were transformed from owners and independent practitioners to employees of Foundation and later, FPA.[161]

The physicians of TDMC voted for union representation in December 1996, and the NLRB certified the election in February 1997.[162] Foundation and FPA claimed that because the ownership transfer was in progress during the time of the vote, the union vote should be nullified.[163] The Board denied this appeal, finding that the transfer was effective as of November 29, 1996, before the union vote.[164] The owners of TDMC also claimed that the physicians were supervisors, and therefore ineligible for collective bargaining.[165] The Board upheld the election, finding that the physicians "were not statutory supervisors or managerial personnel"[166] as defined in the NLRA. This ruling signals the willingness of the NLRB to examine the conditions and details of the relationship between physicians and clinic owners when deciding whether the physicians are employees or independent contractors.

B. Post-Graduate Interns, Residents, and Fellows

After graduating from medical school, students spend one year as an intern and three to seven years in residency and fellowship training, depending on the particular specialty chosen.[167] Under *Cedars Sinai Medical Center and Cedars Sinai House Staff Ass'n*,[168] the NLRB has traditionally viewed these individuals as students, and therefore as ineligible to form unions for collective bargaining purposes.[169] In *Boston Medical Center Corp. and House Officers' Ass'n/Committee of Interns and Residents*,[170] the NLRB recently reversed *Cedar Sinai* and its progeny, finding that house staff officers (the general term for all post-graduate medical students in training programs) are employees for purposes of forming unions and engaging in collective bargaining activities.[171] The Board examined the employment circumstances and working conditions affecting house

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160. *See id.*
161. *See id.*
162. *See* Thomas-Davis Med. Ctrs., 324 N.L.R.B. at 30.
163. *See id.* at 32.
164. *See id.* at 30.
165. *See id.* at 29.
166. *Id.* at 32 n.3.
167. *See* Boston Med. Cent. Corp. and House Officers' Ass'n/Comm. of Interns and Residents, No. 1-RC-20574, 1999 NLRB Lexis 821, at *4 (N.L.R.B. November 26, 1999).
168. 223 N.L.R.B. 251 (1976) (holding that interns, residents, and fellows are primarily students and not eligible within the meaning of 29 U.S.C. § 152(3)).
169. *See id.* at 253.
170. Boston Med. Cent. Corp. and House Officers' Ass'n/Comm. of Interns and Residents, No. 1-RC-20574, 1999 NLRB Lexis 821 (N.L.R.B. November 26, 1999).
171. *Boston Medical Center*, 1999 N.L.R.B. Lexis at *1.

staff officers and found that they qualify as employees under section 152(12) of the NLRA.[172] This section defines a professional employee as:

> [A]ny employee engaged in work...(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...* or
>
> (b) any employee who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a), and (ii) *is performing related work under the supervision of a professional person* to qualify himself to become a professional employee as defined in paragraph (a).[173]

The Board recognized that house staff officers are individuals who have completed a "course of specialized intellectual study in...a hospital" and are "performing related work under the supervision of a professional to qualify" as a professional as defined by the Act.[174]

The Board also examined the legislative history of the 1974 Healthcare Amendments to the NLRA that repealed an exemption of private, non-profit hospitals from the definition of "employer."[175] The Board found that the legislative history was specific enough to conclude that Congress intended to include house staff under the definition of employee.[176] The Board further found that the legislature specifically considered whether house staff were supervisors and found that Congress accepted recent Board decisions clarifying that house staff were not supervisors within the meaning of section 152(11).[177]

Unless the *Boston Medical* decision is overturned or drastically narrowed, it will profoundly affect training hospitals. House staff organizations are likely to form at many training centers and seek NLRB certification of collective bargaining units to address many aspects of their employment, including working hours, patient loads, salaries, and other conditions. Alternatively, the possibility of residents seeking certification from the NLRB may allow house staff and hospital management to effectively negotiate in good faith over these issues.[178]

C. Self-Employed Physicians (Independent Contractors)

Unlike employed physicians and house staff, independent physicians are not exempt from the antitrust laws.[179] "Before physicians can engage in collective

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172. 29 U.S.C. § 152(12) (1994).
173. *Id.* (emphasis added).
174. *Boston Medical Center*, 1999 N.L.R.B. Lexis at *50.
175. *See id.* at *51–52.
176. *See id.* at *53.
177. *See id.*
178. *See* Sarah A. Klein, *Nontraditional Organizer*, AM. MED. NEWS, February 28, 2000, at 10.
179. *See* Lutsky, *supra* note 2, at 78.

