ARTICLES

Physician Unions and the Future of Competition in the Health Care Sector

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INTRODUCTION

The 1990s were hard on doctors. The ascendancy of managed care meant lower pay, a loss of clinical control and markedly diminished economic power. By the middle of the decade, it had become clear that managed care's effects were not going to be limited to a few isolated markets. In 1994, physician income actually declined on a nationwide basis,[1] and researchers were predicting a surplus of 165,000 physicians within the following five years.[2]

While doctors' incomes are rising once again and dire predictions of physician oversupply have yet to materialize, physicians remain intensely concerned about their economic future. With a recent wave of health maintenance organization ("HMO") consolidation, independent doctors feel increasingly vulnerable to exploitation in negotiations over fee schedules and other terms of provider contracts.[3] The American Medical Association ("AMA"), once the proud and effective embodiment of organized medicine, has been largely powerless to stop the erosion of professional prerogatives at the hands of market forces.[4]

Worse yet, in the eyes of many doctors, market-based medicine adds moral insult to economic injury. While medical practitioners have struggled to maintain their incomes, business executives at some managed care organizations ("MCOs") watched their earnings soar to levels far exceeding even the most highly trained spe-

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[1] *See* Carol J. Simon & Patricia H. Born, *Physician Earnings in a Changing Managed Care Environment*, HEALTH AFF., Fall 1996, at 125. *See generally* Carol J. Simon et al., *The Effect of Managed Care on the Incomes of Primary Care and Specialty Physicians*, 33 HEALTH SERVS RES. 549 (1998) (evaluating managed care's effects on market demand for, and income of, primary care physicians, hospital-based specialists, and medical subspecialists).

[2] *See* J.P. Weiner, *Forecasting the Effects of Health Reform on U.S. Physician Workforce Requirement: Evidence from HMO Staffing Patterns*, 272 JAMA 222, 222 (1994).

[3] *See Negotiating Protection for Healthcare Providers: Hearings on H.R. 1304 Before the House Judiciary Comm.*, 106th Cong., 1st Sess. (1999) (statement of E. Ratcliffe Anderson, Jr., M.D., Executive Vice President, American Medical Association) (describing mergers and acquisitions in HMO industry and specific instances of health plan power in local markets); *see also id.* (statement of Hon. Joseph M. Hoeffel) (same).

[4] Indeed, the AMA's recent decision to establish Physicians for Responsible Negotiation, a collective bargaining organization, was apparently the result of grassroots concern over possible membership losses to labor unions actively recruiting physician members. *See generally* Steven Greenhouse, *A.M.A.'s Delegates Vote to Unionize*, N.Y. TIMES, June 24, 1999, at A1 (describing physicians' need to unionize in order to negotiate effectively with HMOs); Robert F. Leibenluft, *Attempts of "Level the Playing Field" — Developments in HMO Merger Enforcement, Antitrust Exemptions and Physician Unions*, HEALTH L. DIG., Aug. 1999, at 4, 12 (ascribing physicians' support of unionization to lack of bargaining power with HMOs).

cialists'.[5] It is as though the market's invisible hand is reaching directly into the profession's collective pocketbook, illicitly transferring the hard-won fruits of professional labor to unworthy corporate managers. A system that formerly heaped economic rewards upon its physicians on account of their undivided loyalty to their patients' health now seems to reward corporate bureaucrats, who specialize in cutting physician fees, burying doctors in mountains of paperwork before they can be paid,[6] and keeping patients away from providers. Moreover, from the physicians' perspective, the odds of getting a fair deal in the marketplace seem poor. While MCOs can use the collective economic muscle of thousands of consumers to extract concessions from individual doctors, antitrust laws prevent physicians from joining forces at the bargaining table.[7]

In the face of these developments, it is no surprise that doctors are fighting back. What is surprising, however, is that in addition to mounting intense lobbying campaigns at all levels of government and launching their own entrepreneurial projects, physicians are increasingly joining labor unions. Since the first physician union was formed in 1957, some 35,000 American doctors have joined unions.[8] Although the significance of the labor movement among physicians has so far been limited, there are a number of

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[5] The Health Administration Responsibility Project reports that the twenty-five highest-paid HMO executives earned an aggregate of $153,778,303 in 1996, exclusive of unexercised stock options. *See* Health Administration Responsibility Project, *HMO Executive Salaries* (visited Aug. 21, 1999) <http://www.harp.org/hmoexecs.htm> (on file with author). Stephen Wiggins, then CEO of Oxford Health Plans and the highest paid HMO executive in the nation, earned $29,061,599 in 1996 (including $1,741,599 in salary and bonus), and held unexercised stock options then valued at $82,799,000. *See id.*; Ron Winslow, *Wiggins, Ex-CEO of Oxford Health, Took 61% Cut in Total Pay Last Year*, WALL ST. J., May 4, 1998, at B8. Mr. Wiggins resigned in 1998 after Oxford suffered a loss of $291.3 million in 1997, receiving a $9 million severance package, which the New York Insurance Department suspended two days after its announcement. *See* Ron Winslow, *Regulators Stop Oxford Ex-Chairman's Severance*, WALL ST. J., Apr. 3, 1998, at B5.

[6] *See, e.g., AMA to Help Ensure Plan Pay Promptly*, AM. MED. NEWS, Jan. 11, 1999, at 17; Gary Shepherd, *HMO Fined for Low, Slow Pay*, BUS. J., (Aug. 16, 1999) <http://www.amcity.com/tampabay/stories/1999/08/16/story1.html> (on file with author).

[7] *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 357 (1982) (holding that physicians' collective negotiation of fees constituted horizontal price-fixing); *see also* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 465-66 (1986) (refusing to permit individual dentists to defend antitrust conspiracy on ground that dentists' goals were consistent with state policy); American Med. Ass'n v. United States, 317 U.S. 519, 529 (1943) (applying Sherman Act to physicians notwithstanding their professional status).

[8] *See* Steven Greenhouse, *Angered by H.M.O.'s Treatment, More Doctors Are Joining Unions*, N.Y. TIMES, Feb. 4, 1999, at A1; *see also* GRACE BUDRYS, WHEN DOCTORS JOIN UNIONS 11-15 (1997) (describing early physician union activity).

reasons to think that physician unions may become an important feature of American health care. First, the proportion of physicians who are employees (and, thus, potentially eligible to participate in collective bargaining) has increased dramatically, from 24.2% in 1983 to 42.3% in 1994.[9] Physician unions have traditionally been associated with doctors that work for government or teaching hospitals; the union doctor of the future is likely to be employed full-time by an MCO.[10] Moreover, physician employment is proliferating even outside captive clinics run by MCOs.[11] In addition, independent physicians are showing strong interest in union organizing. While neither the courts nor the National Labor Relations Board ("NLRB") have shown much sympathy to unions comprised of independent doctors,[12] the ultimate outcome of their unionization efforts is far from certain. Not only does the potential exist for some degree of unionization of independent physicians under current law, but legislation has also been introduced that would expressly permit them to engage in collective bargaining.[13]

Union activity among physicians raises a number of significant problems. First and foremost, widespread collective bargaining would bring competition among physicians, especially price competition, to an abrupt halt, resulting in dramatic increases in health care costs. Legalized collective bargaining would permit physician

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[9] *See* Phillip R. Kletke et al., *Current Trends in Physicians' Practice Arrangements: From Owners to Employees*, 276 JAMA 555, 557 (1996). A subsequent report estimates that as of 1998, 36% of all patient care physicians that were not federal employees and were not in residency or fellowship training were employees. *See* DAVID W. EMMONS & PHILLIP R. KLETKE, THE PRACTICE ARRANGEMENTS OF PATIENT CARE PHYSICIANS 1998 (1999). Seventy-six percent of the employed physicians were employed by institutions, and the remainder were employees of physician-owned groups. *See id.* Of the institutional employees, 27.2% were employed by medical schools and universities, 10.1% by state and local government, 24.2% by hospitals, 7.3% by HMOs, 4.8% by ambulatory sites, and 26.3% by other employers. *See id.*

[10] *See generally* Andrea Adelson, *Physicians, Unionize Thyself: Doctors Adapt to Life as HMO Employees*, N.Y. TIMES, Apr. 5, 1997, at A2 (describing union organization by doctors employed by managed care company); Greenhouse, *supra* note 8, at A1 (explaining physicians' efforts to unionize); Jodie Morse, *Unionizing the E.R.*, TIME, July 5, 1999, at 62 (noting increased physician union activity).

[11] *See* EMMONS & KLETKE, *supra* note 9.

[12] *See, e.g.*, United States v. Federation of Certified Surgeons and Specialists, Inc., 64 Fed. Reg. 5831 (Dep't Justice 1999) (consent decree) (exemplifying settlement of antitrust action involving physician groups); United States v. Federation of Physicians & Dentists, Inc., No. 98-475 (D. Del., filed August 12, 1998) (alleging that labor organization violated Sherman Act in recruiting orthopedic surgeons); College of Physicians and Surgeons of Puerto Rico, 5 Trade Reg. Rep. (CCH) ¶ 24,335 (D.P.R. Oct. 2, 1997) (exemplifying settlement of antitrust action involving physician groups).

[13] *See infra* text accompanying notes 46-50.

unions to function as doctors' cartels, raising physician fees and organizing professional boycotts of MCOs and other institutions that might challenge professional authority in the name of consumer interests. Such collective bargaining is utterly antithetical to present American health policy, which has become progressively more committed to markets and competition.[14]

Union proponents counter that competition is already in danger because MCOs all too often enjoy disproportionate power in health care markets. When MCOs use that power to extract below-market prices from health professionals, consumers' economic interests are damaged because service output and quality fall below economically efficient levels. Union organizers assert that permitting doctors to exercise countervailing economic power would restore balance to health care markets and ultimately benefit consumers.

Surprisingly, physicians rarely make the distributive justice arguments traditionally associated with labor organizing activity — that they deserve greater organizing privileges because their wages are too low or because they are forced to work in oppressive conditions.[15] Instead, they argue that unionization will benefit consum-

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[14] *See* Lynn Etheredge, *The Medicare Reforms of 1997: Headlines You Didn't Read*, 23 J. HEALTH POL. POL'Y & L. 573, 576 (1998) (arguing that recent Medicare reforms amount to governmental endorsement of market-oriented health policy); *cf.* Theodore J. St. Antoine, Connell: *Antitrust Law at the Expense of Labor Law*, 62 VA. L. REV. 603, 604 (1976) ("The antitrust laws are designed to promote competition, and unions, avowedly and unabashedly, are designed to limit it. According to classical trade union theory, the objective is the elimination of wage competition among all employees doing the same job in the same industry.").

[15] Such distributive concerns are the primary reasons Congress has specifically authorized union activity notwithstanding its adverse effects on overall economic efficiency. *See* 29 U.S.C. § 151 (1994) (stating purposes of NLRA); *see also* Thomas J. Campbell, *Labor Law and Economics*, 38 STAN. L. REV. 991, 997-98 (1986); Douglas L. Leslie, *Principles of Labor Antitrust*, 66 VA. L. REV. 1183, 1185 (1980). Employed physicians that already have unionization rights sometimes do make such claims, as do residents.

The chief sponsor of the Quality Health-Care Coalition Act, former Representative Tom Campbell (R-CA), has argued that independent doctors should be able to unionize because, like other workers, they provide an "intermediate service" to HMOs. *See The Quality Health-Care Coalition Act of 1998: Hearings Before the House Committee on the Judiciary*, 105th Cong. 2d Sess. (1998) (statement of Rep. Tom Campbell) [hereinafter Campbell Statement]. However, as FTC Chairman Robert Pitofsky has noted, "[t]he labor exemption already applies to health care professionals under the same standards that apply in other sectors of the economy; that is, physicians who are employees . . . are already covered by the labor exemption under the current law." *See The Quality Health Care Coalition Act of 1999: Hearings Before the House Committee on the Judiciary*, (visited Apr. 23, 2000) <http://www.ftc.gov/os/1999/9906/ healthcaretestimony/htm> (statement of Robert Pitofsky, Federal Trade Commission Chairman) (on file with author). Likewise, intermediate

ers by strengthening the hand of doctors in protecting consumer interests against HMO interference.[16] This is a startling claim, because unions generally achieve their distributive goals at the expense of employers and consumers.[17] Physicians union advocates might well respond that health care is a special case — one in which consumers would benefit from union activity because it would enhance physicians' bargaining power with health plans and other institutions over important health care delivery decisions. While many physicians are undoubtedly concerned about their patients' health prospects under managed care,[18] this claim is highly suspect. The medical profession was the de facto regulatory authority in the health care industry from the early part of this century until 1975, when it lost its antitrust exemption.[19] During the era of professional control, local medical societies routinely suppressed private cost-containment efforts, resisted price competition, prevented the formation of MCOs, and boycotted other professionals that threatened the competitive interests of the profession.[20] Indeed, cost-saving managed care strategies would have been nearly impossible to implement had the government not invoked the antitrust laws to stop physicians' anticompetitive conduct. Union status would allow physicians to recover much of their former exemption from the antitrust laws, so that tactics used in the past to suppress new mechanisms for health care delivery could potentially be reintroduced.

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service providers that are not employees are ineligible to bargain collectively even outside the health care industry.

[16] *See, e.g.*, H.R. 1304, 106th Cong. 1st Sess. (1999) (stating that purpose of legislation is "[to] ensure and foster continued patient safety and quality of care"); Robert L. Weinmann, *Who Needs Doctor's Unions?* (July 18, 1999) <http://www.uapd.com/press/nr0171999.htm> ("As more and more managed-care companies deny or delay benefits to patients, it becomes increasingly necessary for patients and their doctors to have stronger voices at the negotiating table.") (on file with author).

[17] *See, e.g.*, Campbell, *supra* note 15, at 997-98 (observing tendency of unionization to increase production costs).

[18] *See* Richard M. Scheffler, *Physician Collective Bargaining: A Turning Point in U.S. Medicine*, 24 J. HEALTH POL. POL'Y & L. 1071, 1073-74 (1999) (characterizing physicians as unable to exit from managed care system for moral and economic reasons and as turning to unions and physician-controlled networks as mechanisms for making their voices heard). Other nonwage factors, such as a perceived decline in decision making autonomy, may also be motivating physicians' increased interest in union activity. *See, e.g.*, Michael C. Burdi & Lawrence C. Baker, *Physicians' Perceptions of Autonomy and Satisfaction in California*, HEALTH AFF., July/Aug. 1999, at 134 (finding decline in physician satisfaction).

[19] *See infra* note 70 and accompanying text.

[20] *See infra* text accompanying notes 69-77.

The primary purpose of this Article is to evaluate physicians' claims that consumers will benefit from increased physician unionization. More generally, this Article provides an overview of the law governing physician union activity and predicts the likely effects of physician union activity on health care markets.[21] Part I explains existing legal restrictions on collective bargaining by physicians that are not "employees." It also examines efforts to persuade courts, agencies, and legislatures to change the current law to permit independent contractor physicians to bargain collectively with payors. Part II raises the possibility that, notwithstanding existing restrictions, independent contractor physicians may be able to engage in some degree of collective bargaining through participation in a "joint union" primarily composed of employed physicians. Part III considers the degree to which physician unions may lawfully engage in "proconsumer" collective bargaining, something union proponents have promised to use their bargaining power to do. Part IV analyzes the laws forbidding bargaining by physicians deemed "managerial employees" or "supervisors." In each case, analysis of the rules governing physician unionization is coupled with predictions about the effects of the various rules on competition in health care markets.

I. UNIONIZATION AND INDEPENDENT CONTRACTOR PHYSICIANS

A. The Right to Unionize

The law does not prevent any physician from joining a labor union.[22] Under the National Labor Relations Act ("NLRA") and re-

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[21] The competitive impact of unionization among residents and interns is unlikely to be significant, so their status under the labor laws is not discussed here. *See generally* Richard B. Gallagher, Annotation, *Hospital House Staff Physicians as "Employees" Under § 2(3) of the National Labor Relations Act*, 57 A.L.R. FED. 608 (1982 & Supp. 1999) (discussing union status of resident physicians). Until recently, the NLRB had held that residents were not "employees" but "students," and that they were thus ineligible for protection under the NLRA. *See* Cedars-Sinai Med. Ctr., 223 N.L.R.B. 251, 253 (1976). The NLRB has recently ruled that interns and residents are entitled to bargain collectively under the NLRA. *See* Boston Med. Ctr. Corp., 330 N.L.R.B. No. 30 (Nov. 26, 1999); *see also* Michelle Amber, *NLRB Rules that Intern and Residents at Boston Medical Center Are Employees*, 8 Health L. Rep. (BNA) 1862 (1999).

