

Legal Issues in Medicine

**COLLECTIVE BARGAINING BY
PHYSICIANS — LABOR LAW,
ANTITRUST LAW, AND ORGANIZED
MEDICINE**

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COLLECTIVE bargaining has caught the imagination of physicians across the United States. Although physicians' unions have existed since the 1970s, union members have always constituted an extremely small percentage of practicing physicians.¹ However, physicians are turning to unions to increase their bargaining power with managed-care organizations. They are also viewing unions as a way to help reclaim their clinical autonomy and to preserve and enhance the quality of care.²

Leading medical organizations are now supporting these efforts to reclaim clinical autonomy and increase reimbursement through collective bargaining. The American Medical Association (AMA), which opposed the idea of physicians' unions for many years, has established a new organization, Physicians for Responsible Negotiation. It will serve as the bargaining agent, under federal collective-bargaining legislation, for employed physicians who decide to become members of the organization, including physicians who are not members of the AMA.³ Choosing a slightly different path, but with the same goals, the American College of Physicians and the American Society of Internal Medicine have endorsed efforts to permit collective negotiations by physicians through a waiver of federal antitrust laws.⁴

Struggles over reimbursement and physicians' clinical prerogatives are likely to increase during the next decade as health care costs rise. In this article, we examine the relations and tensions between federal labor law and antitrust law in the context of collective bargaining between physicians and managed-care organizations.

LABOR LAW

The principal statute governing collective bargaining in the United States is the National Labor Relations Act of 1935.⁵ That legislation created the National

Labor Relations Board (NLRB), which is charged with interpreting and enforcing the terms of the act.⁶ For physicians who want to unionize, the central issue is that the provisions of the National Labor Relations Act are limited to employees. Although the act's definition of employees includes professionals (and hence physicians),⁷ it excludes independent contractors and persons exercising supervisory or managerial responsibilities.

These exclusions pose three hurdles for physicians who want to bargain collectively with managed-care organizations or hospitals. First, most physicians are not employees; rather, they are self-employed persons who, at least formally, are independent contractors. Second, physicians who are employees may be regarded as managers if they exercise a great degree of control over their conditions of work and participate to a considerable extent in organizational policymaking. Third, physicians who are employees may be regarded as supervisors if in the course of providing clinical care, they direct the work of other health care professionals in order to further institutional goals.

The National Labor Relations Act is intended to protect employees from the power of their employer. It is not intended to help self-employed persons in their contractual relationships with corporations or other entities. The courts,⁸ Congress,⁹ and the NLRB¹⁰ have provided different definitions of an independent contractor. But in general, independent contractors can form a union if they are sufficiently dependent on another entity, both operationally and financially. Some have argued that self-employed physicians may qualify as employees if they have complicated contractual relationships with managed-care organizations.^{11,12}

The NLRB addressed this issue in 1999 in the *AmeriHealth* case.¹³ The board held that primary care physicians who had contracted with AmeriHealth, a managed-care organization, in two counties in New Jersey were independent contractors who did not qualify as employees, even though AmeriHealth had oversight of the physicians' practices, including detailed utilization management. Although the NLRB expressly kept open the possibility that physicians who are independent contractors may occasionally be found to be employees, the clear message of the *AmeriHealth* decision is that this will rarely be the case. Even though managed-care organizations have become more and more aggressive in dictating remuneration and terms of practice to physicians, the NLRB noted that physicians retain substantial control over their practices, which was the key factor in the board's ruling.

In a 1974 ruling, the U.S. Supreme Court interpreted the National Labor Relations Act as excluding managers from collective bargaining.¹⁴ This interpretation is based on the assumption that managers and employees have an adversarial relationship and diametrically opposed interests. Those who argue that physicians

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are managers believe the nature of physicians' work gives them too much involvement in organizational policymaking for them to be classified as employees.¹⁵

The NLRB, however, has stated that managerial work that is part of the routine discharge of professional duties does not trigger the exclusion of managers from collective bargaining. Because this concept has been difficult to apply in practice, there continues to be uncertainty about whether the managerial exclusion applies to physicians.^{16,17} Paradoxically, if physicians minimized their efforts to exert control in the workplace, they would stand a much better chance of being classified as nonmanagers. Yet such an approach might be seen as an abandonment of their professional responsibility to provide optimal care of patients.