bargaining under the labor exemption, the bargaining process must be part of a labor dispute" concerning the terms and conditions of employment.[180] Traditionally, most physicians were viewed as independent practitioners or independent contractors, not as employees, and were therefore unable to engage in collective bargaining activities.[181] However, in this era of expanding managed care, the line between independent contractor and employee is blurring.[182]

Traditionally, the common law "right to control" test has been used to determine whether a worker is an employee or an independent contractor.[183] Under this doctrine, if the purchaser of the service has the right to control the manner in which the work is done or the means by which the results are obtained, then the worker is an employee.[184] However, if that party only controls the results and the one performing the service controls the means by which the results are produced, then the person performing the services is an independent contractor.[185] While the NLRB uses several criteria to determine whether an individual is an employee or independent contractor, it has traditionally considered the extent of control exercised over the worker as the most important factor in its analysis.[186]

However, in several recent decisions the NLRB rejected the argument that the predominant factor is whether the employer has a "right to control" the manner and means of the work performed by the individual.[187] The Board reviewed the factors it considers when determining whether one is a servant (employee) or an independent contractor[188] and stated that the test "encompasses a careful examination of all factors and not just those that involve a right of control."[189]

The pendulum continues to swing back and forth on where the distinctions should be made between employee and independent contractor. In *NLRB v. Hearst*,[190] the NLRB applied a more inclusive definition of employee.[191] Partly in response to the *Hearst* decision, Congress passed the Labor Management Relations Act (Taft-Hartley Act)[192] in 1947. This measure added section 2(3) to

180. Hirshfeld, *supra* note 22, at 55.
181. *See id.* at 56.
182. *See* Lutsky, *supra* note 2, at 78.
183. North Am. Van Lines v. N.L.R.B., 869 F.2d 596, 599 (D.C. Cir. 1989).
184. *See* Gary Enterprises, No. 9-CA-26846, 1990 N.L.R.B. LEXIS 597, at *18 (N.L.R.B. Dec. 31, 1990).
185. *See id.*
186. *See North Am. Van Lines*, 869 F.2d at 599 (finding that the "extent of the actual supervision...of the workers' performance is the most important element").
187. Roadway Package System, 1998 WL 574959, at *12 (N.L.R.B. Aug. 27, 1998) (finding "insufficient basis for the proposition that those factors which do not include the concept of control are insignificant when compared to those that do").
188. *See* RESTATEMENT (SECOND) OF AGENCY, § 220 (1958).
189. Roadway Package System, 1998 WL 574959, at *13.
190. 322 U.S. 111, 126 (1944) (finding the NLRA is "not confined exclusively to 'employees' within the traditional legal distinctions separating them from 'independent contractors'").
191. *See id.*
192. 29 U.S.C. § 141 (1994).

the National Labor Relations Act and specifically excluded independent contractors from the definition of "employee."[193]

However, under certain circumstances involving unequal bargaining power, independent contractors are allowed to engage in collective bargaining activities. Examples include independent truck owner-operators,[194] musicians,[195] independent film directors,[196] baseball players,[197] and other sports players.[198] Some physicians claim that managed care organizations exert similar controls over them.[199]

Recently, 650 New Jersey physicians under contract with AmeriHealth Corporation ("AmeriHealth") sought to form a collective bargaining unit, claiming that the HMO's control over their activities was so extensive that they were in effect employees, rather than independent contractors.[200] The physicians argued that bargaining inequalities could only be corrected by granting them protection under the NLRA, which would benefit patients as well as physicians.[201] The physicians also contended that they were forced to act as agents of AmeriHealth in its efforts to reduce costs.[202]

The Board rejected these arguments, finding the legal issue to be whether "the physicians...are so integrated with and controlled by AmeriHealth that they meet the statutory definition of employees which, in turn, is based on the common law definition of 'servants.'"[203] The Board balanced the elements over which AmeriHealth exerted substantial control over the physicians against those elements in their practices over which the physicians retained significant control.[204] In addition to the control factors, the Board considered the fact that AmeriHealth's market share was less than ten percent and that the physicians offered no evidence concerning the total HMO market share in that area.[205] The

193. 29 U.S.C. § 152(3) (1994).

194. *See, e.g.*, Roadway Package System, 288 N.L.R.B. 196 (1988); Blackberry Creek Trucking, Inc., 291 N.L.R.B. 474 (1988); International Brotherhood of Teamsters v. Oliver, 358 U.S. 283 (1959).

195. *See, e.g.*, American Fed'n of Musicians v. Carroll, 391 U.S. 99 (1968).

196. *See, e.g.*, Home Box Office v. Director's Guild of Am., 531 F.Supp. 578 (S.D.N.Y. 1982).

197. *See, e.g.*, Federal Baseball Club of Baltimore v. National League of Prof'l Baseball Clubs, 259 U.S. 200 (1922).

