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Comment

Destination Unknown: Illinois’ Search for a Solution to the Physician Collective Bargaining Problem

Charles S. Ofstein*

I. INTRODUCTION

On February 28, 2001, Representative Angelo “Skip” Saviano of the Illinois House introduced House Bill 3086, entitled the Health Care Services Contract Joint Discussions Act (“H.B. 3086”). Representative Saviano sought to rectify a perceived imbalance between independent physicians and health care plans. The bill was designed as a legislative response to the health care industry’s abandonment of the traditional “fee-for-service” system of the early 1980s in favor of “managed care organizations” (“MCOs”), a less expensive alternative. In short, H.B.

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2. Ill. H.B. 3086, § 5(b).

3. A “fee-for-service” system exists when the physician is free to set a reasonable fee, and if the insurance company does not pay the full amount, the patient becomes responsible for the remainder. Jeremy Lutsky, Is Your Physician Becoming a Teamster: The Rising Trend of Physicians Joining Labor Unions in the Late 1990s, 2 DEPAUL J. HEALTH CARE L. 55, 57 (1997).

4. The term “Managed Care Organization” (MCO) describes “a variety of organizations [such as HMOs, PPOs, etc.] that control costs and utilization of health care services.” See Barbara A. Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 MERCER L. REV. 1219, 1219 (1997). “In 1995, more than 120 million Americans were enrolled in some type of managed health care plan.” Ellen L. Luepke, White Coat, Blue Collar: Physician Unionization and Managed Care, 8 ANNALS HEALTH L. 275, 275-76 (1999); see also Maura F. Forde, Note, Jones v. Chicago HMO: The Illinois Supreme Court Gives the HMO Industry a Rude Awakening, 32 LOY. U. CHI. L.J. 511, 511 n.3 (2001) (“Approximately 2.5 million Illinois residents are HMO subscribers.”) (citation omitted).

5. MCOs differ from a fee-for-service system in that they rely on capitation, which is “the new managed care form of financing which relies on pre-paid, per capita annual payments to provide a
3086 would allow independent physicians to counter the power of MCOs through collective bargaining.\textsuperscript{6}

The health care industry has experienced tremendous changes during the past decade as a result of abandoning the fee-for-service system; thus, many independent physicians were left with a dwindling patient base, decreasing compensation, and less responsibility for the care of their patients.\textsuperscript{7} In addition, while the MCOs used their ever-increasing patient base to exact demands, the federal antitrust laws restrained independent physicians from using any countervailing leverage\textsuperscript{8} during contract negotiations.\textsuperscript{9} Independent physicians, therefore, turned to state legislatures in the hopes of gaining the power to collectively bargain.\textsuperscript{10}

This Comment will examine joint negotiation legislation at the federal and state levels, which would allow physicians to counter the

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\textsuperscript{6} I11. H.B. 3086, § 5(d) ("Empowering competing health care providers to hold joint discussions with health care plans . . . will help restore the competitive balance . . . in the markets for health care services."). The term "collective bargaining" means "negotiations between an employer and the representatives of organized employees to determine the conditions of employment." BLACK'S LAW DICTIONARY 257 (7th ed. 1999).

\textsuperscript{7} See William S. Brewbaker III, Physician Unions and the Future of Competition in the Health Care Sector, 33 U.C. DAVIS L. REV. 545, 548 (2000) (noting that the "system now seems to reward corporate bureaucrats, who specialize in cutting physician fees, burying doctors in mountains of paperwork before they can be paid, and keeping patients away from providers"); see infra Part I.A (discussing the transition from a fee-for-service to a MCO system).

\textsuperscript{8} The term "countervailing leverage" means to "compensate for" or "to exert force against an opposing . . . force or influence." WEBSTER'S NEW COLLEGIATE DICTIONARY 258 (150th Anniversary Ed. 1981).

\textsuperscript{9} The principal federal antitrust laws applicable to the health care industry are the Sherman Act, 15 U.S.C. §§ 1–7 (2000), and the Clayton Act, 15 U.S.C. §§ 12–27 (2000). Kenneth Laurence, Antitrust Laws, Health Care Providers, and Managed Care, C653 ALI-ABA 279, 291 (1991); see infra Part II.B.1 (providing a more detailed discussion of the federal antitrust acts, specifically the Sherman Act); see also Luepke, supra note 4, at 275-76 (noting as an example of the increasing patient base of MCOs that more than 120 million were enrolled in MCOs as of 1995).