Employees who exercise supervisory responsibilities are also expressly excluded from collective bargaining. To be deemed supervisors, employees must have the authority to perform at least one of a list of supervisory functions spelled out in the National Labor Relations Act (e.g., the authority "responsibly to direct" other employees) and must exercise that authority "in the interest of the employer" and through the exercise of "independent judgment."¹⁸ Like managerial functions, supervisory functions are often part of the exercise of professional discretion. The NLRB has attempted to narrow the definition of supervisory functions in order to allow more potential supervisors to unionize, but the Supreme Court has rejected the board's reasoning twice.^{19,20} In its second decision, the Court held this year that nurses who directed other employees in accordance with professional expertise still met the "independent judgment" criterion for the supervisory exclusion.²⁰

Although both Supreme Court cases involved nurse supervisors, the reasoning would seem to apply to physicians as well. Physicians for Responsible Negotiation has stated that the 2001 decision severely curtails the ability of physicians to bargain collectively.^{21,22} As a result, the AMA House of Delegates resolved in June to direct the association's Board of Trustees to formulate a response, after a debate in which the continuing viability of Physicians for Responsible Negotiation was questioned.²³ One option is to lobby for an amendment to the National Labor Relations Act that clarifies the definition of a supervisor.

At the moment, collective bargaining seems to be a possibility only for employed physicians, most of whom work in staff-model health maintenance organizations or hospitals. Approximately 48 percent of physicians who provide clinical care are employees; if public employees, residents, and fellows are excluded, the proportion is 27 percent (169,261 physicians).²⁴ The proportion of these physicians who exercise neither managerial nor supervisory responsibilities is unclear. In any case, the percentage of physicians who are currently allowed to join unions governed by the National Labor Relations Act is quite small.

The NLRB has treated physicians in training differently from other physicians. In a 1999 case that involved house officers at Boston Medical Center,²⁵ the board held that house staff in private hospitals are employees, not students, for the purposes of the National Labor Relations Act and are therefore entitled to form unions and bargain collectively with the hospitals where they are trained. This decision could have important implications for hospital staffing, since hours of work will be a major issue for negotiation.²⁶ Another issue for negotiation will be whether residents perform such basic services as phlebotomies, placement of intravenous lines, and transportation of patients.²⁷ The American College of Physicians and the American Society of Internal Medicine oppose house-staff unionization, whereas the AMA supports it.²⁸

In our view, the provisions in labor law that prevent unionization by physicians are appropriate from the viewpoint of medicine as a profession. Physicians in practice do act independently, and those who are employed frequently manage and supervise clinical care. Physicians need to be able to manage and supervise in order to carry out their professional responsibilities.²⁹ Clinical autonomy and advocacy for patients require the kinds of activities that members of bargaining units cannot participate in.

ANTITRUST LAW

Given the difficulty of trying to bring physicians within the scope of federal labor laws, it is not surprising that the AMA, the American College of Physicians and the American Society of Internal Medicine, and other organizations have tried to find ways for physicians to engage in collective negotiations with managed-care organizations without resorting to formal unionization. However, any sort of coordinated activity by physicians for economic ends would run afoul of federal antitrust law.

The purpose of antitrust law is to promote competition, on the theory that a competitive marketplace lowers costs and is therefore beneficial for consumers. The primary focus of antitrust law is on "horizontal" restraints. A horizontal restraint limits competition between similar economic entities at the same level in industry (hence, horizontal) that would otherwise compete with one another. A common example is price fixing. The prohibition against horizontal restraints is found in the Sherman Antitrust Act, which states that "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States" is illegal.³⁰

In *Arizona v. Maricopa County Medical Society* in 1982, the Supreme Court ruled that when physicians negotiate collectively with insurers about fees and related matters, and as a consequence do not compete with one another on price, such negotiations represent a horizontal agreement among competitors to fix prices.³¹ The Supreme Court suggested that the obstacle

posed by the ban on price fixing could be overcome if the physicians were financially integrated — for example, if they offered complete medical coverage for a flat fee. Presumably, this arrangement would not be suspect because physicians would have the incentive to practice efficiently, and their efficiency would result in lower costs for consumers.

In 1996, the Department of Justice and the Federal Trade Commission issued a nonbinding Statement of Enforcement Policy in which they explained how they would assess the legality of this sort of arrangement among physicians, which they termed a “physician network joint venture.”³² The statement establishes “safety zones” for physician-operated networks — that is, conditions under which they are unlikely to be challenged. Networks classified as falling within safety zones are those whose members share “substantial financial risk” and constitute a relatively small proportion (20 to 30 percent) of all the physicians practicing the relevant specialty in a specific geographic area. These safety zones, however, do not provide protection against antitrust claims by private parties or state regulators.

The interpretation of substantial financial risk in the Statement of Enforcement Policy is important.³³ Physicians may share substantial financial risk if the network is financially integrated — for example, if it has a capitation arrangement with a health plan, or if it uses financial incentives, such as making compensation contingent in part on the network’s financial performance, to encourage its members to contain costs. The Department of Justice and the Federal Trade Commission also stated that physicians share substantial financial risk when the network is clinically integrated, although the definition of clinical integration is somewhat unclear. However, federal regulators have never approved a network that relied on clinical integration alone to shield it from antitrust liability, suggesting that financial integration is always necessary.