[22] *See* 29 U.S.C. § 152(5) (1994) (defining labor organization as "any organization of any kind . . . in which employees participate and which exists for the purpose, *in whole or in part*, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work") (emphasis added); *see also* NLRB v. Edward E. Budd Mfg. Co., 169 F.2d 571, 576 (6th Cir. 1948) ("Although the definition [of a labor organization] requires that *employees* participate in the organization in order to make it a

lated statutes, however, collective bargaining rights only accrue to organizations that represent "employees."[23] As a result, a health plan is not required to recognize a union attempting to bargain collectively on behalf of nonemployee physicians; nor would such a union be protected by the NLRA's prohibitions against other unfair labor practices.[24] In addition, the labor exemption to the antitrust laws does not generally apply to collective bargaining on behalf of persons other than employees.[25] Thus, if independent physicians attempted to bargain collectively over fees with payors or other institutions, their conduct would likely constitute a per se illegal price-fixing conspiracy.[26]

In determining whether union members are employees for purposes of the NLRA, courts draw on common-law agency principles.[27] Relevant factors under the agency test include employer

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labor organization, it does not require that the organization be composed exclusively of employees.") (emphasis added). The *Edward E. Budd* court continued: "The fact that persons other than employees are members of a labor organization does not prevent a labor organization, which is otherwise qualified, from continuing to function." *Id.*

[23] *See* 29 U.S.C. § 152(5) (defining "labor organization"). Employee union members may use the collective bargaining process to negotiate over issues including wages and conditions of employment. *See* Edward B. Hirshfeld, *Physicians, Unions and Antitrust*, 32 J. HEALTH L. 43, 50 (1999) ("Typically, employed physicians become interested in collective bargaining when the employer: (1) sets goals for increased productivity without consulting physicians about the likely impact of those goals on the quality of patient care; (2) makes significant changes in the patient care facilities, staffing of the facilities, or administrative procedures used in the facilities without consulting physicians; (3) demands reductions in physician income; or (4) breaks promises or uses heavy handed techniques to force physicians to make concessions."). Because independent physicians are ineligible to bargain collectively, unions cannot help them deal with analogous issues presented in their relationships with MCOs and other payors. However, unions can provide services such as legal representation, research, and education. The Union of American Physicians and Dentists ("UAPD") has "develop[ed] a mechanism to secure contracts for fee-for-service members." Union of American Physicians & Dentists, *Private Practice and IPA Information* (visited Aug. 21, 1999) <http://www.uapd.com/ipa/ipa.html> (on file with author). Some unions offer "messenger model" PPO representation to their members. *See* James C. Dechene, *Preferred Provider Organizations*, *in* HEALTH CARE CORPORATE LAW: MANAGED CARE § 2.14.1 (M. Hall & W. Brewbaker eds., 1996 & Supp. 1999) (discussing messenger model of PPO pricing and associated legal risks). The Justice Department recently alleged that one union's "messenger model" PPO was a group boycott illegal under the Sherman Act. *See* United States v. Fed'n of Physicians & Dentists, Inc., 63 F. Supp. 2d 475, 477 (D. Del. 1998).

[24] *See* 29 U.S.C. § 158 (1994) (enumerating unfair labor practices).

[25] *See infra* note 93.

[26] *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 357 (1982) (holding that physicians' collective negotiation of fees constituted horizontal price-fixing).

[27] *See* NLRB v. Town & Country Elec., Inc., 516 U.S. 85, 94 (1995); NLRB v. United Ins. Co., 390 U.S. 254, 258-59 (1968). The application of the common-law test is a benchmark against which a reviewing court will judge the reasonableness of NLRB determinations of employee status; however, the Court has stated its intention to give the NLRB "considerable deference" in interpreting the statutory definition of "employee." *See Town & Country Elec.*,

control, the skill required in the particular occupation, who supplies work instrumentalities, where the work is performed, and the method of payment.[28] Although the test usually focuses primarily on "the hiring party's right to control the manner and means by which the product is accomplished,"[29] no such emphasis governs the analysis in the labor context.[30]

Even though workers in high-skill occupations are usually presumed to be independent contractors, it is clear that physicians can be employees under the NLRA.[31] The NLRB and the courts have recognized bargaining units composed of physicians that were full-time employees of hospitals, university medical centers, medical clinics, and HMOs.[32] As a general rule, however, physicians that maintain independent medical practices — selling services to self-pay patients as well as to patients that may be insured under a vari-

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516 U.S. at 94 ("In some cases there may be a question about whether the NLRB's departure from the common law of agency with respect to particular questions and in a particular statutory context, renders its interpretation unreasonable.").

[28] *See generally* RESTATEMENT (SECOND) OF AGENCY § 220(2)(a-j) (1958) (outlining factors relevant to determining if one is servant or independent contractor). The common-law principles of agency have rarely been used to hold MCOs vicariously liable for the malpractice of physicians that are not their full-time employees. *See generally* William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, 60 LAW & CONTEMP. PROBS. 117, 141-49 (1997) (noting that historically respondeat superior has rarely been applied in managed care litigation). *But see* Schleier v. Kaiser Found. Health Plan, 876 F.2d 174, 178 (D.C. Cir. 1989) (holding staff-model HMO liable for malpractice of nonemployee physician); Dunn v. Praiss, 606 A.2d 862, 872 (N.J. Super. Ct. App. Div. 1992), (holding HMO liable for malpractice of nonemployee consulting physician), *aff'd*, 656 A.2d 413 (N.J. 1995).

[29] *See* Community for Creative Non-Violence v. Reid, 490 U.S. 730, 751 (1989); *cf.* Robb v. United States, 80 F.3d 884, 888 (4th Cir. 1996) (using common-law rules of agency to determine whether physician was "independent contractor" for purposes of Federal Tort Claims Act).

[30] *See* Roadway Package Sys., 326 N.L.R.B. No. 72, slip op. at 12 (Aug. 27, 1998) ("While we recognize that the common-law agency test described by the Restatement ultimately assesses the amount or degree of control exercised by an employing entity over an individual, we find insufficient basis for the proposition that those factors which do not include the concept of 'control' are insignificant when compared to those that do.").

[31] *See, e.g.*, New York Univ. Med. Ctr. v. NLRB, 156 F.3d 405, 411 (2d Cir. 1998) (finding that hospital committed unfair labor practice under NLRA by threatening union psychiatrists); Presbyterian Univ. Hosp. v. NLRB, 88 F.3d 1300, 1305 (3d Cir. 1996) (recognizing physicians as part of bargaining unit); Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. NLRB, 620 F.2d 20, 22 (2d Cir. 1980) (finding that hospital violated NLRA by refusing to bargain with union that included physicians); North Gen. Hosp., 314 N.L.R.B. 14, 15-18 (1994) (permitting physician employees to bargain collectively).

[32] *See, e.g.*, Thomas-Davis Med. Ctrs. v. NLRB, 157 F.3d 909, 914 (D.C. Cir. 1998) (holding that HMO clinic physicians are employees for purposes of NLRA); Thomas-Davis Med. Ctrs., 324 N.L.R.B. 29, 30 (1997) (ordering HMO to bargain with physicians' union); Montefiore Hosp., 261 N.L.R.B. 569, 569 (1982) (recognizing physicians at teaching hospital as employees under NLRA).

ety of different health plans — are not considered employees and are thus ineligible to bargain collectively under the NLRA. In addition, because antitrust law's labor exemption does not protect unions of independent physicians, attempts at collective bargaining may result in antitrust liability.[33]

Independent physicians are now actively challenging the legal barriers to collective bargaining. In *AmeriHealth Inc.*,[34] the United Food and Commercial Workers Union petitioned the NLRB to recognize a bargaining unit composed of 652 independent New Jersey physicians.[35] The New Jersey union had been formed for the purpose of bargaining with AmeriHealth HMO.[36] Although the petitioning physicians contracted, on average, with five or six other payors in addition to *AmeriHealth*,[37] and although forty percent of the physicians were solo practitioners,[38] they nevertheless alleged that the degree of control AmeriHealth exerted over their respective medical practices was sufficient to render them employees under the NLRA.[39] After the regional director dismissed the doctors' initial petition,[40] the NLRB remanded the case for a full factual hearing in order to "provide a more complete picture of the day-to-day interaction between the physicians and the HMOs"[41] and determine the degree to which HMOs control "the physicians' delivery of health care services and access to patients."[42] Noting that "the HMOs place certain conditions and restrictions on the physicians which indicate that they do not have the independence normally associated with an independent contractor,"[43] the NLRB observed that the petition "involve[d] an important issue of first impression."[44] On remand, the regional director again concluded that the independent physicians were not AmeriHealth's employ-

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[33] *See supra* note 7.

[34] *See* AmeriHealth Inc./AmeriHealth HMO, No. 4 RC 196260 (May 25, 1999).

[35] *See id.* at 2.

[36] *See id.*

[37] *See id.* at 8.

[38] *See id.* at 9.

[39] *See id.* at 2.

[40] *See* Letter from Dorothy L. Moore-Duncan, Regional Director, NLRB Region 4, to Robert F. O'Brien, Esq. (Jan. 8, 1998) (regarding AmeriHealth/AmeriHealth HMO) (on file with author).

[41] AmeriHealth Inc./AmeriHealth HMO, 326 N.L.R.B. No. 55, slip op. at 1 (Aug. 27, 1998).

[42] *Id.* at 2.

[43] *Id.*

[44] *Id.* at 1.

ees, and that AmeriHealth would thus not be obligated to recognize the union.

Although this ruling confirmed the conventional wisdom that independent physicians are ineligible to bargain collectively with payors, the NLRB's decision to remand for further fact finding is nevertheless striking. Prior to the remand, the regional director had already made extensive factual findings demonstrating the economic independence of the physicians.[45] The NLRB's remand order may thus signal some degree of openness to future efforts by independent physicians to organize.[46]

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[45] *See* Letter from Dorothy L. Moore-Duncan, Regional Director, NLRB Region 4, to Robert F. O'Brien, Esq. (Jan. 1, 1998) (on file with author). The regional director found that:

> Most significantly, the physicians themselves make the fundamental decisions that determine the profitability of their practices. Thus, they retain the unfettered right to decide matters as basic as whether they will be sole practitioners or enter in to a group practice and whether to become affiliated with one or more HMOs. In fact, AmeriHealth physicians generally contract with several HMOs that directly compete with AmeriHealth and each other. Physicians spend only a minority of their work time and derive a minority of their income from service to AmeriHealth members. The physicians have virtually total control over their expenses. . . .[T]he physicians determine the locations, contents and cost of their offices, and they make significant capital investments in their medical and office equipment. They also determine the number of staff members to employ and their compensation, and they retain full supervisory authority over their employees. The physicians also can substantially affect their incomes. . . . [T]he physicians' professional judgment and efficiency will strongly influence their practices' profitability. . . . AmeriHealth also does not provide fringe benefits, vacation, or sick leave to physicians, nor make any deductions from the physicians' remuneration. . . . Significantly, physicians have a full proprietary interest in their practices; there is no evidence AmeriHealth can restrict them from expanding, contracting or selling their practices or that it controls the organization and management of the work performed in the physician's practices. Moreover, physicians' medical practices hold themselves out to the public and advertise themselves under their own names rather than doing business in AmeriHealth's name. All of these factors convincingly demonstrate that the physicians are independent contractors.

Id. (citations omitted).

[46] Indeed, although the NLRB denied review of the regional director's decision on remand, it stated: "[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." AmeriHealth, Inc./AmeriHealth HMO, 329 N.L.R.B. No. 76, slip op. at 1 n.1 (Oct. 18, 1999). The NLRB also stated that, contrary to the regional director, it

> accord[s] little weight to the fact that AmeriHealth does not exercise substantial control with respect to the physicians' physical conduct in the performance of services . . . since it is not customary in the medical profession for fully trained staff physicians, including traditional staff physicians employed by hospitals or clinics, to be subject to substantial controls over the manner in which they perform their professional duties.

Independent contractor physicians are also working in the legislative arena to secure collective bargaining rights. Texas recently authorized independent physicians to bargain collectively,[47] and other states will soon be considering similar legislation.[48] Congress is also considering legislation that would confer antitrust immunity on physicians in their collective negotiations with health plans,[49] including both managed care plans and indemnity insurers.[50]

Id.

[47] *See* S.B. 1468, 76th Leg. (Tex. 1999). *See generally* Leibenluft, *supra* note 4, at 9-11 (discussing physicians' desire to unionize).

[48] *See* AMA, *Private Sector Objectives: Increase Physicians' Negotiating Leverage* (visited Sept. 8, 1999) <http://www.ama-assn.org/advocacy/psadvocacy/leverage.htm> (on file with author) (outlining strategies for increasing physicians' leverage against HMOs).

[49] *See* Quality Health-Care Coalition Act of 1999, H.R. 1304, 106th Cong. 1st Sess. § 3 (1999) ("Campbell Bill"). The Campbell Bill apparently does not require payors to recognize unions of independent physicians or to refrain from unfair labor practices in their dealings with unions. *See id.* The bill would make physicians "who are engaged in negotiations with a health plan . . . entitled to the same treatment *under the antitrust laws* as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled." *Id.* § 3(a) (emphasis added). However, it further provides that such physicians shall "only in connection with such negotiations, be treated as an employee . . . and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor." *Id.* This apparently superfluous language raises the question whether physicians, once engaged in negotiations, enjoy the rights accorded under the NLRA to employees during the pendency of the negotiations. *See id.* Given the specific limitation of immunity to the antitrust laws, the language is probably best interpreted as an effort to foreclose unduly narrow interpretations of the statute. Given the history of the labor exemption, see *infra* note 98, such an effort would not be unwarranted.

[50] *See* Quality Health-Care Coalition Act of 1999, H.R. 1304, 106th Cong. 1st Sess. § 3 (1999). The federal legislation defines a health plan as "a group health plan, a health insurance issuer that is offering health insurance coverage, a Medicare+Choice organization that is offering a Medicare+Choice plan, or a Medicaid managed care entity . . . ." *Id.* § 3(d)(2)(A). Health insurance issuer and health insurance coverage are also, in turn, broadly defined. *See id.* § 3(d)(2)(B), (C). It would appear to permit a physician organization such as a union or a county medical society representing virtually 100% of local physicians to negotiate a fee schedule with Blue Cross and other payors. *See id.* § 3(a). It also appears to authorize collective negotiation of contractual provisions unrelated to physicians' fees. *See id.* Local physicians might thus collectively refuse to accept payment arrangements, such as capitation or fee withholds, that create incentives for providers to reduce costs. More dramatically, they might refuse any outside review of medical necessity by health plans or attempt to dictate other nonprice features of health plans. *Cf.* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 356-57 (1982) (finding collective negotiations to be per se illegal price fixing conspiracy); United States v. Federation of Certified Surgeons & Specialists, Inc., 64 Fed. Reg. 5831 (Dep't Justice 1999) (consent decree filed Jan. 6, 1999) (stating that defendants collectively sought to obtain higher fees for services than were provided in individually negotiated contracts); College of Physicians and Surgeons of Puerto Rico, 5 Trade Reg. Rep. (CCH) ¶ 24, 335 (D.P.R. 1997) (consent decree) (noting that providers collectively demanded price-related changes to Puerto Rico's managed care plan for indigent).

B. Independent Contractor Unions and Health Care Markets

In light of current efforts to lift restrictions on independent physicians' collective bargaining, physician unionization has emerged as an important policy issue for courts and legislatures. Advocates of increased unionization argue that physician unions will benefit consumers by equalizing bargaining power between doctors and large health plans and by assuring consumers of acceptable health care quality. The most obvious danger of the unionization movement is that it will increase health care costs by legalizing cartel-like physician price fixing and other collective anticompetitive activity. These arguments are considered below.

As noted above, current law permits only employed physicians to engage in collective bargaining. The preceding discussion suggests three possible outcomes regarding independent physicians' collective bargaining rights. First, new legislation might grant independent physicians the right to bargain collectively with virtually any private health plan.[51] Second, should the NLRB and the courts ultimately conclude that HMOs' relationships with their network physicians are the substantial equivalent of employment relationships, independent physicians in markets with significant HMO penetration would be able to engage in collective bargaining with some (though probably not all) plans in those markets.[52] Finally, should the status quo continue, the potential for physician unionization will grow only to the extent that the trend toward increased physician employment continues. Price and cost effects of each of these scenarios are considered in turn below.[53]

1. Market Effects of New Legislation

A study commissioned by the Health Insurance Association of America ("HIAA Study") estimates that passage of federal legislation authorizing collective bargaining by independent physicians would increase health care expenditures by between $34.5 billion and $80 billion annually.[54] The HIAA Study attributes between

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[51] *See supra* notes 47-49 and accompanying text.