\textsuperscript{10} See Brewbaker, supra note 7, at 558. Physicians could, of course, enter into an employment agreement with the MCOs. See Brewbaker, supra note 7, at 549 ("The proportion of physicians who are employees . . . has increased dramatically from 24.2% in 1983 to 42.3% in 1994."). Entering into such an employer-employee relationship with the MCO would allow physicians to unionize. See Lutsky, supra note 3, at 67. Still, the majority of physicians are self-employed. See Brewbaker, supra note 7, at 549.
tremendous leverage that MCOs currently wield in the industry. In Part II, this Comment will examine the situation that independent physicians faced as the health care industry transitioned from a fee-for-service system to MCOs. Next, it will discuss how the federal antitrust acts constrain the ability of physicians to compete with MCOs, as well as Congress' failed efforts to provide relief to doctors who wish to collectively bargain. This Comment will also offer alternatives to federal legislation as a means of providing relief to physicians. This Comment will then examine the state action doctrine, which allows state legislatures to implement laws permitting physicians to collectively bargain. It will also examine additional efforts at the state level to give doctors this right without violating federal antitrust laws. Part III will provide an analysis of Illinois' proposed legislation, H.B. 3086, in greater detail, focusing on whether it complies with the requirements of the state action doctrine. It will also explore another piece of legislation, Illinois House Bill 2115 ("H.B. 2115"), and examine how this legislation attempts to change the way independent physicians contract with MCOs. Next, Part IV will discuss possible modifications that must be made to H.B. 3086 in order for it to comply with the state action doctrine. Part IV will also examine the far-reaching impact that this legislation will have on government at both the state and federal levels. Finally, Part V will propose alternative solutions that would allow physicians and other

11. *See infra* Part II (discussing federal and state legislation as precursors to Illinois' legislation).
12. *See infra* Part II.A (examining the transition from a fee-for-service system to managed care organizations as the dominant type of health care plan).
13. *See infra* Part II.B.1 (discussing the federal antitrust acts).
14. *See infra* Part II.B.2 (exploring attempts at the federal level to modify the federal antitrust acts to give countervailing power to physicians).
15. *See infra* Part II.B.3 (discussing the FTC/DOJ statements and their guidelines for antitrust enforcement policy in health care).
16. *See infra* Part II.C.1 (discussing the state action doctrine).
17. *See infra* Part II.C.2–3 (detailing the Joint Negotiations by Physicians with Health Benefit Plans Act in Texas and other state legislation).
20. *See infra* Part IV.A (discussing how H.B. 3086 may not comply with the state action doctrine).
health care professionals to engage in cooperative discussions with MCOs, to the benefit of all interested parties.22

II. BACKGROUND

Under the fee-for-service system,23 physicians enjoyed strong bargaining power and did not need an antitrust exemption to compete with the health care insurance industry.24 As physicians witnessed the tremendous change in the industry from the fee-for-service system to MCOs, however, physicians recognized a threat to their bargaining power and advocated for a collective bargaining exemption from the antitrust laws to level the playing field.25 Initial attempts were made at the federal level to provide a direct exemption to the federal antitrust laws for physicians.26 When these attempts failed, physicians exercised their influence at the state level to create an exemption through the judicially created state action doctrine.27 These efforts were quite successful in Texas and met with limited success in other states.28 Such successes emboldened state congressional representatives to introduce similar legislation in Illinois.29

A. The Transition from Fee-for-Service to Managed Care Organizations

Until the late 1980s, physicians were largely self-employed or worked in small groups.30 Doctors worked individually with their patients to arrive at what they believed to be the best plan of care.31 Health insurance companies rarely acted as interested third parties under this fee-for-service system thereby alleviating the need for physicians to