198. *See, e.g.*, Haywood v. National Basketball Ass'n, 401 U.S. 1204 (1971); Radovich v. National Football League, 352 U.S. 445 (1957); United States v. International Boxing Club of New York, 348 U.S. 236 (1955).

199. *See* Daniel Srsic, *Collective Bargaining in the United States and Canada*, 15 COMP. LAB. L. 89, 102 (1993).

200. *See* AmeriHealth Inc./AmeriHealth HMO and United Food & Commercial Workers Union, Local 56, AFL-CIO, No. 4-RC-19260, 1999 WL 963200 (N.L.R.B. Oct. 18, 1999).

201. *See id.* at *27.

202. *See id.*

203. *Id.*

204. *See id.* at *27–32.

205. *See id.* at *29.

Board found that physicians in that geographic market were able to replace patients they might lose if they either refused to contract with AmeriHealth or terminated an existing contract.[206] It also recognized that "[w]hile the economics of the industry may be changing...the physicians in this case retain wide entrepreneurial discretion in how they run their practices and make profits."[207] The Board found that "the factors weigh heavily...in favor of independent contractor status" for the physicians.[208]

However, the Board did not foreclose the possibility that under some circumstances, physicians contracting with an HMO might be considered statutory employees.[209] In a market with greater HMO penetration and concentration, there are fewer opportunities for physicians to either attract non-HMO patients or to replace patients lost if they terminate an existing HMO contract.[210] In such circumstances, the Board may find that independent physicians are "employees" under the NLRA.

VI. OPTIONS AVAILABLE TO PHYSICIANS UNDER CURRENT LAW

As discussed above, employed physicians and physicians in residency training programs can take advantage of the labor exemptions to the antitrust laws when negotiating with their employers.[211] Independent physicians, however, are limited in the activities in which they can legally engage.[212] Legitimate options available to independent physicians include making rational business decisions, merging into larger groups, forming networks with other independent physicians, and using the "Third Party Messenger Model" in their negotiations. Each of these options and the application of the antitrust laws to them will be discussed in the sections below.

A. Making Rational Business Decisions—"Just Say No"

When faced with disadvantageous contracts, many physicians fear that if they do not sign, others will, thus leaving them without access to those patients.[213] However, if physicians refuse to sign disadvantageous contracts, the terms of those contracts will probably improve until at least some physicians believe them

206. *See id.*
207. *Id.* at *32.
208. *Id.*
209. *See id.* at *1 ("[W]e are not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees.").
210. *See* United States v. Aetna, 1999-2 Trade Cases (CCH) ¶¶ 72,730, 86,369 (N.D. Texas 1999) (consent decree and competitive statement).
211. *See supra* Parts V.A and V.B.
212. *See supra* Part V.C.
213. *See* Jane Orient, M.D., *In Defense of the Medical Profession*, SOMBRERO, Feb. 2000, at 6.

to be acceptable.[214] Although under-appreciated, this is probably the easiest strategy to pursue.[215] Unlike the other options discussed in this section, rational business behavior does not require any cooperation on the part of other physicians or any concerted actions that risk scrutiny under the antitrust laws. Any number of individual physicians or group practices may reject such contracts, so long as the actions are not undertaken in concert with other individual or group practices.[216] Unilateral action is never a violation of Section 1 of the Sherman Act.[217]

B. Merging into Larger Groups

Mergers and other combinations of competitors are subject to antitrust restraints.[218] Section 7 of the Clayton Act applies to a wide variety of activities, including mergers, consolidations, stock acquisitions, and joint ventures.[219] Section 7 prohibits activities whose effects "may be substantially to lessen competition, or to tend to create a monopoly."[220] While this statute applies to numerous activities, this discussion is limited to horizontal mergers, such as those between physician practices.[221] The DOJ and the Federal Trade Commission ("FTC") issued joint guidelines ("Guidelines") for the analysis of horizontal mergers in 1992 and revised them in 1997.[222]

The Guidelines are not inflexible standards, but suggested criteria to be used by the agencies when analyzing mergers.[223] One unifying theme throughout the Guidelines is that "mergers should not be permitted to create or enhance market power or to facilitate its exercise."[224] The Guidelines outline a five-part analysis to decide whether a proposed merger would tend to create or enhance market power. These elements include assessing (1) market concentration; (2) the potential anticompetitive effects of the merger; (3) whether entry may occur into the market to reduce any anticompetitive effects of the merger; (4) whether

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214. Interview with David Joseph, M.D., Chief Executive Officer, Southern Arizona Anesthesia Services, P.C., in Tucson, Ariz. (Oct. 10, 1999).