[52] *See supra* notes 34-42 and accompanying text.

[53] For a discussion of nonprice effects, see *infra* Part III.

[54] *See* CHARLES RIVER ASSOCIATES, INC., ANTITRUST WAIVERS FOR PHYSICIANS: COSTS AND CONSEQUENCES, SUMMARY OF RESEARCH FINDINGS (June 1999) (commissioned by Health Insurance Association of America) [hereinafter HIAA STUDY]. As this Article went to press, the Congressional Budget Office ("CBO") had just released its "scoring" of the Campbell

$17.8 billion to $27.4 billion of the increase to the projected loss of discounts that managed care plans have been able to negotiate with providers.[55] In addition, the study attributes $16.7 billion to $52.6 billion to changing utilization patterns that could be expected to emerge if union bargaining resulted in the curtailment of utilization review and other policies currently used by health plans to contain costs.[56] Together, these new costs are projected to translate into private sector premium increases of between six and eleven percent.[57] Based on the Congressional Budget Office's estimate that each one percent increase in health insurance costs results in an additional two hundred thousand to three hundred thousand Americans becoming uninsured, passage of this legislation could swell the ranks of the uninsured by as many as three million people.[58]

Physician union proponents argue that immunizing collective bargaining is necessary to prevent competitive distortions caused

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Bill. The CBO estimates that passage of the legislation "would increase expenditures on private health insurance by 2.6 percent in 2006 in the absence of any compensating changes on the part of health plans or other entities." CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE, H.R. 1304, QUALITY HEALTH-CARE COALITION ACT OF 1999 2 (Mar. 15, 2000). The CBO also predicts that "[d]irect [federal] spending for the Federal Employees Health Benefits Program, Medicaid and the State Children's Health Insurance Program (SCHIP) would grow by an estimated $165 million in 2001 and by $11.3 billion over the 2001-2010 period." *Id.* at 1. Finally, the CBO also projects a $145 million loss in federal tax revenue in 2001 as a result of the bill and $10.9 billion in revenue losses between 2001-2010 if the bill is enacted. *See id.*

[55] *See* HIAA STUDY, *supra* note 54, at 1. The *HIAA Study* reflects a range of assumptions about (1) the discounts managed care plans have been able to negotiate from providers and (2) the proportion of those discounts that would be lost in the event of collective bargaining by providers. *See id.* at 3. The *HIAA Study*'s projections include six scenarios. *See id.* at tbl.1. The projections noted in the text do not reflect the best-case cost increase of $20 billion ($5.1 billion price effect plus $14.8 billion utilization effect) or the worst-case increase of $124.2 billion ($45.7 billion price effect plus $78.5 billion utilization effect). *See id.* Unions would presumably be able to recover lost discounts because they would enjoy market power in negotiations with payors. *See infra* Part I.B.3.

[56] *See* HIAA STUDY, *supra* note 54, at 4-5. Significantly, the Campbell Bill would give bargaining by independent physicians "the same treatment under the antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with such collective bargaining." H.R. 1304, 106th Cong. 1st Sess. § 3(a) (1999). As discussed below, the degree to which physician employees are entitled to bargain over the features of managed care plans is subject to debate. *See infra* Part III.

[57] *See* HIAA STUDY, *supra* note 54, at 3.

[58] *See* CONGRESSIONAL BUDGET OFFICE, CBO'S ESTIMATE OF THE IMPACT OF THE MENTAL HEALTH PARITY AMENDMENT IN H.R. 3103 (May 13, 1996); *cf.* JOHN SHIELS ET AL., EXPLORING THE DETERMINANTS OF EMPLOYER HEALTH INSURANCE COVERAGE (1998) (discussing study prepared by Lewin Group for AFL-CIO finding that each 1.0% real increase in health insurance premiums results in a 0.2% to 0.6% decline in number of covered workers).

by large health plans' alleged monopoly buying power ("monopsony").[59] They also argue that physician unions will protect consumers against overaggressive cost cutting that jeopardizes plan quality.[60] Union proponents are correct that permitting health plans to wield monopsony power against health care providers is not in the best interests of consumers. Health plan monopsonists would tend to purchase physician services at depressed prices, with the result that physician output and service would tend to drop below competitive levels.[61]

It does not follow, however, that physician unions are the best available solution to the monopsony problem. Economic theory does not speak to the net welfare effects that would result when a powerful union is empowered to negotiate with an incumbent health plan monopsonist. Permitting physicians to obtain countervailing economic power through labor unions would create a bilateral monopoly, which may or may not improve consumer welfare.[62] On the other hand, a market with healthy competition on both sides of the transaction is clearly preferable to both monopsony and bilateral monopoly.[63] This suggests that more antitrust enforcement, not more unionization, is the better response to monopsony.

In addition, monopsony is not a problem in most markets. Most unionization proposals, however, do not narrowly target only markets in which MCOs have market power.[64] Instead, they would permit doctors to bargain collectively even if the other party to the negotiations is not a monopsonist. A law that gives doctors across-

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[59] *See Negotiating Protection for Healthcare Providers: Hearings on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. 1st Sess. (1999) (statement of E. Ratcliffe Anderson, Jr., Executive Vice President, Chief Executive Officer, AMA) [hereinafter Anderson statement].

[60] *See* H.R. 1304, 106th Cong. § 2(4) (1999) (proposing legislative finding of fact that: "Permitting health care professionals to negotiate collectively with health care plans will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care."); *see also* Anderson statement, *supra* note 59.

[61] *See generally* HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE § 1.2b (1994) (discussing implications of monopsony).

[62] *See* MARTIN GAYNOR & WILLIAM B. VOGT, ANTITRUST AND COMPETITION IN HEALTH CARE MARKETS, NATIONAL BUREAU OF ECONOMIC RESEARCH WORKING PAPER 7112 § 5.3 (May 1999) <http://www.nber.org> (on file with author). *See generally* R.D. BLAIR & J.L. HARRISON, MONOPSONY: ANTITRUST LAW AND ECONOMICS 109-11 (1993) (explaining bilateral monopolies and effects).

[63] *See* GAYNOR & VOGT, *supra* note 62.

[64] The statement in the text is true of legislative proposals. The doctors' theory in *AmeriHealth HMO*, discussed *supra* notes 34-46 and accompanying text, represents a more limited theory.

the-board unionization rights will thus create physician market power in many markets in which no monopsonist is operating.[65]

Paradoxically, union legislation may actually facilitate the entrenchment of health plan monopsonists. In the event physician unions and health plans follow the lead of their counterparts in other industries, one might expect to see unions engaging in "multiplan" bargaining. Large health plans would undoubtedly attempt to use this process to their competitive advantage. In capital-intensive industries, large firms may accept marketwide wage increases knowing that the increase will hurt their smaller, wage-intensive rivals more than the large firms.[66] Large health plans might adopt a similar strategy, acceding to union demands as long as their competitive advantage over smaller rivals is maintained.[67]

The claim that physician unions will improve the performance of health care markets by providing consumers with an appropriate level of quality is also highly dubious, at least if the past performance of organized medicine provides any guidance. Physicians enjoyed a de facto exemption from the antitrust laws until 1975, when the Supreme Court held that professionals were engaged in a trade or business and were therefore not exempt from antitrust laws.[68] Prior to 1975, the medical profession systematically suppressed an impressive array of potential innovations on the ground that they jeopardized health care quality or the "physician-patient

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[65] *See* United States v. Aetna, No. 3-99CV 1398-H, 1999 U.S. Dist. LEXIS 19691 (N.D. Tex. Dec. 7, 1999); *see also* United States v. Aetna Inc., 64 Fed. Reg. 44946 (Aug. 18, 1999) (competitive impact statement); Leibenluft, *supra* note 4, at 4-7.

[66] *See* HOVENKAMP, *supra* note 61, at § 7.10. *See generally* Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 YALE L.J. 209 (1986) (examining whether exclusionary practices that increase competitors' costs enable excluding firm to exercise monopoly power); Oliver Williamson, *Wage Rates as a Barrier to Entry: the* Pennington *Case in Perspective*, Q.J. ECON., Feb. 1968, at 85 (stating that one group of firms can manipulate wage rates to disadvantage of another group of firms).

[67] The Campbell Bill may not immunize multiplan bargaining. See H.R. 1304, 106th Cong. 1st Sess. § 3(a) (1999) (providing for immunity "only in connection with . . . negotiations"); Campbell Statement, *supra* note 15, at 30 (testifying that bill "is only dealing with the statutory exemption").

[68] *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 791-92 (1975) (holding that county bar association fee schedule constituted illegal price fixing conspiracy); *see also* American Med. Ass'n v. FTC, 638 F.2d 443, 449-50 (2d Cir. 1980) (describing professional norms that facilitated anticompetitive practices among health care providers), *aff'd by an equally divided court*, 455 U.S. 676 (1982), *reh'g denied*, 456 U.S. 966 (1982); Clark Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 343 (1978) (observing significance of *Goldfarb*'s holding that learned professionals are not exempt from antitrust laws).

relationship."[69] Organized medicine tried (successfully in many cases) to prevent the formation of HMOs,[70] to discourage hospital-based medical practice,[71] and to limit the professional opportunities of osteopaths, psychologists, chiropractors, nurse practitioners, and other personnel.[72] It simultaneously limited the supply of physicians through the accreditation process[73] and resisted even mildly intrusive efforts at cost containment.[74] Fearing limitations on professional autonomy, the profession at various times actively opposed both private and public health insurance programs.[75] Although the medical community accomplished some of these goals through government-conferred political authority, economic coercion was at least as important a weapon. Physicians that associated with disfavored practitioners or engaged in prohibited business arrangements were threatened with expulsion from the local medical society, loss of hospital admitting privileges, referral blacklisting, or expulsion from physician-controlled health insurance

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[69] *See* Havighurst, *supra* note 68, at 306-19 (discussing opposition of medical profession to cost-containment).

[70] *See* United States v. Oregon State Med. Soc'y, 343 U.S. 326, 339 (1952) (holding that government did not prove Sherman Act violation charges); Sams v. Ohio Valley Gen. Hosp., 413 F.2d 826, 829 (4th Cir. 1969) (holding hospital's regulations barring physicians from having their offices and practice outside of county was unconstitutional under Fourteenth Amendment); American Med. Ass'n v. United States, 130 F.2d 233, 253 (D.C. Cir. 1942) (holding that there was sufficient evidence against physicians of conspiracy to restrain trade), *aff'd*, 317 U.S. 519 (1943); Group Health Coop. v. King Co. Med. Soc'y, 237 P.2d 737, 766 (Wash. 1951) (preventing physicians from combining as restraint on trade).

[71] *See* Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 937, 979-80 (1954) [hereinafter *Power, Purpose, and Politics*] (describing AMA's efforts to suppress hospital practice by radiologists, pathologists and anesthesiologists). "Medical societies have characterized hospital practice as primarily a moral problem; they fear exploitation and lowering the dignity of the profession, and envision lay-employer control as forcing a lower standard of care for the patient." *Id.* at 979.

[72] *See id.* at 963-69; CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 832-38 (2d ed. 1998) (providing overview of conflicts between medical profession and unorthodox practitioners).

[73] *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 112-27 (1982) (tracing historical development of accreditation process); Reuben A. Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267 (1970) (describing AMA's role in deciding output of physicians); *Power, Purpose and Politics*, *supra* note 71, at 969-74 (commenting on AMA's accrediting of medical schools).

[74] *See, e.g.*, Lawrence G. Goldberg & Warren Greenberg, *The Effect of Physician Controlled Health Insurance:* U.S. v. Oregon State Medical Society, 2 J. HEALTH POL. POL'Y & L. 48, 72-73 (1977) (noting doctors' opposition to price controls).

[75] *See* STARR, *supra* note 73, at 235-89 (commenting on physicians' resistance to health insurance); *Power, Purpose and Politics*, *supra* note 71, at 981-82, 997-1000 (noting that AMA has not always been supportive of health insurance).

plans.[76] Doctors boycotted insurance plans that did not submit to professional rules and threatened to take their patients elsewhere when hospitals did not accede to their demands.[77]

One might well respond that physician unions' attempts to serve consumer interests, even if badly flawed, would nevertheless result in more extensive consumer protections than an imperfectly functioning market would generate. The obstacles to a well-functioning market in health care services are well known. Relatively few consumers today enjoy a wide range of choices among health plans, and information regarding health plans and providers is not always sufficient to ensure that consumers are able to make an adequate comparison among the available choices. Nevertheless, these problems are anything but unnoticed at present; managed care reform has become a cottage industry at both the federal and state levels.[78] Given the intense scrutiny health plans are now facing from democratically accountable institutions, consumers have little to gain from giving physicians the power to dictate the policies of managed care plans through collective bargain-

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[76] *See, e.g.*, Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605, 608 (6th Cir. 1990) (noting denial of staff privileges and malpractice insurance), *cert. denied sub nom.*, Nurse Midwifery Assocs. v. Hendersonville Community Hosp., 502 U.S. 952 (1991); Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 478 (4th Cir. 1980) (refusing to permit insurance coverage of competitors' services); Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826, 827 (4th Cir. 1969) (discussing denial of staff privileges); AMA v. United States, 130 F.2d 233, 239 n.23 (D.C. Cir. 1942) (stating that AMA imposed disciplinary action against individual with intent to affect individual's practice association), *aff'd*, 317 U.S. 519 (1943); *id.* at 250 n.87 (describing Mundt Resolution, which withheld AMA accreditation from internship programs where all staff physicians were not members of local medical societies); Health Corp. of Am. v. New Jersey Dental Ass'n, 424 F. Supp. 931, 932 (D. N.J. 1977) (discussing harassment of innovative plans); Hubbard v. Medical Serv. Corp., 367 P.2d 1003, 1005 (Wash. 1962) (discussing situation where referrals withheld). *See generally* Havighurst, *supra* note 68, at 307-15 (noting ethical rules that denied professional opportunities to doctors who participated in professional groups); *Power, Purpose and Politics*, *supra* note 71, at 988-96 (describing AMA's method of punishing physicians associated with disapproved schemes).

[77] *See* Havighurst, *supra* note 68, at 312.

[78] Legislatures are proving to be quite willing to respond to demands for consumer protection. *See* Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 1 (1999); *see also Hearings on the Quality Health Care Coalition Act of 1998, H.R. 4277, Before the House Comm. on the Judiciary*, 105th Cong. 18 2d Sess. (1998) (statement of Robert Pitofsky, Chairman, FTC) ("'[Q]uality of care arguments . . . easily can be invoked as a justification for even the most egregious anticompetitive conduct. They have been advanced to support, among other things, broad restraints on almost any form of price competition, policies that inhibited the development of managed care organizations, and concerted refusals to deal with providers or organizations that represented a competitive threat to physicians.") (footnote omitted).

ing. On the contrary, organized medicine's track record of resisting virtually every intrusion on professional control suggests that consumers may have a lot to lose from widespread unionization.

2. Market Effects of Changes in Decisional Law

Even if Congress and the state legislatures decide not to change the laws governing physician union activity, the NLRB and the courts may yet conclude that some physicians that contract with MCOs are de facto employees and thus should be entitled to bargain collectively under the NLRA. The NLRB's actions in *AmeriHealth* suggest that it is open to such an argument.[79] It seems likely, however, that de facto employee status will occur only in markets where managed care penetration is high enough such that network affiliation is a precondition to an economically viable medical practice.

If the NLRB and the courts begin holding that independent physicians can sometimes enjoy de facto employee status, one would expect the effects on health care prices and plan structure to be similar to those discussed above in connection with union enabling legislation.[80] However, as just noted, these effects would likely be confined to markets with significant penetration by highly integrated managed care plans. Some observers believe that consumer preference for plans permitting greater provider choice will limit the ultimate success of tightly integrated plans in most markets.[81] If they are correct, physician unions representing de facto employees of local payors would be of only limited importance.

On the other hand, predictions of the demise of highly integrated health plans may prove incorrect. Recent health care cost increases combined with the end of the current economic expansion may rejuvenate consumer interest in lower-cost plans, even those that restrict consumers' choice of provider. Even without a change in consumer preference, unions' effects in markets with high managed care penetration should not be underestimated. Even limited collective bargaining with MCOs would tend to diminish the cost differential between MCOs and fee-for-service

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[79] *See supra* text accompanying notes 34-46.

[80] *See e.g., supra* Part I.B.1.

[81] *See* Robert A. Berenson, *Beyond Competition*, HEALTH AFF., March/April 1997, at 171.

plans, presumably reducing the pressure on fee-for-service plans to keep costs down.