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22. See infra Part V (identifying alternative solutions to rectify the problems plaguing physicians in the health care industry).
23. Lutsky, supra note 3, at 57; see also supra note 3 (defining a "fee-for-service" system).
24. See infra Part II.A (detailing the situation that independent physicians faced under the fee-for-service system as compared to a managed care system).
26. See infra Part II.B.2 (analyzing the failed attempts at the federal level to give physicians an antitrust exemption).
27. See infra Part II.C.1 (detailing the state action doctrine).
28. See infra Part II.C.2-3 (discussing the Texas legislation and other state legislation).
30. Noah, supra note 5, at 1219 (noting that the market was comprised mainly of self-employed physicians in solo or small group practices).
31. Luepke, supra note 4, at 278.
negotiate with patients, the buyers of their services. Indeed, physicians were fairly and adequately compensated for whatever services they recommended, regardless of their cost. The physicians enjoyed significant bargaining power and the largest professional association of physicians, the American Medical Association, strongly opposed any attempts at unionization.

However, by the early 1990s, sophisticated corporate employers recognized that their employees' health care costs could be lowered and turned to MCOs as the preferred choice of health plan. Intent on maximizing profits, these corporations enrolled their employees in MCO plans and abandoned the more expensive fee-for-service system. Reluctantly, physicians found themselves becoming "cogs in the corporate health care machinery" with less control over patient care decisions.

Additionally, the emergence of MCOs exerted tremendous downward pressure on physician incomes and limited physician autonomy and

32. See id. at 275. "In the days of fee-for-service, the physicians and patients controlled health care decisions and insurers, for the most part, simply acted as payers." Id.
33. Id. at 278-79 (noting that "physicians recommended treatment, patients accepted it, and indemnity insurance plans paid the bills"); Lutsky, supra note 3, at 57.
34. See Luepke, supra note 4, at 294. In 1984, the AMA Board stated that unions traditionally are ill suited to a physician’s "professional values of individualism and autonomy." Id.
35. Id. at 275-76. Essentially, MCOs injected themselves as middlemen between medical decision-making and the practice of medicine. Id. at 276. MCOs describe "a variety of organizations [such as HMOs and PPOs] that control costs and utilization of health care services." Noah, supra note 5, at 1219.
36. See Forde, supra note 4, at 511 (noting that America’s health care market transformed from the traditional fee-for-service method of payment to a less expensive alternative).
37. Lutsky, supra note 3, at 55. MCOs, for example, implemented highly regimented processes for determining the appropriate costs and courses of medical services and influenced physician behavior by implementing new administrative and management strategies. Thomas H. Segars, Comment, Bad Medicine: The Anticompetitive Side Effects of Physician Unionization, 76 CHI.-KENT L. REV. 1303, 1305 (2000). These strategies included shortening patient stays in hospitals and regulating medical procedures. Jeffrey Rugg, An Old Solution To a New Problem: Physician Unions Take the Edge off Managed Care, 34 COLUM. J.L. & SOC. PROBS. 1, 7 (2000). MCOs even hired non-physician accountants to carry out the utilization management and review procedures of their contracting physicians. Luepke, supra note 4, at 277. MCOs further instituted strict control measures on physicians in an attempt to increase efficiency. Rugg, supra, at 7. These procedures only briefly stabilized health care costs, however, and premiums have continued to rise. See id. at 11.
38. Farmer & Douglas, supra note 25, at 37 (noting that managed care is responsible for reducing physician incomes forty-four percent from where they would have been under a fee-for-service system); Micah Berman, Note, The "Quality Health Care Coalition Act": Can Antitrust Law Improve Patient Care?, 53 STAN. L. REV. 695, 699 (2000) (commenting that, while the evidence is ambiguous, the advent of managed care dropped physician salaries almost four percent in 1994).
style of practice. Many physicians restructured their patient-centered medical practices into bottom line-focused businesses in order to meet the stringent demands of MCOs. In some instances, physicians attempted to circumvent MCO requirements in order to provide patients with what they viewed as a necessary treatment. Either way, physicians had to concentrate less on patient care and more on the financial bottom line, which in turn had an impact on the overall level and quality of patient care in the health care industry.

The significant bargaining power traditionally enjoyed by physicians was also affected by these changes in the health care industry. Statistics indicate that a majority of Americans with private health insurance became enrolled in managed care plans in 1993 and 1994. As the number of participants in these plans grew, MCO leverage increased to the point that individual physicians faced a “take-it-or-leave-it” choice. On the one hand, a physician could choose not to

39. See Segars, supra note 37, at 1306. MCOs influence physician behavior by implementing financial incentives, administrative or management strategies, and information or normative influences. Id.