215. *See id.*

216. *Compare, e.g.*, Capital Imaging Assoc., P.C. v. Mohawk Valley Med. Assoc., 996 F.2d 537 (2nd Cir. 1993) (holding that unilateral conduct on the part of a single firm does not come under the purview of Section 1 of the Sherman Act) *with* United States v. Alston, 974 F.2d 1206 (9th Cir. 1992) (finding that concerted action by a group of dentists to fix prices is a per se violation of the antitrust laws).

217. *See* MILES, *supra* note 47, at § III(A)(1)(a).

218. *See supra* Part II.C.

219. *See* HOLMES, *supra* note 55, § 5.02.

220. 15 U.S.C. § 18 (1994).

221. *See* HOLMES, *supra* note 55, § 5.02 (defining horizontal mergers as those between "firms that are selling the same or similar products in the same geographic market").

222. UNITED STATES DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES (1997) [hereinafter GUIDELINES], *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,104.

223. *See* HOLMES, *supra* note 55, § 5.03[3].

224. GUIDELINES, *supra* note 222, § 0.1.

efficiency gains occur that could not be achieved by other means; and (5) whether either party is likely to fail and exit the market without the merger.[225]

An analysis of the market concentration involves several steps. First, the product and geographic markets must be determined.[226] Once market participants and their market shares have been determined, the concentration of the market is determined by calculating the Herfindahl-Hirschman Index ("HHI").[227] The HHI is the sum of the squares of the market shares of the individual firms in that particular market and is considered indicative of market concentration.[228]

A post-merger HHI of less than 1000 indicates a market that is not concentrated.[229] Mergers in this range "are unlikely to have adverse competitive effects and ordinarily require no further analysis."[230] A post-merger HHI of 1000 to 1800 indicates a moderately concentrated market.[231] If the pre-merger to post-merger change in the HHI is less than 100, then agency challenge is unlikely.[232] If the increase is greater than 100, then it is more likely that the merger will be challenged.[233] A post-merger HHI greater than 1800 indicates a highly concentrated market, but a challenge is unlikely if the increase in the HHI is less than 50.[234] A challenge is highly likely if the increase in the HHI is 50–100.[235] The need for a challenge is "presumed" if the change is greater than 100, but this presumption may be rebutted if non-statistical factors "make it unlikely that the merger will create or enhance market power or facilitate its exercise."[236]

Although physician mergers may create efficiencies that offset their anticompetitive effects, any merger that significantly increases physician bargaining power may be subject to agency challenge. Physician practices contemplating a merger sometimes seek a Business Review Letter from the DOJ according to its review procedure.[237] In general, firms seeking such a review supply the DOJ with information that allows it to conduct an analysis of the merger.[238] The DOJ then issues a letter that either states its intention to bring suit

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225. *See id.*
226. *See, e.g.*, MILES, *supra* note 47, at § III(B)(1)(a), (b); HOLMES, *supra* note 55, § 5.03[3].
227. *See* HOLMES, *supra* note 55, § 5.03[3].
228. *See id.*
229. GUIDELINES, *supra* note 222, § 1.51(a).
230. *Id.*
231. *See id.* § 1.51(b).
232. *See id.*
233. *See id.*
234. *See id.* § 1.51(c).
235. *See id.*
236. *Id.*
237. *See* 28 C.F.R. § 50.6 (1999) (describing procedure for obtaining a Business Review Letter).
238. *See id.*

to block the merger[239] or stating that "the Department has no present intention to challenge the merger."[240]

C. Forming Networks with Other Independent Physicians

Many physicians seek to maintain the independence of solo or small group practices while gaining some of the advantages of economic integration.[241] These physicians form or participate in "provider-controlled partially integrated networks" that market the physicians' services directly to patients, employers, HMOs, and other managed care organizations ("MCO").[242] This strategy allows physicians to offer health plans that constitute "a package of high quality medical services in a defined geographic area at a competitive cost."[243]

Such networks have varying degrees of integration and may be organized as an independent practice association, a preferred provider organization, a physician hospital organization, or a physician organization.[244] Whatever their form, these networks share certain common characteristics: 1) they include physicians who normally compete against one another; 2) they are only partially integrated, making Sections 1 and 2 of the Sherman Act applicable to these groups; and 3) they sell their services as a group and must establish a price for their services.[245]

The DOJ and the FTC issued a series of nine statements in 1996[246] outlining the agencies' approach to evaluating these networks under the antitrust laws.[247] The most important for analyzing physician networks are Statement 8,[248] which concerns physician network joint ventures, and Statement 9,[249] which covers multi-provider networks. These Statements are very similar, except that

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239. *See, e.g.*, Business Review Letter to Danbury Surgical Associates (Aug. 28, 1987).