3. The Legal Status Quo and Prospects for the Future

Even if Congress and the courts do not give independent physicians collective bargaining rights, physician unions may still have a noticeable effect on health care markets. Members of employee unions may sometimes enjoy a measure of market power in one or more markets for physician services. Where this is the case, the union may succeed in raising its members' wages over a sustained period of time, likely increasing health care costs within that market.[82]

To understand the circumstances in which a union might achieve market power, consider two hypothetical cases. In the first, all physicians sell their services in a fully competitive market at a price approximating the cost of providing the services. In such a case, any doctor that attempted to raise prices would lose all his or her business because consumers would immediately look elsewhere for services available at the lower market price. Nor would any physician have an incentive to sell services at a reduced rate, because the physician would not be able to sell any additional services by doing so.

Suppose next that instead of competing with each other, all physicians in our hypothetical market join a labor union and decide collectively to raise fees ten percent above the competitive price. Unlike the decision by a single doctor in a competitive market, the union's decision may prove both sustainable and profitable for the union members. Seriously ill patients are unlikely to find good substitutes for physician services, forcing them to pay the higher price rather than travel a long distance or forgo needed medical care. Moreover, licensure laws and other barriers to entry may limit the extent to which the union's high price invites entry into the market by nonunion physicians on a significant scale for some time to come.

No real world market, especially not a medical services market, meets the theoretical requirements of either perfect competition

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[82] *See* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW §§ 10.10, 11.1 (5th ed. 1998) (explaining that amount of cost increase passed along to consumers will depend on elasticity of demand for product).

(the first hypothetical) or monopoly (the second).[83] Nevertheless, the polar cases shed light on the unions' capacity to raise the price of physician services in a given community. The less market power a labor union enjoys, the less successful it is likely to be in raising its members' wages above competitive levels. All things being equal, union price increases will lead purchasers to seek cheaper alternatives.[84] Moreover, as the two hypotheticals suggest, market power is not a function of market share, but ultimately depends on elasticities of demand and supply for the relevant product — the ability of purchasers in the market to substitute other goods or services for those of the seller in the event of a price increase above competitive levels and the ability of new sellers to enter the relevant market.

Because it is impractical to measure either the relationship of a firm's prices to its costs or relevant elasticities of demand or supply, courts generally use a firm's share of a relevant product and geographic market as a benchmark for market power.[85] Most courts presume that firms with less than fifty percent of the market cannot unilaterally raise prices above competitive levels.[86] In such cases one would expect to find good substitutes for the dominant firm's goods or services already available in the market, as well as firms that could be expected to expand output in response to a price increase by the dominant firm. In the context of purchasing health care services, however, physicians that jointly hold a market share of less than fifty percent may, in fact, represent a threat to competition. The federal agencies charged with enforcing the antitrust laws assume that a market share as low as twenty percent or

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[83] Physician services are neither entirely fungible nor entirely differentiated. Neither sellers nor buyers have perfect information. Barriers to entry are usually present but never perfect and sellers are rarely either completely atomized or utterly without competition.

[84] The labor laws limit this effect to some degree by forbidding employers to pay replacement workers a higher wage than their striking counterparts, by permitting strikers to picket, and by preventing the employer from completely severing the employment relationship with striking workers. *See* POSNER, *supra* note 82, at § 11.2.

[85] *See e.g.*, Eastman Kodak Co. v. Image Technical Servs., 504 U.S. 451, 464 (1992); Jefferson Parish Hosp. v. Hyde, 466 U.S. 2, 17 (1984); United States v. Grinnell Corp., 384 U.S. 563, 571 (1966); Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 611-13 (1953); *see also* IIA PHILLIP AREEDA ET AL., ANTITRUST LAW ¶ 531 (1995) (discussing court's definition of market power); HOVENKAMP, *supra* note 61, § 3.1b.

[86] *See, e.g.*, Blue Cross & Blue Shield United v. Marshfield Clinic, 65 F.3d 1406, 1411 (7th Cir. 1995) ("Fifty percent is below any accepted benchmark for inferring monopoly power from market share."); *see also* IIA AREEDA ET AL., *supra* note 85, ¶ 532.

thirty percent may threaten competition.[87] Where physicians collectively control such a significant portion of the market, they may make it difficult for payors to enter a market by foreclosing access to the physician base needed to form an adequate provider network.[88]

If the relevant market is defined to include all physicians in a given community, physician unions will rarely attain a market share in the range of twenty percent and thus might be presumed incapable of harming competition.[89] However, because not all physicians in any community actually compete with each other, it is usually wrong to include them all in the relevant market. In some areas, a union of employed physicians might thus achieve market power with respect to specific physician services (e.g., family physicians),[90] resulting in supercompetitive wages for the affected practitioners. In addition, independent and employed physicians may not be good substitutes for each other, because managed care plans may prefer to enter into a single contract with an integrated medical group rather than organize their own network or contract with a loosely integrated independent practice association.[91] On the whole, however, physician unions are probably unlikely to affect competition significantly as long as existing rules remain in place.[92]

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[87] *See generally Statements of Antitrust Enforcement Policy in Health Care*, [1996] Antitrust & Trade Reg. Rep. (BNA) No. 71, at S-16 (Aug. 29, 1996) [hereinafter *Antitrust Statements*] (describing antitrust safety zones for physician network joint ventures).

[88] *See id.* (noting that "relevant geographic markets for the delivery of physician services are local"); *see also* 2 JOHN J. MILES, HEALTH CARE & ANTITRUST LAW §§ 15.8-15.13 (1992 & Supp. 1999).

[89] Nationwide, only about 42% of the nation's doctors are even eligible to join labor unions. *See* Kletke, *supra* note 9, at 557. Of this group, many practice in small-group settings in which unionization is unlikely. *See id.* Moreover, only 40,000 of the nation's roughly 620,000 practicing physicians nationwide belong to unions. *See* Greenhouse, *supra* note 8, at A1, A22. While the number of employee physicians would be expected to be higher in communities with government hospitals, teaching hospitals or high managed care market penetration, the likelihood that a union will organize as many as one of every five physicians in any single community in the foreseeable future is low.

[90] I am assuming that the most important source of union activity is doctors that are employees of MCOs. Hospitals commonly employ specialists such as radiologists, pathologists, anesthesiologists, and emergency physicians, and teaching hospital employees include the full gamut of specialists. *See infra* text accompanying notes 111-15 (discussing physician markets).

[91] *But see infra* text accompanying notes 116-18.

[92] For a more extensive analysis of markets for physician services, see *infra* notes 111-15 and accompanying text (noting that physicians often compete across specialty lines).

II. JOINT UNIONS?

A. The Permissible Legal Scope of Joint Union Activity

As noted, the labor exemption to the antitrust laws does not permit groups of independent contractors to bargain collectively.[93] However, the exemption arguably permits unions composed of both employees and independent contractors ("joint unions") to fix the price of the independent contractors' services without antitrust liability. There are at least two primary strategies through which this might be accomplished. First, the union might adopt internal bylaws that require independent contractor members to adhere to a union fee schedule in their individual bargaining with payors. Second, the union might extract an agreement with one or more employers to pay independent contractors (union members or otherwise) at some minimum specified rate. Invoking the Supreme Court's famous dictum in *Apex Hosiery Co. v. Leader*,[94] some courts have held that unions' interest in maintaining the wages of their employee members would justify either of the two strategies suggested above.[95]

1. Internal Regulation of Members' Prices

In order to evaluate both the legal status of joint physician unions and also such unions' potential effects on competition, consider hypotheticals based on the two strategies mentioned above. Suppose, first, that twenty percent of local physicians are employees, and two-thirds of those physicians are represented by a single union that has collective bargaining agreements ("CBAs") with various employers, including hospitals, multi-specialty clinics and

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[93] *See* Columbia River Packers Ass'n v. Hinton, 315 U.S. 143, 145 (1942); *see also* Los Angeles Meat & Provision Drivers Union, Local 126 v. United States, 371 U.S. 94, 101 (1962); United States v. Women's Sportswear Mfg. Ass'n, 336 U.S. 460, 463-64 (1949); American Med. Ass'n v. United States, 317 U.S. 519, 525 (1943); Taylor v. Local No. 7, Int'l Union of Journeyman Horse-Shoers, 353 F.2d 593, 605 (4th Cir. 1965).

[94] 310 U.S. 469, 503 (1940) ("An elimination of price competition based on differences in labor standards is the objective of any national labor organization.").

[95] *See* H.A. Artists & Assoc., Inc. v. Actor's Equity Ass'n, 451 U.S. 704 (1981); American Fed'n of Musicians v. Carroll, 391 U.S. 99 (1968); Teamsters' Union v. Oliver, 358 U.S. 283 (1959); Home Box Office v. Directors' Guild of America, 531 F. Supp. 578 (S.D.N.Y. 1982), *aff'd per curiam*, 708 F.2d 95 (2d Cir. 1983); *see also* Charles Craver, *The Application of Labor and Antitrust Laws to Physician Unions: The Need for a Re-evaluation of Traditional Concepts in a Radically Changing Field*, 27 HASTINGS L.J. 55, 90-92 (1975); Hirshfeld, *supra* note 23, at 59-60 (noting possibility of joint physician unions).

HMOs. If the union recruits independent contractor members as well as employee members, could it require its independent contractors to adhere to a minimum union fee schedule without incurring antitrust liability?[96]

The first question our hypothetical joint union would face is whether its adoption of bylaws fixing the independent physicians' minimum prices would be immune from antitrust scrutiny under the labor exemption. Similar agreements among independent physicians outside the union context constitute illegal price fixing, and have been a major focal point of government enforcement activity.[97] Notwithstanding the government's concerns that such arrangements have the potential to harm consumers, a plausible case can be made for their immunity.

The history of the labor exemption is a complex story of back-and-forth decision making between Congress and the judiciary.[98] The end result has been the creation of two separate, albeit closely related,[99] legal rules: the "statutory" and "nonstatutory" exemptions. The statutory exemption rests on the Sherman, Clayton, and Norris-LaGuardia Acts,[100] and shields agreements among employees

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[96] *Cf. Home Box Office*, 531 F. Supp. at 582-85 (upholding union bylaws that prevented independent contractor producer-director members from working for firms that had not executed collective bargaining agreement with union). *Home Box Office* also involved the execution of a CBA on behalf of "freelance" directors, whom the court held to be employees. *See id.* at 582; *see also Carroll*, 391 U.S. at 104 (upholding bylaws and union rules governing "club-date" performances and collective bargaining agreements governed non-club-date ("steady") engagements).

[97] *See* United States Department of Justice Antitrust Division, Health Care Task Force, Recent Enforcement Actions (visited Mar. 20, 2000) <http://www.usdoj.gov/atr/public/health_care/2044.htm> (on file with author); Richard A. Feinstein, *FTC Antitrust Actions in Health Care Services and Producers* (Feb. 10, 2000) <http://www.ftc.gov/bc/atahcsvs.htm> (on file with author).

[98] *See generally* United Mine Workers v. Pennington, 381 U.S. 657, 700-03 (1965) (opinion of Goldberg, J.) (commenting on congressional responses to Court's interpretation of Sherman Act); United States v. Hutcheson, 312 U.S. 219, 230-31 (1941) (noting controversy in Congress over Clayton Act and Court's case-by-case interpretation of Sherman Act); Bernard D. Meltzer, *Labor Unions, Collective Bargaining and the Antitrust Laws*, 6 J.L. & ECON. 152, 154-58 (1963) (outlining history of union activity and antitrust litigation); Ralph K. Winter, *Collective Bargaining and Competition: The Application of Antitrust Standards to Union Activities*, 73 YALE L.J. 14, 30-38 (1963) (describing history of Sherman Act in regulating union activities). For a detailed and influential analysis of the labor exemption, see Douglas L. Leslie, *Principles of Labor Antitrust*, 66 VA. L. REV. 1183, 1183 (1980).

[99] *See* IA PHILLIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW, ¶ 255c (1997) (arguing that factual distinction between statutory and nonstatutory exemptions is "more one of historical convenience than substance" and that there is "single taproot" underlying both exemptions: "whether the challenged activities are seen as 'legitimate' labor activities directed at the wages, hours and working conditions of the employees").

[100] Section 6 of the Clayton Act provides:

and labor organizations from antitrust scrutiny.[101] The nonstatutory exemption, on the other hand, is a judge-made immunity covering agreements between unions and nonlabor parties.[102] The nonstatutory exemption rests on the recognition that antitrust immunity for agreements made within and between labor organizations would be of little use if the end result of successful union activity — a CBA with one or more employers — is an unprotected antitrust conspiracy.[103]

Because the hypothetical fee schedule involves an intra-union agreement, analysis begins with the statutory exemption.[104] In order to obtain immunity the union must show (1) that the agreement does not involve a "nonlabor party,"[105] (2) that the agreement was entered into in the union's self-interest[106] and, (3) that the

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> 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.

15 U.S.C. § 17 (1994). Section 20 of the Act forbids courts from enjoining strikes, boycotts, or picketing "in any case between an employer and employees, or between employers and employees, or between employees, or between persons employed and persons seeking employment, involving, or growing out of, a dispute concerning terms or conditions of employment. . . ." *Id.* § 52. Later, in the wake of a Supreme Court decision holding that the Clayton Act applies only to "lawful" labor union activities, *Duplex Printing Press v. Deering*, 254 U.S. 443, 473 (1921), Congress passed the Norris-LaGuardia Act, 29 U.S.C. §§ 101-115 (1994), which further expanded the protection against labor injunctions, specifically forbidding the courts from enjoining secondary boycotts and clarifying Congress's intent to grant broad immunity to union activities.

[101] Although the statute is aimed at preventing judicial use of the injunction as a remedy in connection with labor activities, it has been interpreted to immunize covered conduct from liability under the antitrust laws as well. *See* United States v. Hutcheson, 312 U.S. 219, 236 (1941) ("The Norris-LaGuardia Act reasserted the original purpose of the Clayton Act by infusing into it the immunized trade union activities as redefined by the later Act. In this light § 20 removes all such allowable conduct from the taint of being 'violations of any law of the United States,' including the Sherman Law.").

[102] *See* Connell Constr. Co. v. Plumbers & Steamfitters Local 100, 421 U.S. 616, 621-22 (1975).

[103] *See* IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 256a.

[104] One might argue that because the fee schedule will affect the members' agreements with third-party payors, it should be analyzed under the nonstatutory exemption. However, as we shall see, the tests under the two exemptions are substantially similar, so applying the nonstatutory exemption test should not change the result. *See infra* notes 144-47 and accompanying text.

[105] *See* H.A. Artists & Assocs., Inc. v. Actors Equity Ass'n, 451 U.S. 704, 717 (1981); American Fed'n of Musicians v. Carroll, 391 U.S. 99, 105-06 (1968); *Hutcheson*, 312 U.S. at 232.

[106] *See H.A. Artists*, 451 U.S. at 715; *Hutcheson*, 312 U.S. at 232.

challenged agreement is related to the union's legitimate interests.[107]

a. Agreement with Nonlabor Parties

The statutory exemption is embodied in section 20 of the Clayton Act and section 13 of the Norris-LaGuardia Act. Section 13 specifically defines "labor disputes" to include

> any controversy concerning terms or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, regardless of whether or not the disputants stand in the proximate relation of employer and employee.[108]

In order to show that independent physicians are "labor parties," the union must prove that its employee members are either in "job or wage competition"[109] with the independent physicians or that there is some "other [common] economic . . . [interest] affecting legitimate union interests between the union members and the independent contractors."[110]

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[107] *See H.A. Artists*, 451 U.S. at 718; *Carroll*, 391 U.S. at 106; Local 189, Amalgamated Meat Cutters v. Jewel Tea Co., 381 U.S. 676, 691-92 (1965); United Mine Workers v. Pennington, 381 U.S. 657, 665-66 (1965); *see also* IA AREEDA & HOVENKAMP, *supra* note 99, ¶¶ 255c, 255e. There is considerable debate over the precise contours of the appropriate legal test for evaluating immunity under the labor exemption. Supreme Court precedent in this area has created an impression that cases are decided on an almost ad hoc basis. *See* Campbell, *supra* note 15, at 998 n.30 (describing important labor antitrust cases). Scholarly treatment of the exemption has likewise failed to bring about any consensus test. *See* IA AREEDA & HOVENKAMP, *supra* note 99, ¶¶ 255-57; *id.* at 998-1004; Leslie, *supra* note 15, at 1184-85.

[108] 29 U.S.C. § 113(c) (1994); *see also H.A. Artists*, 451 U.S. at 714 n.14, 715; Los Angeles Meat & Provision Drivers Union, Local 626 v. United States, 371 U.S. 94, 103 (1962).