40. Rugg, supra note 37, at 7. Indeed, many physicians have sold their practices to health networks or have had to merge with hospitals. Id. These strict control measures include shortening patient stays in hospitals and regulating medical procedures. Id.

41. See generally id. at 9 (noting that over twenty-eight percent of the physicians surveyed agreed with the statement that, “today it is necessary to game the system to provide high quality care”).

42. Eggleston, supra note 5, at 926 (noting that “the essential economic mandate of the new order of the health care industry is now in direct conflict with the health policy goal of quality care and universal access”).

43. See Segars, supra note 37, at 1308. Many physicians “attribute [the] deterioration in the quality of health care and [the] economic slump . . . to an unequal bargaining power enjoyed by many consolidated MCOs.” Id.


45. Warren S. Grimes, The Sherman Act’s Unintended Bias Against Lilliputians: Small Players’ Collective Action as a Counter to Relational Market Power, 69 ANTITRUST L.J. 195, 215, 216 (2001); William G. Kopit, White Coats and Blue Collars: Physician Collective Bargaining Legislation on the National and State Levels, SF28 ALI-ABA 93, 102 (2000) (“[T]here can be little question that individual physicians . . . feel powerless to negotiate with large [MCOs].”). Indeed, this “take-it-or-leave-it” choice was more than just black and white. As MCOs grew more powerful, their physician contracts became more and more one-sided in favor of the health plan, sometimes including “lowest cost” language, and clauses that would allow the MCO to change the terms of their fee schedules at will. See Berman, supra note 38, at 702.
deal with the MCOs, working only with patients paying for their own care or with alternative health care plans. However, this approach required the physician to turn away both established and new patients simply because they were insured by an MCO. By turning away these patients, a physician risked reducing his or her patient base and revenues to the point that practice would no longer be profitable.

Conversely, a physician could retain at least a portion of his or her patient base by contracting with an MCO. Physicians contracting with an MCO, however, risked losing established patients not covered by that MCO. Indeed, the only way for a physician to maintain his or her entire patient base was to enter into an agreement with every MCO that represented one of his or her patients.

Under either of the scenarios described above, physicians were forced to accept the MCO's fee schedule or risk losing a substantial portion of their patient base. For most physicians, the choice was all too clear: either lose their practice or contract with MCOs against their will.

B. Attempts at Federal Regulation

Under federal antitrust law, a physician facing a “take-it-or-leave-it” contract from an MCO is limited to independent negotiations. As a result, physicians confronted with this dilemma began to lobby at the

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46. Rugg, supra note 37, at 7. Cash payers were usually not covered by any sort of health care plan and therefore paid for their own care. See id. Likewise, physicians could “pick and choose patients based on the level of reimbursement provided by their health plan.” Grimes, supra note 45, at 215.

47. Rugg, supra note 37, at 8 n.40 (discussing how physicians who accept old-fashioned health insurance or cash have to tailor their practices to fewer patients) (citation omitted).


49. See Luepke, supra note 4, at 275 (noting that, by 1995, 85% of American physicians had a contract with at least one MCO); Noah, supra note 5, at 1219 (stating that three quarters of the physicians in the country practice or contract with an MCO).

50. See Grimes, supra note 45, at 215. For some doctors, turning away these patients could again reduce revenues to the point that their practice would no longer be profitable. See id.

51. Thus, it has been said that “many American physicians have sacrificed their autonomy to survive financially.” Kopit, supra note 45, at 102-03 (citation omitted). Indeed, physicians sometimes only had to contract with the dominant MCO and wait for a merger to occur. See Brewbaker, supra note 7, at 547. Mergers of MCOs occurred many times during the 1990s. Id. For further discussion of whether or not this was done in an anticompetitive fashion, see infra Part V.A (calling for an investigation into the mergers of MCOs in an effort to ensure physicians are adequately compensated and that the quality of patient care is maximized).

52. See Kopit, supra note 45, at 102 (noting that two out of three privately insured Americans are enrolled in some form of managed care plan).

53. Id. at 101-02. “Though physicians complain[ed] bitterly about the economic power of [MCOs], many contract with those organizations because they control the patients.” Id.