The AMA has argued that many physicians are unable to organize networks, because of the financial barriers involved and because of difficulties in achieving clinical integration. There are, however, many examples of physician networks. Group-model health maintenance organizations that are both clinically and financially integrated can negotiate collectively with insurers without violating antitrust laws, as can independent practice associations that are financially integrated to a sufficient degree. Nonetheless, some physicians neither can nor wish to participate in networks that are integrated financially or clinically, or both. For example, some physicians may be reluctant to accept financial incentives that encourage cost containment, for personal economic reasons or because such incentives have the potential to create a conflict of interest between reducing costs and providing good clinical care.

NEXT STEPS

With the limitations of labor laws and existing antitrust doctrine,³³ it is not surprising that physicians have lobbied to amend antitrust laws in order to exempt collective negotiations between physicians and managed-care organizations. The Quality Health Care Coalition Act of 2000, sponsored by Representatives Tom Campbell (R-Calif.) and John Conyers (D-Mich.)³⁴ and passed by a wide margin in the House of Representatives in the last session of Congress, would do just that. There are plans to resubmit the bill,³⁵ probably once the Patients’ Bill of Rights has been enacted. The position of the Bush administration is not clear, although while President George W. Bush was governor of Texas, he signed into law a bill authorizing collective negotiation of physicians’ fees with health plans.^{36,37} This law permits such negotiations if the health plan has substantial market power, if the physicians represent no more than 10 percent of those in the plan’s defined geographic area, and if the likely benefits of collective negotiation outweigh the disadvantages of a reduction in competition. Similar legislation has been introduced in 10 other states in 2001.³⁵

The current version of the Campbell–Conyers bill extends the right of collective bargaining to all health care professionals (not just physicians) who do not have this right under the National Labor Relations Act, with the same antitrust exemption enjoyed by bargaining units under federal and state laws. The bill pertains only to negotiations with group health plans that provide insurance coverage or with health insurers, not to negotiations with other entities, such as hospitals. Collective negotiations with Medicare and Medicaid are also excluded. The act would not give health care professionals the right to strike, and exemptions would expire after three years.

Professional and industrial organizations, as well as the Federal Trade Commission and the Department of Justice, have debated the merits of an antitrust exemption in terms of its effects on the cost and quality of care.^{38–40} The principal proponent of an exemption has been the AMA, now joined at least in part by the American College of Physicians and the American Society of Internal Medicine. These organizations have defended an antitrust exemption on the grounds that physicians will use their collective bargaining power to regain professional autonomy in medical decision making and will thus provide care in accordance with the best interests of their patients, not the financial interests of managed-care organizations. Unfortunately, there is no evidence to support the claim that collective bargaining by physicians will improve the quality of care.

The principal objection to the Campbell–Conyers bill is that it may substantially increase health care costs. Collective negotiation under the bill would allow physicians to try to eliminate or reduce existing cost-saving measures. In particular, if physicians focus

on improving remuneration, overall costs may increase, possibly with no benefit to patients. Although compensation of physicians represents only about 20 percent of all health care costs, increased payments to physicians will leave less money for other groups, unless employees, government, and other payers are willing to pay higher premiums.

Again, however, critical empirical evidence is lacking. The estimated costs of higher remuneration of physicians as a result of curbs on cost-containment measures differ widely. Charles River Associates, an economics consulting firm, estimated that the Campbell-Conyers bill would increase private health insurance premiums by 4.7 to 13.2 percent annually and would increase total annual health care costs by \$29 billion (2.5 percent) to \$95 billion (8.3 percent).⁴¹ In contrast, the Congressional Budget Office estimated that if the antitrust exemption were permanent, private health insurance expenditures would increase by 1.9 percent annually.⁴² The differences between the two sets of estimates are due, in large part, to different assumptions — for example, with respect to the number of physicians who would take advantage of the exemption and the magnitude of the cost savings achieved by managed-care organizations.⁴³ As with the effect on the quality of care, the costs of an antitrust exemption are quite uncertain.

At this point, it seems unlikely that a federal antitrust exemption will be passed by Congress this year. For now, organized medicine has made the passage of the Patients' Bill of Rights its top priority in trying to counter the power of managed-care organizations. But if managed care returns to the legislative agenda in the spring of 2002, an antitrust exemption will probably be an important goal. Given that enactment of the Patients' Bill of Rights is likely to increase the cost of health care, legislators will have to weigh the additional costs of an antitrust exemption.

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