[109] *See H.A. Artists*, 451 U.S. at 718; *cf. Los Angeles Meat*, 371 U.S. at 103 (holding that independent contractors were ineligible for labor exemption because they did not compete with employee union members); United States v. Fish Smokers Trade Council Union, Inc., 183 F. Supp. 227, 235 (S.D.N.Y. 1960) (same).

[110] *See H.A. Artists*, 451 U.S. at 718; *Carroll*, 391 U.S. at 106; *Los Angeles Meat*, 371 U.S. at 103; *see also* Milk Wagon Drivers Union Local No. 753 v. Lake Valley Farm Prods., 311 U.S. 91, 97-99 (1940) (holding that union attempting to organize competing independent vendors engaged in labor dispute as defined by Norris-LaGaurdia Act). The Court has stated that "a party seeking refuge in the statutory exemption must be a bona fide labor organization, and not an independent contractor or entrepreneur." However, this purported rule has been honored mostly in the breach. *H.A. Artists*, 451 U.S. at 717 n.20. In both *Carroll* and *H.A. Artists*, the Court's two most recent efforts to interpret the statutory exemption, the Court specifically held that independent contractors could be "labor parties." *See id.* at 720-

It should usually be possible to prove that there is significant job and wage competition between employed physician union members and the independent physicians they may seek to bring into the union. Physicians practicing in the same local community are generally regarded as geographic competitors,[111] and at least some portion of local physicians will compete with each other in any given product market. The most obvious division in the product market for physician services is between primary care providers and specialists. Many different types of physicians are potential competitors in the primary care market. Family physicians compete for the primary care loyalties of all patients; internists (even those who also practice a particular subspecialty such as cardiology or pulmonology) provide primary care to adults; pediatricians provide primary care to children, and; obstetrician-gynecologists may provide primary care to women. Each of these groups of physicians competes with one or more of the other groups in that a significant portion of each group's practice is likely to represent services that could be offered by the others.[112]

Analyzing specialty services is more complicated. Some specialty services are provided only by specialists of a particular category. Only cardiothoracic surgeons, for example, are likely to offer heart bypass surgery. Other services, such as some types of cosmetic surgery, may be performed by general surgeons, plastic surgeons, dermatologists, and otolaryngologists. Moreover, some services are available from both specialists and primary care physicians.[113] Specialists are also more likely to compete with physicians outside the local community, as patients needing specialized nonurgent treatment are more likely to travel reasonable distances to obtain it

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21 (theatrical agents); *Carroll*, 391 U.S. at 106 (orchestra leaders); *id.* at 113 (booking agents).

[111] *See Antitrust Statements*, *supra* note 87, at S-16 n.26 (noting that "relevant geographic markets for the delivery of physician services are local"). *See generally* MILES, *supra* note 88, at § 15.13.

[112] *See, e.g.*, HTI Health Servs. v. Quorum Health Group, 960 F. Supp. 1104, 1115-16 (S.D. Miss. 1997) (finding that market for primary care physician services includes general practitioners, family practitioners, internists and pediatricians as distinct submarket but does not include obstetrician-gynecologists); Letter from Joel I. Klein, Acting Assistant Attorney General, to Robert M. Langer (July 30, 1997) (on file with Department of Justice, Business Review Letter to Vermont Physicians Clinic).

[113] *See, e.g.*, Letter from Anne K. Bingaman, Assistant Attorney General, to Oswald L. Mikell, M.D. (Nov. 1, 1995) (on file with Department of Justice, Business Review Letter) (noting that it is appropriate to include internists, general practitioners, family practice physicians, and dermatologists in dermatology product market).

than patients seeking primary care.[114] In any given market, it is likely that some significant portion of independent primary care specialists will be in "job competition" with the employee members of our hypothetical union.[115]

The strongest argument that employed physicians do not compete with their independent counterparts is that MCOs would not regard organizing a network of independent physicians as a good substitute for owning or contracting with an integrated multispecialty clinic staffed by employed physicians.[116] If this were the case, competition from independent physicians would not necessarily limit the ability of an employed physicians union to extract wage increases and other concessions from an MCO.

This argument, however, is ultimately implausible. Many MCOs provide care through networks of independent physicians rather than through clinics staffed by employees. Indeed, the current trend is for MCOs to offer consumers greater choice among providers, suggesting that most MCOs prefer looser networks to more tightly integrated structures.[117] Thus, an MCO would likely substitute the services of independent physicians for those of its employees if its wage costs rose too dramatically.[118]

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[114] *See* MILES, *supra* note 88, at § 15.13; Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, to Neil E. Ayervais (Sept. 23, 1994) (Federal Trade Commission Advisory Opinion) (on file with author).

[115] This same rationale would justify a finding, in the alternative, that employees and independent physicians have common economic interests affecting legitimate union interests. *See supra* note 110 and accompanying text. Because the purchasers of physician services (most notably MCOs, but also other payors) can substitute the services of union members for those of independent physicians and vice-versa, the presence of independent contractors in physician services markets will directly affect the union's ability to succeed in bettering the wages and working conditions of its members.

[116] This argument was made and rejected in *HTI Health Services v. Quorum Health Group. See HTI Health*, 960 F. Supp. at 1117-20; *see also* Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406, 1409-11 (7th Cir. 1995) (holding that HMO services do not constitute separate product market), *cert. denied*, 116 S.Ct. 1288 (1996); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300 & n.5 (W.D. Mich. 1996) (rejecting focus on hospital services purchased by managed care organizations).

[117] *See* Berenson, *supra* note 81, at 171 (arguing that health care markets have not evolved as managed competition theorists predicted, in part because of consumers' desire to maintain access to personal physicians).

[118] Only if one first regards managed care plans as occupying a separate product market from more conventional forms of health insurance (presumably a product appealing to buyers who place an unusual premium on low cost) and, second, finds that physician-employees are the only means of providing low-cost, efficient service to consumers, might one then conclude that employed physicians should be treated separately from their independent counterparts. It is worth noting that every court to address the issue in the context of an antitrust dispute has refused to find that managed care plans do not compete with

b. Self-Interest

As noted above, to gain immunity under the statutory exemption a union must also prove that it is acting in its own interest and is pursuing legitimate union objectives. These additional requirements present some significant obstacles for our hypothetical fee schedule bylaws. As long as independent physicians continue to outnumber employed physicians, unions that attempt to organize independent physicians will almost certainly be accused of acting not in their self-interest, but rather in the interest of the independent doctors. Indeed, if joint physician unions were to succeed, independent physicians might join the union solely for the purpose of availing themselves of the union's antitrust exemption. Where the union allows itself to be used for such purposes, the antitrust exemption should not be available.

In order to succeed in organizing independent doctors, physician unions will have to demonstrate how the organizing activity benefits the employed physicians who form the core of the union.[119] In particular, the union should be able to show the connection between union policies and the economic interests of its employee members. For example, a union's independent contractor

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more conventional forms of health insurance. *See* Doctors Hosp. v. Southeast Med. Alliance, Inc., 123 F.3d 301, 308 n.15 (5th Cir. 1997); *Marshfield Clinic*, 65 F.3d at 1409-11; U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993); Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1331-32 (7th Cir. 1986), *reh'g denied*, 788 F.2d 1223 (7th Cir. 1986); The Orthopedic Studio, Inc. v. Health Ins. Plan, No. CV-95-4338, 1996 WL 84503, at *5 (E.D.N.Y. Feb. 9, 1996); Total Benefits Servs., Inc. v. Group Ins. Admin., Inc., 875 F. Supp. 1228, 1237-38 (E.D. La. 1995); Hassan v. Independent Practice Assocs., P.C., 698 F. Supp. 679, 691 (E.D. Mich. 1988); Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360, 1478-79 (D. Kan. 1987), *aff'd in part*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1990); Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 574 F. Supp. 457, 469-71 (M.D. Pa. 1983), *aff'd*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985); *see also* Capital Imaging Assocs., P.C. v. Mohawk Valley Med. Assocs., Inc., 996 F.2d 537, 547 (2d Cir. 1993), *cert. denied*, 510 U.S. 947 (1993). To the extent an MCO enjoyed a cost advantage over its competitors, it would have some degree of flexibility in its pricing. Determining that the MCO and its competitors compete in the same market represents a judicial policy judgment about "how much market power we want to squeeze out of markets, given our capabilities and the costs of antitrust enforcement." HOVENKAMP, *supra* note 61, at 85.

[119] Employees form the core of a joint union in the sense that the labor laws are intended to protect employees and, only incidentally, independent contractors. *See* International Ass'n of Heat & Asbestos Workers v. United Contractors Ass'n, Inc., 483 F.2d 384, 390 (3d Cir. 1973) (discussing sham union controlled by employer-independent contractors); Carpenters' Dist. Council v. United Contractors Ass'n, 484 F.2d 119, 121 (6th Cir. 1973) (same).

fee schedule specifying minimum prices for services not regularly offered by employee members would be highly suspect.[120]

c. Legitimate Union Interests

The third element of the statutory exemption requires our hypothetical physicians' union to demonstrate that its fee schedule furthers legitimate union interests.[121] The need for judicial scrutiny of the legitimacy of union interests arises from an inherent conflict between labor and antitrust policy. Although the object of antitrust policy is to ensure competitive markets, a union's effectiveness requires the elimination of competition from nonunion workers.[122] Inevitably, suppression of competition in the labor market affects the employer's product market as well, eliminating at least "that part of such competition which is based on differences in labor standards."[123] If antitrust law were to condemn all anticompetitive effects in the product market, it would virtually eviscerate federal labor policy.[124] On the other hand, blanket antitrust immunity for any union-imposed restraint could have dramatic effects on industry competition. The courts thus attempt to steer a middle ground, "tolera[ting] . . . the lessening of business competition based on differences in wages and working conditions," but refusing to permit unions to "impose direct restraints on competition among those who employ its members."[125] The labor exemption will thus almost always apply to agreements related to wages, hours and working conditions — issues that are mandatory subjects of collective bargaining.[126] It would not apply, however, to a union

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[120] *Cf.* Local 24, Int'l Bhd. of Teamsters v. Oliver, 358 U.S. 283, 293-94 (1959) (holding that narrow scope of collective bargaining agreement provisions fixing equipment lease prices for independent contractor drivers "show[s] that its [lawful] objective is to protect the negotiated wage scale against the possible undermining through diminution of the owner's wages for driving which might result from a rental which did not cover his operating costs").

[121] *See* IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 255e1; *see also* USS-POSCO Indust. v. Contra Costa County Bldg. & Constr. Trades Council, 31 F.3d 800, 808 (9th Cir. 1994); *supra* note 107 and accompanying text.

[122] *See* Apex Hosiery Co. v. Leader, 310 U.S. 469, 503 (1940) ("[I]n order to render a labor combination effective it must eliminate the competition from nonunion made goods . . . .").

[123] *Id.* ("[A]n elimination of price competition based on differences in labor standards is the objective of any national labor organization.").

[124] *See* Connell Constr. Co. v. Plumbers & Steamfitters Local Union No. 100, 421 U.S. 616, 622 (1975).

[125] *Id.* at 622.

[126] *See* 29 U.S.C. § 158(d) (1994).

strike demanding, for example, that an employer charge a high price in the product market in order to create more available cash for wage increases.[127] In general, courts are far less concerned about union-generated restraints in the labor market than about restraints in the employer's product market. Restraints in the product market are tolerated only when there is no less restrictive alternative to achieving the union's legitimate objective.

The first step in determining whether our hypothetical fee schedule bylaws further legitimate union interests is thus to identify the union's purported interest in promulgating the fee schedule. The union's obvious motive — keeping its employee members' wages high — is at the core of American labor policy.[128] Nevertheless, because courts do not give even core labor interests unlimited deference, the connection between the union's interest in high wages and the fee schedule must be identified and scrutinized.[129]

The connection between the fee schedule and high wages for employed union members is clear. The union cannot sustain its demand for high wages over the long term unless it can suppress competition in the market for its members' services. As long as employee union members must compete with independent physicians, increases in the employees' wages will only make the services

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[127] *See* IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 255c.

[128] Indeed, wages are among the mandatory subjects of collective bargaining. *See* 29 U.S.C. § 158 (1994); *see also* American Fed'n of Musicians v. Carroll, 391 U.S. 99, 108-09 (1968) (characterizing union price list that specified amounts that orchestra leader-union members would pay themselves and the "side musician"-union members they hired as "simply a means for coping with the job and wage competition of the leaders to protect the wage scales of musicians who . . . are employees" and characterizing the price list as "indistinguishable in its effect from all collective bargaining provisions in Teamsters Union v. Oliver") (internal citations omitted); Local 24, Int'l Bhd. of Teamsters v. Oliver, 358 U.S. 283, 294 (1959) ("The inadequacy of a rental which means that the owner makes up his excess costs from his driver's wages not only clearly bears a close relation to labor's efforts to improve working conditions but is in fact of vital concern to the carrier's employed drivers; an inadequate rental might mean the progressive curtailment of jobs through withdrawal of more and more carrier-owned vehicles from service."); *id.* at 294-95 (holding that equipment lease price schedule was mandatory subject of collective bargaining); Craver, *supra* note 95, at 91 (arguing that regulation of independent doctors' fees would be in legitimate interest of union of employed physicians). *But see Carroll*, 391 U.S. at 110 n.10 (suggesting potential for different result if prices set had been maximum prices or had been "set so high as to cover not merely compensation for the additional services rendered by a leader but entrepreneurial profit as well.").

[129] *See* Local Union No. 189 v. Jewel Tea Co., 381 U.S. 676, 690 n.5 (1965) (stating that "crucial determinant is not the form of the agreement — e.g., prices or wages — but its relative impact on the product market and the interests of union members"); IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 255c3.

of independent doctors more attractive to payors and other purchasers. As a result, the presence of competing nonunionized, independent physicians will tend to limit the union's ability to raise its members' wages and improve their working conditions. The fee schedule limits price competition from independent physicians and thereby reduces the incentives of health care purchasers to respond to union wage demands by substituting away from union physicians.[130]

Having identified the union's means of accomplishing its objective — the fee schedule — the next step is to identify the anticompetitive effects the fee schedule will cause in the relevant labor and product markets as well as any plausible less restrictive alternatives. Distinguishing between labor market effects and product market effects[131] can be especially difficult in health care markets because the physician labor market and the market for medical services were historically one and the same. For most of the twentieth century, doctors practiced independently, selling their services directly to their patients on a fee-for-service basis.[132] Early forms of health insurance, most notably Blue Shield, were designed to preserve this arrangement. Physicians were essentially free to set their own prices, and the insurer acted as a passive payor, indemnifying the patient for expenses incurred.[133]

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[130] *See supra* text accompanying notes 111-15.

[131] *See supra* text accompanying notes 118-24.

[132] Significantly, this mode of practice was largely the result of policies instituted by organized medicine. The ethical code of the medical profession forbade "contract practice" — in which a physician sells services to a corporate "middleman" — until the Federal Trade Commission successfully attacked the code as a restraint of trade. *See* AMA v. FTC, 638 F.2d 443, 450-51 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982), *reh'g denied*, 456 U.S. 966 (1982) (upholding FTC order prohibiting American Medical Association from imposing restraints on certain advertising, solicitation and contractual practices of physicians). Professional ideology in this respect was also reflected in state laws that prevented corporations from employing physicians. *See generally* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 507-18 (1988) (discussing history of corporate practice of medicine doctrine); Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 458-67 (1987) (examining development of corporate practice doctrine and recounting history of medical profession's ethical restraints on corporate practice).

[133] *See* STARR, *supra* note 73, at 385-87; *see also* Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, *in* AMERICAN HEALTH POLICY 87, 98 (Robert B. Helms ed., 1993). Havighurst argues that payors' passivity was the product of professional ideology. *See id.* ("Under the [professional] paradigm the characteristics of medical care are a scientific and professional matter, to be determined with no more than cursory regard to cost considerations. Accordingly, all important decisions concerning medical care are entrusted exclu-

The fundamental feature of managed care, however, is the interposition of payors between consumers and providers on the theory that the payor will organize and manage the delivery of health care services for the benefit of the consumer. Significantly, even traditional insurers commonly use managed care techniques to control costs. As a result, it is now meaningful to speak of separate labor and product markets in medical care.[134] Physician services have become but one input into the complex bundle of health care finance and delivery services sold by most health plans.

This development is most easily seen in the context of "staff model" HMOs, which employ physicians directly and, in effect, resell their services on a prepaid basis to HMO members. Instead of buying discrete medical services directly from a physician for a negotiated fee, HMO members pay a monthly fee that guarantees them access to specified medical care if and when it becomes necessary. The product purchased by the consumer is a bundle of health care finance and delivery services, of which physician services are only one component. Thus, a distinction arises between the physician services labor market, in which the staff model HMO is one of many purchasers, and the product market, in which consumers buy varying packages of health coverage.