54. See infra Part II.B.1 (discussing the federal antitrust acts).
federal level for an antitrust exemption, which would allow them to collectively bargain with the dominant MCOs. The Quality Health-Care Coalition Act of 2000, which would allow physicians to collectively bargain, met with opposition and did not move out of committee in the United States Senate. Consequently, physicians looked to the states for relief.

1. The Federal Antitrust Acts

   a. The Sherman Act

Federal antitrust policy is predicated on the assumption that competition produces the most efficient allocation of economic resources. To encourage competition, 15 U.S.C. § 1, commonly known as the Sherman Act, blocks certain combinations formed with the purpose or effect of restraining trade. Although all contracts or combinations restrain trade to some degree, courts have interpreted section 1 of the Sherman Act as prohibiting only those agreements that unreasonably restrain trade. Therefore, most allegations regarding a violation of section 1 of the Sherman Act are analyzed under the “rule of reason” test, which compares an agreement’s procompetitive and

55. See infra Part II.B.2 (discussing the Quality Health-Care Coalition Act of 2000); see also Brewbaker, supra note 7, at 558-64 (making the proposition that new legislation might grant independent physicians collective bargaining rights).
56. See infra Part II.B.3 (exploring the FTC/DOJ Antitrust Guidelines and their opposition to the Quality Health-Care Coalition Act of 2000).
57. See infra Part II.C (examining state legislation through the state action doctrine).
58. Segars, supra note 37, at 1309-10.
60. Remis, supra note 44, at 117. As provided in the Act, “[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is hereby declared to be illegal.” 15 U.S.C. § 1.
61. Glassman, supra note 59, at 105.
62. The definition of the “rule of reason” was articulated by Justice Louis Brandeis in 1918: “The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.” Chi. Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).
anticompetitive features. The Supreme Court has found particular
types of agreements to be per se illegal. In this type of situation, no
procompetitive justifications can be offered to show that the agreement
is reasonable.

Likewise, section 2 of the Sherman Act prohibits anyone from
monopolizing, attempting to monopolize, or conspiring to monopolize
the sale of their products. Economists use the term “monopsony” to
describe a comparable prohibition on the buyer side of the equation.
Courts apply a two-part test to determine whether a defendant has
violated section 2 of the Sherman Act. First, a defendant must have
“market power” in the relevant product market. Second, a defendant

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63. Analysis under the “rule of reason” test considers market conditions, procompetitive
justifications, effects of the agreement, and other relevant facts. Berman, supra note 38, at 703.
64. Some restraints are considered per se unlawful “because of their pernicious effect on
competition and lack of any redeeming virtue [and thus] are conclusively presumed to be
U.S. 1, 5 (1958) (alteration in original). Per se treatment is appropriate only when experience
“with a particular kind of restraint enables the Court to predict with confidence that the rule of
reason will condemn it . . .” Arizona v. Maricopa County Med. Soc’y, 457 U.S. 332, 344
(1982). Today, the only behaviors that qualify for per se status are: agreements among
competitors relating to prices, the division or allocation of product or geographic markets
between competitors, coercive or exclusionary group boycotts or concerted refusals to deal with
competitors; and certain kinds of tying arrangements involving coercive use of market power.
Laurence, supra note 9, at 302. Horizontal price fixing, which is the most relevant version of
price-fixing in the health care industry, is defined as cooperation between competitors to
eliminate or reduce competition based on price. Berman, supra note 38, at 704. Indeed,
physicians who have unionized in the past have been the subjects of successful litigation. See
Segars, supra note 37, at 1312 n.68; see generally Berman, supra note 38, at 706 (noting that
horizontal combinations are not barred by antitrust laws as long as mergers do not result in
unacceptably large concentrations of market power).
65. Berman, supra note 38, at 703. The Supreme Court has been unwilling to expand these
per se categories and is open to applying a rule of reason whenever a persuasive argument can be
made for it. Id.; see, e.g., Nat’l Collegiate Athletic Ass’n v. Bd. of Regents, 468 U.S. 85, 101
(1984) (noting that college football is “an industry in which horizontal restraints on competition
are essential if the product is to be available at all”); Broad. Music, Inc. v. CBS, 441 U.S. 1, 23
(1979) (noting that not all arrangements among actual or potential competitors are per se
violations of the Sherman Act).
monopolize, or combine or conspire with any other person or persons, to monopolize any part of
the trade or commerce among the several States . . . shall be . . . guilty of a felony.”).
67. Monopsony power refers to “a buyer’s ability or power to depress the price of a good or
service below competitive levels.” Segars, supra note 37, at 1322.
68. See Antitrust Coalition for Consumer Choice in Health Care: Hearing on H.R. 1304
Before House Committee on the Judiciary, 106th Cong. (1999) (statement of Bill Jones),
69. Glassman, supra note 59, at 103.
70. Courts have traditionally used market share as proxy for market power in their evaluation.
Id. at 103-04. Market share is defined as “the percentage of the market for a product that a firm
supplies.” BLACK’S LAW DICTIONARY 985 (7th ed. 1999). Most courts presume that groups
must have engaged in, or attempted to engage in, anticompetitive conduct.\footnote{Brewbaker, supra note 7, at 566.} This element is satisfied when a defendant acquires, or attempts to acquire, monopoly power through unlawful means or wields such power to prevent or impede competition.\footnote{Glassman, supra note 59, at 104.}