240. *E.g.*, Business Review Letter to CVT Surgical Center and Vascular Surgery Associates of Baton Rouge (Apr. 16, 1997).

241. *See* John J. Miles, *Joint Venture Analysis and Provider-Controlled Health Care Networks*, 66 ANTITRUST L. J., 127, 127 (1997).

242. *Id.*

243. Edward Hirshfeld, *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 ANNALS HEALTH L. 1, 2 (1997).

244. *See* Miles, *supra* note 241, at 127–28.

245. *See id.* at 128.

246. UNITED STATES DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *reprinted in* 4 Trade Reg. Rep. (CCH) ¶¶ 13,153, 20,799 (1996).

247. *See* Hirshfeld, *supra* note 243, at 1.

248. UNITED STATES DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION, STATEMENT 8: ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES [hereinafter STATEMENT 8], *reprinted in* 4 Trade Reg. Rep. (CCH) ¶¶ 13,153, 20,814 (1996).

249. *See* UNITED STATES DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION, STATEMENT 9: ENFORCEMENT POLICY ON MULTIPROVIDER NETWORKS [hereinafter STATEMENT 9], *reprinted in* 4 Trade Reg. Rep. (CCH) ¶¶ 13,153, 20,826 (1996).

Statement 8 applies to networks comprised only of physicians while Statement 9 applies to networks that include non-physician providers, such as hospitals.[250] Statement 8 outlines size criteria that create "antitrust safety zones" for networks when combined with "the sharing of significant financial risk."[251] Networks falling within these criteria are presumed to be legal and will not be challenged by the agencies except under extraordinary circumstances.[252]

Physicians participating in networks seek to "level the playing field" in their dealings with managed care plans.[253] This can take one of two very different forms.[254] First, the network may be a method of creating a group of physicians capable of competing on the basis of its ability to provide a healthcare delivery product.[255] In that respect, the network is procompetitive and immune from antitrust liability. However, the network may also be a method of increasing the market power of physicians in an attempt to counteract the perceived power of the MCOs. [256] The antitrust enforcement agencies have rejected the latter justification for network formation.[257]

By their very nature, these networks are comprised of competing physicians that jointly set fees, which, if taken alone, are per se violations of the antitrust laws.[258] Statement 8 allows fee setting if the competitors are economically integrated in the joint venture and the fee setting arrangement is necessary to achieve the procompetitive benefits of that integration.[259] In that case, the activity is evaluated under the rule of reason.[260]

Statement 8 does not directly define the degree of integration necessary to qualify for the safety zones, but "illustrates types of arrangements that can involve the sharing of substantial financial risk among a network's physician participants, which is necessary for a network to come within the safety zones."[261] Statement 8 gives several examples of arrangements that qualify as substantial financial risk,[262] including: 1) capitated rates;[263] 2) percentage of premium;[264] 3) significant

250. *See* STATEMENT 8, *supra* note 248; STATEMENT 9, *supra* note 249.

251. STATEMENT 8, *supra* note 248, § A.

252. *See* Hirshfeld, *supra* note 243, at 2.

253. Miles, *supra* note 241, at 128 (quoting comments of Robert Pitofsky, chairman of the Federal Trade Commission, delivered at National Health Lawyers Ass'n Antitrust in the Health Care Field Seminar (Feb. 13, 1997)).

254. *See id.*

255. *See id.*

256. *See id.*

257. *See id.*

258. *See* STATEMENT 8, *supra* note 248, § B1 ("Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal.").

259. *See id.*

260. *See id.*

261. *Id.* § A.

262. *See id.* § A4.

263. *See id.* (defining "capitated rate" as a rate paid per person covered by the plan).

264. *See id.* (defining "percentage of premium" as similar to capitated rate but based on a set percentage of the premiums charged).

financial incentives for the network physicians, such as a "withhold"[265] from the payments made to the physicians or setting an overall cost target with substantial rewards or penalties for either achieving or failing to achieve that target; or 4) undertaking complex or extended care of patients for a fixed fee.[266]

In addition to the shared financial risk component of the safety zone, there are restrictions on the size of a network. The size allowed depends on whether the network is exclusive or non-exclusive.[267] An exclusive network is one in which the physicians are contractually prohibited from individually contracting with other networks or health plans.[268] On the other hand, a non-exclusive network is one in which the physicians are free to contract with other networks or directly with health plans.[269] Enforcement agencies will not ordinarily challenge an exclusive network that constitutes twenty percent or less of the physicians in each specialty in a given geographic market[270] or a non-exclusive network that constitutes thirty percent or less of the physicians in each specialty in that market.[271]

D. The Third-Party-Messenger Model

Independent physicians who are not members of an integrated network can engage in a form of joint negotiation with health plans by using the third-party-messenger model.[272] This is a process by which independent physicians can "arrive at a fee schedule with payers without physicians agreeing among themselves about what fee schedule they will accept."[273] This process involves an independent third party acting as a messenger between multiple physicians and the purchasers of the physicians' services.[274] The process works as follows:

- The messenger communicates with the individual physicians regarding the fees and conditions they are willing to accept.
- The messenger aggregates the information and develops a fee schedule that shows how many physicians or what percentage of physicians in the network will accept a certain fee. The messenger may not share this information with the individual physicians.