A similar separation of labor and product markets now exists in most private health plans, including those not generally regarded as managed care products. Any health plan that negotiates payment rates with physicians,[135] instead of merely reimbursing its members' expenses, effectively buys physician services as one input in a package of health care and financial services sold to consumers. This is true even for plans that afford their members substantial choice of provider, such as PPO or POS plans, at least with respect to in-network physicians. While consumers retain the right to choose their doctor, the doctor has already committed to a discounted payment rate on the theory that the health plan will steer patients to his or her practice.[136] Moreover, in the context of the

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sively to professionals who are accountable only to the medical profession itself or to standards of its making.") (internal citation omitted).

[134] *See* Brewbaker, *supra* note 28, at 129-30.

[135] Such negotiation might occur directly or through an intermediary such as a physician network or multispecialty clinic.

[136] *See* Brewbaker, *supra* note 28, at 151. *But see* Berenson, *supra* note 81, at 175-76 (noting physician reluctance to drop MCO contracts because of loyalty to patients).

modern health plan, physicians compete not only for patients but also for positions as network physicians.

Having identified the relevant labor and product markets, we can now (1) evaluate the anticompetitive effects of the independent physician fee schedule and (2) consider whether a less restrictive alternative would have been available to our hypothetical union. Assuming wide participation by independent physicians, the fee schedule could be expected to have a pronounced effect in the physician labor market. Price competition among independent physicians would be suppressed as to the specified fees. In addition, because independent physicians could not attract business away from the employed physicians by reducing the prices charged to MCOs and other payors, price competition between employed and independent physicians would be suppressed. Presumably, wage rates and scheduled fees could be kept in an equilibrium designed to prevent payors from forcing the employed and independent physicians to compete against each other on the basis of price.

The changes in the physician labor market occasioned by the adoption of the fee schedule would tend to have significant effects in the product market as well. If plans are no longer free to obtain low prices for their members by negotiating aggressively with physicians, costs, and thus prices, could be expected to increase.[137] From a health policy perspective, this would be a dramatic and undesirable development. Under the statutory exemption, however, in the absence of a less restrictive means of promoting union objectives, rising health care costs have little, if any, relevance. It is well-established that "successful union activity . . . may have some influence on price competition [in the product market] by eliminating that part of such competition which is based on differences in labor standards."[138] Indeed, the Supreme Court has noted that eliminating such competition is "the objective of any national labor organization."[139] The union fee schedule would thus seem to fall into a category of arrangements the courts have repeatedly approved — union agreements made in pursuit of their self-interest

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[137] *See supra* notes 54-57 and accompanying text (discussing HIAA STUDY).

[138] Apex Hosiery Co. v. Leader, 310 U.S. 469, 503 (1940).

[139] *Id.* The *Apex* court went on to suggest that this sort of diminution in competition was not thought to violate the Sherman Act, even in the absence of the statutory exemption. *See id.* at 503-04; *see also* American Fed'n of Musicians v. Carroll, 391 U.S. 99, 106 (1968); United Mine Workers v. Pennington, 381 U.S. 657, 666 n.2 (1965).

whose primary effects are felt in the labor market but which incidentally affect product market prices because wage or labor standard competition has been diminished.

As noted, the final consideration in our analysis of a hypothetical fee schedule is whether the union's objective might have been accomplished through means less restrictive of competition.[140] Given the danger to competition a fee schedule would pose, the range of services covered by the schedule must be as narrow as possible. Because the fee schedule would be illegal if developed and implemented by independent physicians acting alone, all terms in the schedule must bear some relationship to the union's legitimate interest in protecting the *employed* physicians' economic fortunes. A fee schedule that fixed prices for services not provided by employed physicians would only further the independent physicians' interest in restraining competition among themselves and not the union's legitimate objectives.[141]

2. Collective Bargaining over Nonmembers' Prices

Let us now consider a second hypothetical. Suppose a union of employed physicians negotiates a CBA with one or more of the health plans that employ its members. The CBA requires the health plan to adhere to a minimum fee schedule when it contracts with nonunion independent physicians. Such an agreement would benefit union members by diminishing implicit price competition between the union members and independent physicians.[142] Because the agreement includes one or more employers, and does not concern only labor parties, it is governed under the nonstatutory exemption.

Under the nonstatutory exemption, a CBA is immune from antitrust scrutiny if its terms "are intimately related to a mandatory subject of bargaining and do not have 'a potential for restraining competition in the business market in ways that would not follow naturally from elimination of competition over wages and working

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[140] *See* Connell Constr. Co. v. Plumbers & Steamfitters Local Union No. 100, 421 U.S. 616, 625 (1975); IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 255e3.

[141] *See* Craver, *supra* note 95, at 92. Even so, courts should be careful not to exercise too much hindsight in their scrutiny of union activities.

[142] *See supra* notes 111-15 and accompanying text.

conditions.'"[143] As with the statutory exemption, the basic question is whether the restraint of trade effected by the CBA is sufficiently tethered to the core purposes of the labor laws.[144]

Under this test, our hypothetical CBA should be exempt from antitrust scrutiny. The CBA's independent contractor price term is directly related to employee union member wages, as long as the specified prices relate to services that are, or could be, provided by the union, and wages are among the mandatory subjects of collective bargaining.[145] The resulting restrictions on competition in the relevant labor and product markets likewise follow naturally from elimination of competition over wages and working conditions.[146] Indeed, a CBA bearing a strong resemblance to our hypothetical was approved by the Supreme Court in *Teamster's Union v. Oliver*.[147]

In most markets today, negotiating a CBA that sets independent competitors' fees (the second hypothetical) would not likely be as effective a union strategy as attempting to bring the independent physicians into the union (the first hypothetical). The CBA strategy would only be effective if the union could engage in multiemployer bargaining with a substantial portion of the health plans in the relevant market. Otherwise, the union's attempt to restrict independent physicians' fees would only put the contracting employer at a competitive cost disadvantage. On the other hand, if a substantial proportion of local independent physicians can be brought into the union's membership and held to a fee schedule, union members might be effectively insulated from competition.

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[143] II AMERICAN BAR ASS'N, ANTITRUST LAW DEVELOPMENTS (FOURTH) 1307 (1997) (quoting *Connell*, 421 U.S. at 635); *see also* Local Union No. 189 v. Jewel Tea Co., 381 U.S. 676 (1965); IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 256d (noting that some courts apply three-part test that would exempt collective bargaining agreements if "(1) 'the restraint on trade affects only the parties'; (2) the agreement 'concerns a mandatory subject of collective bargaining,' such as wages, hours and conditions of employment; and (3) the agreement 'is the product of arm's length bargaining.'") (citations and footnotes omitted).

[144] *Cf.* IA AREEDA & HOVENKAMP, *supra* note 99, ¶ 256 (characterizing "the basic policy question" as "[w]hich union restraints should be deemed legitimate").

[145] *See* 29 U.S.C. § 158 (1994).

[146] *See supra* note 143 and accompanying text.

[147] 358 U.S. 283 (1959). In *Oliver*, the CBA specifically restricted the terms of the employer's wage and lease agreements with independent contractor drivers that were effectively in competition with the union drivers. *See id.* at 293.

B. Joint Unions and Competition

The specific competitive effects of joint union activity have been discussed above in connection with the analysis of the statutory and nonstatutory exemptions. Obviously, the promulgation of a mandatory fee schedule for independent physician union members could potentially destroy price competition.[148] If joint unions become popular, their anticompetitive effects could resemble those of the proposed legislation considered in Part I. However, joint union activity should be somewhat less harmful to competition than blanket statutory immunity because the joint union's restraints on its independent contractor members must be closely tied to the economic interests of its employee members to remain exempt from antitrust scrutiny.[149]

Even if joint unions did not attract large numbers of independent physicians, joint union activity might nevertheless threaten price competition among nonmember doctors. There is a significant danger that price or other terms developed by an employee-based union in connection with joint union activity could facilitate collusion among nonmember independent physicians in the community. Were the contents of union bylaws regarding acceptable price and nonprice terms in plan/provider contracts made public, nonunion physicians might adopt them as a benchmark for tacit agreements about minimum acceptable contract terms.[150] An agreement about price terms would clearly violate antitrust laws. Such agreements, however, are notoriously difficult to detect and prove. The antitrust laws might thus be an inadequate deterrent to such conduct.

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[148] *See supra* notes 135-37 and accompanying text.

[149] *See supra* notes 119-20 and accompanying text.

[150] As long as union membership is limited to employed physicians, it seems unlikely that physician unions will facilitate collusion, at least between union physicians and independent physicians who are ineligible to unionize. One of the main difficulties in organizing and maintaining a cartel of any sort is arriving at and policing an agreement among cartel members without being detected. Union wage negotiations are likely to focus on the salary and benefits paid to employed physicians. Independent physicians, however, do not receive a salary from the payors with whom they do business but are usually paid either on the basis of a set fee per service or on the basis of a capitation payment of some sort. The wage negotiated by the union with one or more employers could thus not serve as an obvious benchmark for fees negotiated by independent physicians. Any express attempt by union members and independent physicians to arrive at a fee schedule comparable to the union wage rate would not only be illegal (assuming the independent physicians were not union members) but would likely be detectable and thus subject conspirators to legal liability.

III. PHYSICIAN UNIONS AND THE SHAPE OF HEALTH CARE DELIVERY

Thus far, this Article has focused primarily on the effects of physician unionization on price competition. As we have seen, a significant increase in physician union activity would tend to raise health care costs because collective bargaining would force MCOs and insurers to increase payments to physicians.[151] However, physician unions may also bring about changes in the shape of the health care delivery system — changes that are potentially even more costly than the fee increases associated with collective bargaining.[152]

The labor exemption shields most CBA provisions from antitrust scrutiny. CBA terms are immune as long as they "are intimately related to a mandatory subject of bargaining and do not have 'a potential for restraining competition in the business market in ways that would not follow naturally from elimination of competition over wages and working conditions.'"[153] The basic question is whether the competitive restraints the CBA imposes are sufficiently related to the core purposes of the labor laws.

The nonstatutory exemption undoubtedly shields a great deal of union activity that could affect the traditional business structure of tightly integrated HMOs. Unions are clearly entitled to negotiate with employees over the scope of union work within the employer's business. Such issues are mandatory subjects of bargaining.[154] Thus, for example, a physicians' union would be entitled to restrict the role of nurse practitioners and other allied health personnel within a health care institution. Because nurse practitioners perform services that are often performed by physicians, any resulting restriction of competition between physicians and nurse practitioners is related to union interests protected by core labor policies. A similar analysis would apply to bargaining over physician staff composition and review procedures.

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[151] *See* POSNER, *supra* note 82, §§ 10.10, 11.1 (noting that sellers cannot automatically pass along cost increases to consumers).

[152] More than half of the premium increases estimated to occur as a result of the passage of legislation enabling independent physician unions are the result of projected changes in utilization patterns that could emerge from collective bargaining over nonfee issues. *See supra* note 55 (providing background on *HIAA Study*).

[153] II AMERICAN BAR ASS'N, *supra* note 143, at 1307 (quoting Connell Constr. Co. v. Plumbers & Steamfitters Local Union No. 100, 421 U.S. 616, 635 (1975)).

[154] *See* Fibreboard Paper Prods. Corp. v. NLRB, 379 U.S. 203, 215 (1964).

The prospects that large physician unions could reassert control over staffing issues in the American health care industry should be disturbing to consumers. Like other labor unions, physician unions would no doubt guard the work prerogatives of their members to the detriment of consumers who might prefer patronizing nonphysician providers for some services. A strong union could insist that the health plans with which it bargains limit the role of competing professionals, including nurses, optometrists, psychologists, physical therapists, midwives, and other allied health professionals.[155] Through the collective bargaining process, physicians could effectively deny consumers access to competing providers, regardless of the relative value of the providers' services.[156]

Union proponents have also indicated that physician unions are likely to seek concessions from MCOs on consumer protection issues such as medical necessity review, coverage of specific procedures and tests, a "reasonable layperson" standard for emergency room care, the provision of information to patients about plan policies, and economic conflicts between patients and physicians.[157] Surprisingly, unions may not need an antitrust exemption when they bargain over these issues. The labor exemption is only relevant if the underlying conduct would otherwise violate the antitrust laws. In principal, union members' collective refusal to deal with a payor unless the payor institute proconsumer policies unrelated to the physicians' individual competitive interests should violate antitrust laws.[158] Nevertheless, it appears unlikely that the antitrust authorities would criminally prosecute doctors engaged in such activity.[159] Payors might well have an incentive to pursue damages or an

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[155] *Cf.* text accompanying notes 69-77 (describing AMA efforts to suppress competition from nonphysicians).

[156] A recent study, for example, suggests that health outcomes of patients whose primary care is provided by a nurse practitioner are comparable to those of patients that obtain primary care from a physician. *See* Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59 (2000). *But see* Harold C. Sox, *Independent Primary Care Practice by Nurse Practitioners*, 283 JAMA 106 (2000) (noting limitations of study).

[157] *See generally* David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 418-25 (1999) (describing reform proposals).

[158] In general, an agreement among competitors restraining the terms on which they will compete is unlawful if it has no procompetitive purpose or effect. *See* NCAA v. Board of Regents, 468 U.S. 85, 110 (1984).

[159] *See, e.g.*, Marilyn Werber Seratini, *Physicians Unite!*, NAT'L J., June 5, 1999, at 1524, 1528 (reporting FTC Chairman Robert Pitofsky's statement that FTC probably would not bring case against physicians if they boycotted health care plan that insisted they participate

injunction, but their claims would almost certainly be judged under the rule of reason.[160] The difficulty of obtaining a favorable judgment under the rule of reason standard and the negative market impact of suing a physicians' union over "propatient" demands would be strong deterrents to litigation. Moreover, some courts might even conclude that the "worthy purpose" of consumer protection justifies the suppression of competition.[161]

If one assumes antitrust liability is a live issue, however, the labor exemption will provide only limited protection for consumer oriented bargaining. The exemption applies most clearly to agreements between unions and employers that relate to mandatory subjects of bargaining — topics related to "wages, hours and other terms and conditions of employment."[162] As a general proposition, mandatory subjects of bargaining relate primarily to the economic interests of employers and employees, not those of third parties.[163] In addition, policies that relate to employers' core managerial prerogatives are generally not proper subjects of mandatory bargaining.[164] Moreover, the fact that consumer-oriented collective bargaining focuses on the health care product market, and not the labor market, weighs against applying the nonstatutory exemption.

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in its full line of managed care plans, as long as physicians were not trying to increase their fees).

[160] The agreement might be characterized as a group boycott, which will be evaluated under the per se rule if the union has market power. *See* Northwest Wholesale Stationers v. Pacific Stationery & Printing Co., 472 U.S. 284, 293 (1985). However, the recent opinion in *California Dental Association v. FTC* suggests that even a "quick-look" rule of reason analysis may not suffice where professional groups take action designed to alleviate information problems in markets for professional services. *See* 526 U.S. 756, 771-72 (1999).

[161] *See, e.g.*, United States v. Brown Univ., 5 F.3d 658, 677-78 (3d Cir. 1993) (finding precompetitive features of Ivy League financial aid program justified its anticompetitive effects) (cited with approval in California Dental Ass'n v. FTC, 526 U.S. 756, 771-72 (1999)).

[162] 29 U.S.C. § 158(d) (1994).

[163] *See* Chemical & Alkali Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157, 168 (1971) (holding company's policies toward retirees' health plan not mandatory subject of bargaining). Terms affecting third parties are mandatory subjects of bargaining where the third party's economic interests directly affect the economic fortunes of union members. *See* Local 24, Int'l Bhd. of Teamsters v. Oliver, 358 U.S. 283, 293 (1959) (finding that collective bargaining agreement terms related to prices to be charged by independent contractors who compete with union drivers were within the scope of NLRA's mandatory bargaining provisions); Fibreboard Paper Prods. Corp. v. NLRB, 379 U.S. 203, 214-15 (1964) (holding that employer must bargain over replacement of janitorial staff with outside contractors).

[164] *See* Ford Motor Co. v. NLRB, 441 U.S. 488, 498 (1979) (Stewart, J., concurring) (describing management decisions that are fundamental to direction of corporate enterprise as excluded from duty of collective bargaining). *See generally Fibreboard*, 379 U.S. at 223 (finding that some essential management decisions are not subject to collective bargaining).