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265. *Id.* (defining withholds as a set percentage of fees owed to the physician that are retained by the network to cover the risk of having to provide more services than anticipated. These withholds are returned to physicians as a reward for achieving cost targets.).

266. *See id.* (noting that extended care of patients for a fixed fee is sometimes referred to as global fees or all-inclusive case rates).

267. *See* STATEMENT 8, *supra* note 248, § A.

268. *See id.*

269. *See id.*

270. *See id.* § A1.

271. *See id.* § A2.

272. *See* STATEMENT 9, *supra* note 249, § C.

273. Hirshfeld, *supra* note 22, at 61.

274. *Id.*

- The messenger presents this information to payers who can then make contract offers to the physicians in the network.
- The messenger can accept a contract with satisfactory terms on behalf of physicians who have authorized the messenger to do so.
- If the terms are not within the previously authorized range, the contract offer is forwarded to the physician for consideration. The physicians cannot communicate with one another concerning whether to accept the contract.
- The messenger can provide objective information concerning the contract, such as the meaning of terms or how the offer compares to offers made by other payers. However, the messenger can neither advise physicians in the network as to whether to accept the contract nor actively bargain on behalf of the physicians.
- After ascertaining whether each physician will accept the offer, the messenger reports that information back to the payer.[275]

At least one physician union, the Federation of Physicians and Dentists ("FPD"), markets its ability to effectively conduct third-party-messenger negotiations as one of the reasons independent physicians should join it.[276] While some physicians see this as worthwhile, others do not see the value of having a third party perform such negotiations, since these negotiations offer little or no advantage over individual negotiations and rational decision making.[277]

There is the possibility that communications, either by the messenger to the physicians or among the physicians themselves, may convert the process into one of price fixing or boycotting, which are per se violations of the antitrust laws.[278] The DOJ recently alleged that the FPD, representing essentially all orthopedic surgeons in Delaware during their negotiations with Blue Cross and Blue Shield of Delaware, "cloak[ed] its patently illegal activities...as an effort to implement a 'messenger model arrangement.'" [279] This case is pending, but its outcome will likely affect the activities of physician unions in either aggressively pursuing such arrangements or abandoning them as ineffective or too risky.

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275. *See id.* at 61–62.

276. Jack Seddon, Presentation to anesthesiologists, Federation of Physicians and Dentists, in Tucson, Ariz. (Jan. 14, 1999) (concerning the advantages of the union).

277. Interview with David Joseph, Chief Executive Officer, Southern Arizona Anesthesiologists Services, P.C., in Tucson, Ariz. (Jan. 18, 1999).

278. *See generally* Complaint, United States v. Federation of Physicians and Dentists, (D. Del. filed Aug 12, 1998) (No. CIV.A. 98-475) (alleging an understanding that federation members would only communicate with a payor through the federation, constituting a boycott in violation of antitrust laws).

279. *Id.* at 7.

VII. PROPOSALS FOR ANTITRUST EXEMPTION FOR PHYSICIAN UNIONS

A. H.R. 1304—The Campbell Bill

By an overwhelming majority, the House of Representatives recently passed House Resolution 1304, which would allow physicians to collectively bargain with health care plans.[280] The purpose of this bill, introduced by Representative Tom Campbell (R-Calif.), is to "ensure and foster continued patient safety and quality of care" by applying the antitrust laws to negotiations between physicians and health plans "in the same manner as such laws apply to collective bargaining by labor organizations under the National Labor Relations Act."[281]

The Campbell Bill notes specific findings, including: (1) a tenfold increase in the number of Americans enrolled in managed care plans over the last twenty years; (2) a tremendous concentration among the health care plans, with more than 162 mergers in the last ten years; (3) competition will be promoted and patient care will improve by allowing physicians to negotiate collectively with health care plans; and (4) allowing such negotiations will not diminish the physicians' ethical duty to provide medically necessary care to patients.[282]

Predictably, insurers oppose the Campbell Bill. In a recent statement, the American Association of Health Plans, a coalition of MCOs, stated that the bill: (1) would only benefit physicians, not patients; (2) would grant "unprecedented collective bargaining rights" to physicians by allowing them to fix prices without any regulatory oversight; and (3) is not necessary to allow physicians to "conduct legitimate collective negotiations" or "address quality of care issues."[283] Other organizations also opposed the bill during those same congressional hearings.[284] Others, predominantly physician groups, testified in support of the bill.[285]

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280. *See* The Quality Health Care Coalition Act of 1999, H.R. 1304, 106th Cong. (1999).