Consider three general categories of issues that might be pressed by consumer-minded union negotiators: (1) contractual coverage issues, (2) consumer grievance procedures, and (3) issues related to consumer choice of provider. The contractual coverage issues would be motivated by concerns similar to those underlying mandated benefits legislation. A physicians' union might insist, for example, that a health plan cover annual mammograms for women of a certain age or procedures sometimes considered experimental, such as bone marrow transplant therapy. Such agreements are unlikely to be sheltered from antitrust scrutiny under the labor exemption, because there is no apparent link to the physicians' "wages, hours and . . . terms and conditions of employment."[165] In addition, determining the contours of the products a firm will sell has been traditionally regarded a managerial prerogative. Finally, the provisions of the contract between an MCO and its members are quintessentially product market issues. Importantly, the hypothetical CBA would restrain trade in the product market by restricting the plan's freedom in offering benefit packages to employers and other purchasers. To save a product market restraint, the union must show the restraint's connection with the market for physician services.[166] No obvious connection exists.

Analyzing bargaining over consumer grievance procedures is somewhat more complex. Arguably, there is a stronger connection with physicians' working conditions, because patient grievances are most likely to arise when health plans resist paying for physician-recommended treatment. Physicians might credibly argue that an outside review process could advance their interests as employees, not just the quality of patient care. A physician that is too aggressive with a corporate medical director in advocating that a patient receive expensive care might fear reprisals from his employer. In addition, advocating on behalf of patients for needed treatment makes the physician's job more difficult; a union might well argue that physicians' personal interests would be best served by a system that gave greater deference to the medical opinions of treating physicians. A CBA implementing changes in the consumer grievance process would restrict the product market in a fashion similar

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[165] 29 U.S.C. § 158(d). Physicians might argue that they have professional misgivings about being associated with a health plan that refuses to pay for adequate coverage for its members.

[166] *See supra* notes 111-18 and accompanying text.

to agreements over mandated benefits, but would be legally defensible because its restrictions could be traced to physicians' efforts to better their own employment conditions.

Unions might also wish to negotiate over consumers' ability to select the provider of their choice. However, an employed physicians union would be unlikely to seek this privilege on consumers' behalf because giving plan members freedom to seek physician services outside of the plan network may threaten the job security of union members. An independent physicians union, on the other hand, might well seek great patient freedom in this regard, assuming union membership includes most physicians in a given community.[167]

Similarly, if an HMO were to employ unionized primary care physicians but used a network of independent physicians for specialist care, the union might negotiate for greater patient access to non-network specialists, at least if the primary care physicians can control patient access to specialists. Again, these restrictions would restrain trade in the product market to some degree, because the plan must now alter its contracts with consumers and employers to meet the union requirements. However, greater specialist access arguably directly benefits union members by reducing patient care and administrative workload.

Interestingly, independent physician unions could presumably implement a provider choice term in a CBA with the full protection of the labor exemption. Independent physicians might well conclude that it is in their collective economic interest to permit patients, not health plans, to choose their doctors. And, because, in a heavily unionized environment, health plans would have difficulty obtaining discounts by contracting selectively with independent physicians, health plans would have a reduced interest in resisting such a demand. Although the CBA would restrain the product market, the restriction would have a direct link to the economic fortunes of the physician union members.

In general, collective bargaining over consumer protection issues will tend to have the same effects on health care markets as consumer protection legislation does. Increasing health plan benefits, provider options, and grievance processes unquestionably make health plans more expensive. Commentators are divided, however,

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[167] Joint unions, as a matter of law, would be required to favor the interests of the employee members. *See supra* notes 119-20 and accompanying text.

over whether the benefits obtained are worth their costs, both in real dollars and their effects on the affordability of health coverage at the margins.[168]

Consumer protection efforts by labor unions are, however, likely to have effects that are both broader and narrower than consumer protection legislation. Particularly if new legislation authorizing bargaining by independent physicians is enacted, labor union consumer protection efforts are likely to affect the nonprice features of every health plan offered in a unionized market. Because the Employment Retirement Income Security Act of 1974 ("ERISA") has preempted many of the consumer protection statutes enacted at the state level,[169] labor unions' efforts could prove to be more important than state legislative activity. If new legislation is not enacted, union membership is likely to remain largely limited to employed physicians, with the result that more tightly integrated health plans will be more affected by consumer-oriented bargaining than other plans. Such bargaining will tend to diminish whatever cost advantages such plans might have enjoyed over their more loosely organized competitors. This could be significant, not only in limiting consumers' health plan options but also in removing a potentially important competitive stimulant to cost-containment by less-integrated health plans.

If courts permit labor unions to bargain over consumer protection matters without incurring antitrust liability, it is virtually certain that such bargaining will become a frequent feature of union negotiation. A union that can claim to be using the bargaining process to protect the public might expect considerably more public support in a labor dispute than a union whose primary complaint is that their physicians' incomes are too low. It will only be

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[168] *See, e.g.*, David Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2000) (criticizing "patients bill of rights" proposals); Korobkin, *supra* note 78 (defending proposals).

[169] *See, e.g.*, Prudential Ins. Co. v. National Park Med. Ctr., Inc., 154 F.3d 812, 829 (8th Cir. 1998) (holding that ERISA preempts state preferred provider regulation); American Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 360 (4th Cir. 1997) (holding that ERISA preempts state mandated benefits statute); Cigna Healthplan v. Louisiana, 82 F.3d 642, 649 (5th Cir. 1996) (holding that ERISA preempts "any willing provider" statute); *see also* Margaret Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 252 (1997) (arguing that ERISA may prevent effective state-level health care reform).

possible to gauge a union's sincerity in pressing for consumer protections after negotiations are concluded.[170]

IV. MANAGERIAL AND SUPERVISORY STATUS OF PHYSICIAN UNION MEMBERS

As a final matter, it is appropriate to consider the market effects of the rules that prevent employees that are deemed either "supervisors" or "managerial employees" from participating in collective bargaining. Both exceptions result from a concern that the employer be assured of "the undivided loyalty of its representatives."[171] The supervisor exception appears in the NLRA itself and applies to employees that exercise authority over other employees in the employer's interest.[172] The court-created managerial employee exception applies to employees who "formulate and effectuate management policies by expressing and making operative decisions of their employer."[173] Managerial employees are generally "much higher in the managerial structure" than supervisors;[174] the courts have assumed that Congress did not include an explicit managerial

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[170] In some cases, union members' economic interests will coincide easily with consumer protection rhetoric. *See supra* text accompanying notes 167-69.

[171] NLRB v. Yeshiva Univ., 444 U.S. 672, 682 (1980) (citing Beasley v. Food Fair, 416 U.S. 653, 661-62 (1974) and NRLB v. Bell Aerospace Co., 416 U.S. 267, 281-82 (1974)). Judge Posner has written:

> The exclusion of supervisors is one of the brakes [the Taft-Hartley Act imposed on unionization]. If supervisors were free to form or join unions and enjoy the broad protection of the Act for concerted activity, the impact of a strike would be greatly amplified because the company would not be able to use its supervisory personnel to replace strikers. More important, the company — with or without a strike — could lose control of its work force to the unions, since the very people in the company who controlled hiring, discipline, assignments and the other dimensions of the employment relationship might be subject to control by the same union as the employees they were supposed to be controlling on the employer's behalf. We might become a nation of worker-controlled firms. Syndicalism is not the theory of the amended National Labor Relations Act. Stated less dramatically, allowing supervisors . . . to bargain collectively could create serious conflicts of interest.

NLRB v. Res-Care, Inc., 705 F.2d 1461, 1465-66 (7th Cir. 1983) (citation omitted).

[172] *See* 29 U.S.C. § 152(11) (1994) (defining supervisor); *see also id.* § 152(3) (excluding "supervisors" from definition of "employee").

[173] *See* NLRB v. Bell Aerospace Co., 416 U.S. 267, 286 (1974) (quoting Palace Laundry Dry Cleaning Co., 75 N.L.R.B. 320, 323 n.4 (1947)).

[174] *Id.* at 283.

employee exception because it was clearly understood that they were beyond the scope of the NLRA.[175]

A. When Are Physicians Managerial Employees?

Whether physicians will be considered managerial employees and thus ineligible for collective bargaining will depend on the degree of influence they exert over the policies of their employers. In hospitals, for example, physicians typically serve on medical staff committees that formulate medical policies; in some institutions these committees have final authority over such matters.[176] Other health care institutions, such as large group practices and HMOs, likewise employ medical staff committees in the policy formulation process.[177]

The managerial employee exception may prove to be an important obstacle to physician unionization. The leading case, *NLRB v. Yeshiva University*,[178] involved an organizing campaign by the faculty of Yeshiva University. The Supreme Court ultimately held that the faculty were managerial employees; the "controlling consideration" was their "absolute" authority in academic matters.[179] As is the case with many physicians working in health care institutions, the Yeshiva faculty were organized into departments and committees that developed policy on specific issues.[180] Significantly, the Court re-

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[175] *See id.* at 283-88 (reviewing legislative history and early NLRB decisions regarding managerial employees).

[176] *See generally* William S. Brewbaker III, *Antitrust Conspiracy Doctrine and the Hospital Enterprise*, 74 B.U. L. REV. 67, 76-82 (1994) (describing medical staff's role in hospital governance).

[177] Indeed, state enabling legislation for HMOs appears to contemplate an internal quality assurance process based on the hospital model. *See* National Association of Insurance Commissioners, Health Maintenance Organization Model Act § 7 (1991).

[178] 444 U.S. 672 (1980).

[179] *See id.* at 686. The Court described faculty authority in the following terms:

> They decide what courses will be offered, when they will be scheduled, and to whom they will be taught. They debate and determine teaching methods, grading policies, and matriculation standards. They effectively decide which students will be admitted, retained, and graduated. On occasion their views have determined the size of the student body, the tuition to be charged, and the location of a school. When one considers the function of a university, it is difficult to imagine decisions more managerial than these. To the extent the industrial analogy applies, the faculty determines within each school the product to be produced, the terms upon which it will be offered, and the customers who will be served.

Id.

[180] *See id.* at 675-77 (describing Yeshiva University's organizational structure).

jected the NLRB's argument that the faculty should not be considered managerial employees because the faculty's exercise of administrative authority involved "independent professional judgment."[181] Because the faculty effectively determined critical university policies, the Court deemed them managerial employees even though they were expected to draw on professional standards in making their decisions.[182]

Yeshiva thus suggests that the more actual influence physicians exert within an organization, the more likely they are to be regarded as managerial employees.[183] Indeed, shortly after the Court decided *Yeshiva*, the NLRB refused to permit collective bargaining by physician employees in a staff-model HMO that delegated significant managerial authority to physician-run committees.[184] The NLRB found that,

> many of the decisions made at the committee level, which include managing the organization's protocol system, overseeing its medical records system, setting its medicinal prescription policy, reviewing and modifying the benefits and working conditions of its staff, establishing procedures and staff training for medical emergencies, and minimizing the institution's risk of medical

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[181] *See id.* at 673.

[182] *See id.* at 686. The *Yeshiva* Court also made clear that the relevant question is not whether the employees have the ultimate legal authority to make managerial decisions, but rather how decisions are actually made within the relevant institution:

> [T]he fact that the administration holds a rarely exercised veto power does not diminish the faculty's effective power in policymaking and implementation. The statutory definition of "supervisor" expressly contemplates that those employees who "effectively . . . recommend" the enumerated actions are to be excluded as supervisory. Consistent with the concern for divided loyalty, the relevant consideration is effective recommendation or control rather than final authority. That rationale applies with equal force to the managerial exclusion.

Id. at 683 n.17 (citations omitted).

[183] *Cf.* FHP, Inc., 274 N.L.R.B. 1141, 1142-43 (1985) ("As professional employees, staff physicians may also be managerial if their activities on behalf of their employer fall outside the scope of decision-making routinely performed by similarly situated health care professionals and that is primarily incident to their treatment of patients.").

[184] *See id.* at 1143. The committees on which the physician-employees served included: peer review committee, physician and therapeutics committee, advisory committee on provider work environment, emergency services committee, patient services committee, advisory committee to the board of directors, and ad hoc committees dealing with issues such as defining the role of the family practitioner or dealing with high-risk pregnancies. *See id.* at 1142.

> malpractice liability, lie at the core of health maintenance organization's operations.[185]

Subsequent NLRB rulings have distinguished *Yeshiva* and permitted physician employees to bargain collectively notwithstanding the claim that the physicians were managerial employees. In *Montefiore Hospital and Medical Center*,[186] which, interestingly, involved the medical center affiliated with Yeshiva University,[187] the NLRB distinguished *Yeshiva* on the ground that hospital policy was effectively made by departmental chairpersons.[188] Although physician employees participated in a committee structure dealing with issues of hospital policy, their role was largely advisory.[189]

Although the NLRB and two reviewing federal courts have recently affirmed a regional director's recognition of a physician employees union, the future of collective bargaining by HMO physician employees remains open.[190] Resolution of the question of physicians' managerial status will be fact specific and will turn on the degree of control the employed physicians exert over important managerial policies. Employers such as HMOs who confer a great deal of authority on their medical directors are less likely to successfully argue that other physician employees perform managerial functions that make them ineligible to bargain collectively.[191]

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[185] *Id.* at 1143.

[186] 261 N.L.R.B. 569 (1982).

[187] *See* WILLIAM J. CURRAN ET AL., HEALTH CARE LAW & ETHICS 1249 (1998).

[188] *See Montefiore Hosp.*, 261 N.L.R.B. at 570.

[189] *See id.* at 571 ("As a general proposition, the chairmen make every major administrative decision with respect to the operation of their departments that is not dictated from above. Staff doctors have some input, but this is only in the form of recommendations which, for the most part, the chairmen or their designees evaluate."); *see also* Medalia Healthcare, LLC, No. 19-RC-13554, slip op. at 26-29 (N.L.R.B. Region 19 Apr. 24, 1998) (finding that physicians serving on numerous management committees in multispecialty clinic acted in advisory capacity and were thus not managerial employees); *cf.* NLRB v. Yeshiva Univ., 444 U.S. 672, 684 n.17 (1983) (noting that Yeshiva University did not argue its faculty's role in policy making was "merely advisory").

[190] *See* Thomas-Davis Med. Ctrs., P.C., 324 N.L.R.B. 29, 32 (1997) (refusing to address argument that union doctors are supervisors or managerial personnel in unfair labor practices proceeding where issue was or could have been litigated in representation proceeding), *review denied and enforcement granted*, Thomas-Davis Med. Ctrs., P.C. v. NLRB, 157 F.3d 909 (D.C. Cir. 1998).

[191] Ironically, this also suggests the possibility that a union that successfully uses the collective bargaining process to obtain greater physician control over medical policymaking might ultimately lose its protected status under the NLRA.

B. When Are Physicians Supervisors?

As noted above, the NLRA specifically prevents "supervisors" from enjoying the benefits otherwise accorded to employees under the statute.[192] Section 152(11) of the NLRA defines a supervisor as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the exercise of independent judgment.[193]

Pursuant to this definition, the Supreme Court has adopted a three-part test which considers whether (1) "the employee [has] authority to engage in 1 of the 12 listed activities,"[194] (2) "the exercise of that authority requires 'the use of independent judgment,'"[195] and (3) "the employee hold[s] the authority 'in the interest of the employer.'"[196] Each of these questions must be answered in the affirmative for the employee in question to be classified as a supervisor.[197] As the definition suggests, classification of an employee as a supervisor requires a searching inquiry into the authority the employee exercises within the relevant institution.

Despite the highly fact-intensive nature of the inquiry, some important generalizations can be made about the application of the test to employed physicians. To begin, the twelve supervisory activities noted in the definition relate primarily to personnel matters. As a result, the more a physician is involved in hiring, firing, and scheduling personnel, the more likely it is that he or she will be deemed a supervisor. For example, if an HMO physician's recommendation will effectively result in the hiring or dismissal of nursing or other personnel, the physician will meet the first prong

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[192] *See* 29 U.S.C. § 152(3) (1994).

[193] *Id.* § 152(11).

[194] NLRB v. Health Care & Retirement Corp. of Am., 511 U.S. 571, 574 (1994). The authority must be actual, not merely theoretical. *See* New York Univ. Med. Ctr. v. NLRB, 156 F.3d 405, 414 (2d Cir. 1998); Food Store Employees Union, Local 347 v. NLRB, 422 F.2d 685, 690 (D.C. Cir. 1969).

[195] *Health Care & Retirement Corp.*, 511 U.S. at 574.

[196] *Id.*

[197] *See id.* at 573-74.

of the test.[198] On the other hand, if the physician's recommendation is subject to independent evaluation by others, his or her participation in the evaluation process will not alone justify supervisory status.[199]

Next, the fact that physicians regularly give directions to nurses and other health professionals concerning the medical care their patients should receive does not make them supervisors for purposes of the statute.[200] The NLRA specifically contemplates unionization by professional employees[201] and expressly acknowledges

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[198] *See* 29 U.S.C. § 152(11) ("The term 'supervisor' means any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees . . . or *effectively to recommend such action* . . . .") (emphasis added).