281. *Id.*, preamble.

282. *See id.* § 2(1)–(5).

283. *The Quality Health-Care Coalition Act: Hearings on H.R. 1304 Before the House Committee on the Judiciary*, 106th Cong. (June 22, 1999) (statement of the American Association of Health Plans).

284. *See id.* (statements of the U.S. Chamber of Commerce; Robert Pitofsky, Chairman, Federal Trade Commission; Joel Klein, Assistant Attorney General, Antitrust Division, Department of Justice; the Antitrust Coalition for Consumer Choice in Health Care).

285. *See id.* (statements of E. Ratcliffe Anderson, Jr., M.D., Executive Vice President and Chief Executive Officer, the American Medical Association; William W. Tipton, Jr., Executive Vice President, American Association of Orthopaedic Surgeons; Robert L. Weinmann, M.D., President, Union of American Physicians and Dentists).

B. Actions at the State Level

While the debate goes on in Washington concerning antitrust relief at the national level, some states are taking actions on their own under the state action immunity exemption from the antitrust laws.[286] Governor George W. Bush signed a Texas bill into law in 1999 that allowed independent physicians to collectively bargain with health plans without fear of prosecution under federal antitrust laws.[287] However, there are many restrictions on the size of such collective bargaining units and the methods of bargaining,[288] so the law's effectiveness will be unknown for some time.

Illinois, Delaware, the District of Columbia, New Hampshire, New Jersey, New York, and Pennsylvania have introduced bills to allow collective bargaining by physicians.[289] Other states, including California, may follow suit in the next few months.[290] A bill was recently introduced in the Arizona legislature that would have allowed collective bargaining.[291] But like the Texas bill, the Arizona legislation had so many restrictions that its effectiveness was questionable.[292] The bill did not receive support from the medical community and was held in committees.[293] Activity at the state level will probably continue, at least until its necessity is obviated by federal action.

VIII. COMPROMISE PROPOSAL

Most discussions concerning physician unionization have taken an all-or-nothing approach. This polarized attitude leaves little room for compromise or effective problem solving. However, it is possible to craft a middle-of-the-road approach to the problem. This Note seeks to balance the competing interests of the participants (purchasers, providers, and consumers) as well as the public policy interests that are represented in the antitrust and labor laws. Rather than a one-size-fits-all solution, this proposal involves analyzing each market and tailoring permissible physician activities to those conditions present in that market.

In markets without significant managed care penetration, the options available to physicians under current law[294] allow effective physician negotiations. Antitrust relief is unnecessary. Physicians can form networks or use the messenger

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286. *See supra* Part VII.B.

287. *See* Chad Bowman & Kurt Fernandez, *More Physician Bargaining Bills Expected as M.D.s Seek Strength Through State Action*, U.S. LAW WEEK, Feb. 8, 2000, at 2461.

288. *See id.*

289. *See id.*

290. *See id.*

291. *See* S. 1169, 44th Leg., 2nd Reg. Sess. (Ariz. 2000).

292. Interview with David Landrith, Arizona Medical Association, in Phoenix, Ariz. (Feb. 15, 2000).

293. *See* Arizona Legislative Informational Services ("ALIS") (visited Feb. 20, 2000) <http://www.azleg.state.az.us>.

294. *See supra* Part VI.

model to negotiate.[295] However, as discussed above, perhaps the easiest, safest, and most powerful tool is for each physician to make rational business decisions without consulting other physicians.[296] Absent such rational decision making, antitrust relief is meaningless.

Markets with significant managed care penetration, but which lack significant concentration, can tolerate additional physician activities without increasing the risk that consumers (the ultimate beneficiaries of the antitrust laws) will suffer because of these activities. What constitutes "significant managed care penetration" must be determined. Single firms do not usually raise market power concerns until they exceed about thirty percent of the market.[297] Alternatively, since physician networks consisting of as little as twenty percent of physicians in the market raise DOJ concerns,[298] perhaps this should be used as a measure of significant managed care penetration. Regardless of the level of penetration by MCOs, lack of concentration in the market ensures that a number of plans will compete with each other in the downstream market, thereby benefiting consumers.