[199] *See* Medalia Healthcare, LLC, No. 19-RC-13554, slip op. at 31-32 (NLRB Region 19 Apr. 24, 1998); Gem Urethane Corp., 284 N.L.R.B. 1349, 1349 (1987) ("Similarly, the authority to evaluate work performance is not evidence of supervisory status if it is subject to independent investigation and decision by others."); *see also New York Univ. Med. Ctr.*, 156 F.3d at 413 ("Evaluations that do not affect job status of the evaluated person are inadequate to establish supervisory status."); Highland Superstores Inc. v. NLRB, 927 F.2d 918, 921-22 (6th Cir. 1991) (stating that leadmen's recommendations were insufficient to establish supervisory status); NLRB v. Res-Care, Inc., 705 F.2d 1461, 1467 (7th Cir. 1983) (noting that recommending promotion or discharge does not establish supervisory status); Greenspan, 318 N.L.R.B. 70, 76-77 (1995) (finding compatibility screen does not create supervisory status); North Gen. Hosp., 314 N.L.R.B. 14, 18 (1994) (noting that recommendation must be effective to establish supervisory status); First W. Bldg. Servs., Inc., 309 N.L.R.B. 591, 600 (1992) (recognizing power to make recommendation that will not necessarily be followed does not create supervisory status); General Dynamics Corp., 213 N.L.R.B. 851, 859 (1974) (noting supervisory status not created where co-equals supervise each other intermittently). *But see* Legal Aid Soc'y, 324 N.L.R.B. 796, 796-97 (1997) (excluding attorney that supervises paralegals from collective bargaining).

[200] As a matter of statutory interpretation, this sort of professional "supervision" should not constitute the performance of any of the twelve activities enumerated in the NLRA's definition of "supervisor." *See Res-Care*, 705 F.2d at 1468 ("The licensed practical nurses' greatest discretion is in deciding which nurse's aide shall do what task, but this discretion is exercised in accordance with a professional judgment as to the best interests of the patient rather than a managerial judgment as to the employer's best interests. *It is no different from a doctor's telling his nurses which patients to provide what care to, which is not supervision under the statute.*") (emphasis added); Providence Hosp., 320 N.L.R.B. 717, 720-30 (1996) (discussing similarities of duties of charge nurses and RN's). *But see infra* text accompanying notes 214-17 (discussing "independent judgment" prong of statutory test for supervisory status).

[201] *See* 29 U.S.C. § 152(12) (1994) (defining professional employee); *id.* § 152(3) (defining employee). "Professional employee" was defined in order to prevent all highly skilled and educated workers (such as physicians) from being classified as supervisors under the NLRA because of the "distinction between authority arising from professional knowledge and authority encompassing front-line management prerogatives." NLRB v. Health Care & Retirement Corp. of Am., 511 U.S. 571, 583 (1994); *see also* NLRB v. Yeshiva Univ., 444 U.S. 672, 681 n.12 (1980) ("The [National Labor Relations] Act provides broadly that 'employees' have organizational and other rights. Section 2(3) defines 'employee' in general terms, [section] 2(12) defines 'professional employee' in some detail, and [section] 9(b)(1) prohibits the Board from creating a bargaining unit that includes both professional and non-

that professional work "requires the consistent exercise of discretion and judgment in its performance."[202] Because "most professionals have some supervisory responsibilities in the sense of directing another's work — the lawyer his secretary, the teacher his teacher's aide, the doctor his nurses, the registered nurse her nurse's aide and so on,"[203] a contrary rule would significantly undercut Congress's intention to permit professional employees to join unions. Although the question has not been squarely presented in the case of physicians, the *Yeshiva* Court noted that "only if an employee's activities fall outside the scope of the duties routinely performed by similarly situated professionals will he be found aligned with management."[204] Supervisory status should prevent physicians from participating in union activities only when those physicians have a substantial decision making role in matters traditionally associated with the personnel function, such as hiring, firing, discipline, or scheduling.[205]

In fact, even physicians that have more significant involvement in personnel matters may not be supervisors under the NLRA. The NLRB has held that "[t]he issue of supervisory status usually arises where authority is *regularly exercised* on the employer's behalf."[206] Thus, occasional exercise of supervisory authority need not result in the exclusion of an employee from a bargaining unit.[207]

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professional employees unless a majority of the professionals vote for inclusion.") (citations omitted)).

[202] 29 U.S.C. § 152(12)(a)(ii).

[203] *Res-Care*, 705 F.2d at 1465.

[204] *Yeshiva Univ.*, 444 U.S. at 690. The Court further noted with apparent approval the NLRB's use of a test that asks in each case "whether the decisions alleged to be managerial or supervisory are 'incidental to' or 'in addition to' the treatment of patients, a test Congress expressly approved in 1974." *Id.* at n.30.

[205] The second and third prongs of the "supervisor" test may create some latitude for physician participation even in these activities. *See infra* text accompanying notes 206-14. *But see* National Union of Hosp. & Health Care Employees v. Cook County, 692 N.E.2d 1253 (Ill. App. Ct. 1998).

[206] Adelphi Univ., 195 N.L.R.B. 639, 644 (1972) (emphasis added).

[207] *See id.* ("[A] . . . conflict of interest is [not] necessarily created whenever persons occasionally exercise some authority over other employees of the employer."). The NLRB has prescribed a multifactor test to determine whether an employee's exercise of supervisory authority necessitates treating the employee as a statutory supervisor. Relevant factors include "the business of the employer, the duties of the individuals exercising supervisory authority and those of the bargaining unit employees, the particular supervisory functions being exercised, the degree of control being exercised over the non-unit employees, and the relative amount of interest the individuals at issue have in furthering the policies of the employer as opposed to those of the bargaining unit in which they have been included." Detroit College of Bus., 296 N.L.R.B. 318, 321 (1989); *see also* Legal Aid Soc'y, 324 N.L.R.B. 796 (1997); Medalia Healthcare, LLC, No. 19-RC-13554, slip op. at 25 (Apr. 24, 1998).

The second and third prongs of the test for supervisory status ask, respectively, whether the employee's exercise of the enumerated supervisory authority requires "the use of independent judgment" and whether the authority is exercised "in the interest of the employer."[208] Until recently, the NLRB had held that a health care professional's "direction of less-skilled employees, in the exercise of professional judgment incidental to the treatment of patients, is not authority exercised 'in the interest of the employer'" but rather in the interest of patient care.[209] The Court rejected this position in *NLRB v. Health Care & Retirement Corp.*, holding that "[t]he welfare of the patient . . . is no less the object and concern of the employer than it is of the nurses."[211] The Court noted, however, that its holding "casts no doubt on Board or court decisions interpreting parts of § 2(11) other than the specific phrase 'in the interest of the employer.'"[212]

In the wake of *Health Care & Retirement Corp.*, the NLRB changed its position on the supervisory status of health care professionals.[213] It still maintains that doctors or nurses that make professional judgments regarding patient care that result in some incidental level of supervision are not necessarily not supervisors. However, the NLRB now bases its conclusion on the second prong of the test, finding that such direction does not involve "independent judgment," but is rather an incidental consequence of professional discretion.[214]

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[208] NLRB v. Health Care & Retirement Corp. of Am., 511 U.S. 571, 574 (1994).

[209] *Id.* at 574.

[210] *Id.*

[211] *Id.* at 580.

[212] *Id.* at 583.

[213] The NLRB has characterized the "patient care" rule rejected in *Health Care & Retirement Corp.* as "a tool designed, in part, to avoid the confusing dichotomy between the judgment exercised by all nurses due to their professional or technical training and the exercise of independent judgment by a supervisor." Providence Hosp., 320 N.L.R.B. 717, 726 (1996).

[214] *See id.* at 729; Ten Broeck Commons, 320 N.L.R.B. 806, 810 & n.7 (1996); *see also* Memorandum OM 99-44 (Aug. 24, 1999) (NLRB Guidance Memorandum on Charge Nurse Supervisory Issues), *reprinted in* 8 Health L. Rep. (BNA) 1459 (1999). It remains to be seen whether the NLRB's new position will fare better in the courts than the "patient care" rule rejected in *Health Care & Retirement Corp.* *See* Beverly Enters., Va., Inc. v. NLRB 165 F.3d 290, 298 (4th Cir. 1999) (finding that nurses exercised independent judgment); Mid-America Care Found. v. NLRB, 148 F.3d 638, 640-41 (6th Cir. 1998) (same); Passavant Retirement & Health Ctr. v. NLRB, 148 F.3d 243, 248-49 (3d Cir. 1998) (same); Mid-America Care Found. v. NLRB, 148 F.3d 638, 640-41 (6th Cir. 1998) (same); *see also* NLRB v. Grancare, Inc., 170 F.3d 663, 665-66 (7th Cir. 1999) (en banc) (finding that nurses exercised independent judgment); Beverly Enters., Minn., Inc. v. NLRB, 148 F.3d 1042, 1046-48 (8th Cir. 1998) (finding no exercise of independent judgment); Beverly Enters., Pa., Inc. v. NLRB, 129 F.3d

Whether the courts ultimately sustain the NLRB's position should have little consequence for the ability of most employed physicians to participate in physician unions. If the NLRB's expansive reading of "independent judgment" is upheld, even physicians with some significant supervisory authority over other health care personnel may not be excluded from collective bargaining.[215] On the other hand, even if the Court rejects the NLRB's position, physicians' traditional authority to issue orders to nurses and others in connection with patient care plans should not be considered "assignment" or "responsible supervision" under the NLRA. Moreover, physicians and nurses typically operate under separate lines of employment authority.[216] Only when a physician is an effective participant in "recruiting, hiring, scheduling, and the other categories of supervisory responsibility" should his or her ability to participate in collective bargaining potentially be compromised.[217]

C. Implications for Competition

The labor laws that prohibit the participation of managerial employees and supervisors in collective bargaining are unlikely to produce substantial effects on competition in health care markets.

1269, 1270-71 (D.C. Cir. 1997) (same); Caremore, Inc. v. NLRB, 129 F.3d 365, 371 (6th Cir. 1997) (same); Providence Alaska Med. Ctr. v. NLRB, 121 F.3d 548, 552-55 (9th Cir. 1997) (same). On its face, the "blanket assertion" that direction of other employees resulting from professional judgments about patient care does not satisfy the "independent judgment" requirement bears a striking resemblance to the NLRB's failed attempt to argue that such judgments could never be made "in the interest of the employer." *Health Care & Retirement Corp.*, 511 U.S. at 577-78; *see also Caremore*, 129 F.3d at 371 ("The NLRB's position generally has been that supervisory status is almost never to be accorded nurses whose supervisory authority is exercised . . . in the interest of patient care."). Nevertheless, as noted above, some courts have deferred to the NLRB's interpretation of the statute and upheld findings that health care professionals did not exercise "independent judgment" in supervising less-skilled workers. *Cf. Beverly Enters., Pa.*, 165 F.3d at 302 (Phillips, J., dissenting) (characterizing NLRB's position as "that the judgment exercised by [professional nurses] in exercising their incidental supervisory authority over [nurse's aides] is not the 'independent judgment' concerned with management prerogatives that is contemplated by § 2(11), but is more properly viewed as 'professional judgment' exercised in getting *their* assigned work done with the assistance of [nurse's aides] employed specifically for that purpose.").

[215] *See* Memorandum OM 99-44, *supra* note 214, at 1461-63 (discussing application of "independent judgment" test).

[216] *See* New York Univ. Med. Ctr. v. NLRB, 156 F.3d 405, 412 (2d Cir. 1998) (noting that physicians and other medical professionals such as nurses "functioned within their own, entirely separate, lines of authority").

[217] *Id. But see id.* at 412 n.2 (suggesting possibility that unit chief physicians had supervisory authority over residents); National Union of Hosp. & Health Care Employees v. Cook County, 692 N.E.2d 1253, 1258-62 (Ill. App. Ct. 1998) (holding that attending physicians in teaching hospital are residents' supervisors).

To begin, the rules only come into play if a physician is an employee under the NLRA. Assuming that collective bargaining rights continue to be extended only to employees, physician unions would be unlikely to exert a significant competitive effect in most markets in the near term even were all eligible physicians to join a union.[218] Thus, excluding some portion of those physicians eligible to bargain on the ground that they are supervisors or managerial employees should generally make little competitive difference.

Two additional points bear mentioning, however. First, as already noted, if the statutory definition of supervisory authority were interpreted to include the direction physicians routinely give to other health professional regarding patient care, virtually no physician would be eligible to bargain. Such a decision would effectively end collective bargaining by physician unions and, as a result, any adverse competitive effects that might be expected. It would also contravene the structure of the NLRA, which explicitly contemplates unionization by "professional employees."[219]

Second, the judicially created exception for managerial employees suggests that employed physicians will lose their eligibility to bargain if they are given effective decision making authority over core institutional policies. This exclusion might turn out to be particularly significant in cases where a physician has sold his or her medical practice to a hospital or physician practice management company. In such cases, the physician may well be an employee but may have negotiated an agreement that gives her effective day-to-day control over policies and personnel. Moreover, an employer facing a genuine prospect of union organizing might possibly blunt a union drive by giving staff doctors greater power to set medical policy within the organization.[220] Such a decision might remove some portion of the motivation for the union as well as facilitate a legal challenge to the union's operation.

CONCLUSION

The physician union movement presents legislators and judges with a number of important policy decisions. First and foremost,

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[218] *See supra* note 89.

[219] *See supra* notes 200-05 and accompanying text.

[220] *See* Hirshfeld, *supra* note 23, at 52-53.

Congress and state legislatures must decide whether to change current law to permit independent physicians to bargain collectively with health plans. I have argued that enhancing the bargaining rights of independent physicians would probably harm most consumers. Indeed, given the magnitude of the costs the union movement will likely impose on consumers, it is more than a little ironic that physicians have assumed an altruistic posture in the unionization debate. Competition in health care markets is the de facto health policy in the United States, and, whatever its defects, price competition has played a large part in the U.S. health care industry's success in curbing inflation in recent years. Depending on the permissiveness of the legal rules that govern them, physician unions threaten to end price competition among doctors and have a chilling effect on nonprice competition among health plans as well.

The need for countervailing economic power in health care markets is not a compelling argument for increased union activity. Organized medicine is certainly correct in asserting that an antitrust policy that allows health plans to exercise monopsony purchasing power is bad for consumers, because unduly low prices will tend to suppress the output and quality of health care services. But even if monopsony is a real problem, the appropriate response to it is aggressive antitrust enforcement, not inviting physicians in every American market to set their fees on a collective basis.

Even if one agrees that consumers are in significant need of protection from their health plans, it does not follow that physicians are the ones to protect them. For a significant portion of the twentieth century organized medicine was in substantial control of the health care industry. During this period physician leaders talked a great deal about protecting patient interests but instead created a system that was guided by the economic interests of doctors. Although the political process is far from perfect, legislators, at least at the state level, have demonstrated a considerable willingness to regulate all aspects of managed care operations. Physicians can and should look out for their patients' medical interests. But, in light of their track record, consumers' interests are more likely to be protected if binding decisions about the shape of health care delivery are made in institutions, such as legislatures and markets, in which consumers are at least nominally represented.

Courts will also likely make crucial decisions affecting the future of physician bargaining. Even if Congress and the states refuse to change current law, a number of significant questions will remain to be answered. These include the scope of employed physicians' bargaining rights,[221] unions' ability to bargain over consumer protection issues that do not affect physicians' direct economic interests,[222] and whether employed and independent physicians may band together in joint unions.[223] Resolution of these issues will have important consequences for consumers.

Indeed, Congress and the states appear to be considering precisely the wrong sort of physician union legislation. As this Article illustrates, the labor laws may already permit physicians (including independent physicians) to engage in a surprising range of collective action strategies. At this point, it remains to be seen how much latitude courts will give physician unions in using these strategies. There is a clear danger, however, that independent physicians, having so far lost their battles for organizing rights in Congress, may yet obtain those rights in court. Judges interpreting the labor laws may well fail to take into account either the absence of any compelling distributive justifications for union activity or the dangers physicians' collective action could pose to consumer interests. The public interest may ultimately be best served not by legislation expanding physicians' bargaining rights, but rather by legislation to ensure that the medical profession cannot use the labor laws to re-institute wholesale professional control over the American health care system.

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[221] *See supra* Part IV (discussing managerial and supervisory status).
[222] *See supra* Part II.
[223] *See supra* Part III.