Once the significant level of managed care penetration is reached, physicians would be allowed to collectively bargain with those plans. These collective bargaining units, or unions, would not be the same as traditional labor unions, where one union represents all the workers in that field in a particular geographic area. Instead, these unions would have two restrictions:

1) A size limit similar to the restrictions that govern physician networks, i.e., thirty percent if non-exclusive or twenty percent if exclusive; and

2) Only physicians deriving at least twenty percent of their income from managed care contracts could participate in these unions.

The first requirement ensures competition for managed care contracts. If a union is limited in size, there will be other union or non-union competitors (physician networks, physician groups, and other competitors in the market) competing with it. This restriction satisfies a primary purpose of antitrust law: preserving market competition for the benefit of consumers.[299]

The second requirement ensures that physicians participating in these unions will have a significant stake in the negotiations. This restriction acts as a substitute for the DOJ/FTC requirement that physicians in a network share significant financial risk.[300] Having a non-trivial portion of income at risk is a strong incentive to negotiate vigorously, but in good faith. Physicians with only minimal income derived from managed care plans may be unreasonable in their demands since they have little to lose by "playing hardball." Alternatively, they may use the negotiation process as a guise to prevent MCO entry into the market. Neither of these activities is desirable.

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295. *See supra* Part VI.C–VI.D.
296. *See supra* Part VI.A.
297. *See* Hirshfeld, *supra* note 243, at 19.
298. *See supra* Part VI.C.
299. Reiter v. Sonotone Corp., 442 U.S. 330, 344 (1979).
300. *See* STATEMENT 8, *supra* note 232, § 4.

It may appear that allowing only participants who already derive a significant portion of their income from managed care plans to participate in collective bargaining activities permanently excludes those who don't meet that criteria from participating in unions. However, those physicians can increase their managed care income through non-union activities, such as directly contracting with the plans or participating in networks that contract with those plans. Once their managed-care incomes reach the necessary threshold for participation, those physicians may choose to join a union or may find their current situation satisfactory without union activity.

In markets with both significant penetration and concentration, MCOs may have market power in both the upstream and downstream markets.[301] Market penetration gives MCOs significant market share in the aggregate, while market concentration apportions this total share to only a few firms (or one firm in the worst case scenario).[302] Those firms can exert pressure on the physicians in the upstream market, while facing little competition in the downstream market.[303] The DOJ recognized this as a potentially significant problem.[304]

If such a market develops without violating antitrust laws, the DOJ and FTC are less likely to take actions similar to the divestiture ordered in the Aetna/Prudential merger.[305] Considering the degree of control that the plans could exert in such a situation, the physicians contracting with them could be treated as "quasi-employees." As discussed in Section V.C, *supra*, the NLRB opened the door to this possibility in *AmeriHealth*, although it did not reach that far in that particular case.[306]

As quasi-employees, all the physicians contracted with those plans could form a single union without the size limitations imposed on unions in unconcentrated markets. To promote competition, separate unions would represent the physicians contracted with each plan. One union could not represent all the physicians contracted to the various plans. This would allow other groups of physicians, or unions representing those other physician groups, to compete with the currently contracted group for a contract with the plan, giving the plan alternative sources for necessary physician services.

This scenario does not confer unlimited power on those employees or their union. Even in markets with high penetration and concentration, a plan's ability to raise rates to compensate for increased costs imposed by unreasonable union demands would be constrained by indemnity insurance plans or other managed care plans that could enter the market. This limits the union's ability to make unreasonable demands.

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301. *See supra* Part IV.
302. *See supra* Part IV (discussion of the Aetna/Prudential merger).
303. *See supra* Part IV.
304. *See supra* Part IV.
305. *See supra* note 210 and accompanying text.
306. *See* AmeriHealth/AmeriHealth HMO and United Food & Commercial Workers Union, Local 56, AFL-CIO, 1999 WL 963200 (N.L.R.B.).

Although contracted physicians may be treated as employees in some respects under this plan, they are not true employees. Not all labor laws that protect unionized employees would apply to these physicians. If the demands are clearly unreasonable and negotiations futile, the plan may terminate the physicians under the terms of their contracts and seek physician services from another group. In that case, the plan would have to negotiate with another group of physicians or their union. Therefore, both sides have incentives to negotiate in good faith.

IX. CONCLUSION

The rapidly changing health care system has greatly changed the dynamics between its participants. As a result, the methods by which the competing interests interact with one another and among themselves have also changed. While once unthinkable, physician unionization is now supported by a significant number of medical professionals and has received political support. By balancing the interests of the various parties and the public policy interests embodied in the antitrust and labor laws, a compromise solution can be developed. This proposed solution is only a starting point, but one that could bring all parties to the table. It is unclear where these discussions will lead, but a polarized approach to the healthcare system's problems benefits no one, least of all its ultimate beneficiaries: patients.