A violation of the Sherman Act is a felony.\footnote{Glassman, supra note 59, at 104.} The Department of Justice is charged with the public enforcement of the Sherman Act, and the Federal Trade Commission is also authorized to bring legal action in response to a violation of the Act.\footnote{Glassman, supra note 59, at 104.} The felony provision of the Sherman Act places a strong proscription on cartel-like conduct and monopolization.\footnote{Glassman, supra note 59, at 104.} Thus, the Sherman Act, in the absence of a legislative exemption, stands in the path of collective action by physicians.\footnote{Glassman, supra note 59, at 102-03.}

b. The National Labor Relations Act

Congress granted employees a legislative exemption in the Clayton Act to form labor unions free from antitrust scrutiny under section 1 of the Sherman Act.\footnote{See Berman, supra note 38, at 706.} The National Labor Relations Act ("NLRA")\footnote{See Rugg, supra note 37, at 30-34.} further defines this exemption and regulates unions that engage in collective bargaining to enhance employment conditions.\footnote{See National Labor Relations Act, 29 U.S.C. § 151 (1994).}

\footnote{Clayton Act, 15 U.S.C. § 17 (2000). The Clayton Act "operates by exempting human labor from the definition of a ‘commodity or article of commerce,’ [thereby] removing it from regulation under the Sherman Act and allowing labor organizations to conduct the ‘legitimate objects’ of their organization." Luepke, supra note 4, at 282. A “union” has been defined as: “A combination so formed, especially an alliance or confederation of people, parties, or political entities for mutual interest or benefit." American Heritage Dictionary of the English Language (4th ed. 2000).}

\footnote{Id. § 152(5) (defining labor organizations). "Labor exemptions have been restricted to unions acting in their own interest [and] unions using the least restrictive means available . . . ." Segars, supra note 37, at 1310-11.}
Physicians, however, are not considered "employees" under the NLRA. In *Goldfarb v. Virginia State Bar*, the Supreme Court limited the scope of the NLRA by holding that Congress did not intend any "sweeping exclusion" for learned professions. Because physicians are learned professionals, this ruling means that they are not included within the antitrust exception for employees. In addition, under the NLRA, physicians are considered independent contractors instead of employees. Moreover, the Court ruled, in a series of cases, that the health care industry is not entitled to any special antitrust immunity. Thus, the full weight of the federal antitrust laws was thrust upon physicians, making it per se illegal for them to jointly raise, lower, or otherwise fix prices. As a result, the right to act collectively in response to the growth of MCOs had to be achieved through legislation.

2. The Quality Health-Care Coalition Act of 2000

The 105th Congress proposed the first legislative attempt to give physicians the countervailing power to negotiate with MCOs in 1998.88
After the Quality Health-Care Coalition Act of 1998 failed to move out of committee, Representative Tom Campbell of California reintroduced the idea in the 106th Congress. This time, however, the legislation garnered the support of the American Medical Association. The new version of the bill, entitled the Quality Health-Care Coalition Act of 2000 ("QHCCA"), would create an exemption to the federal antitrust laws specifically for health care professionals. This exemption would permit collective bargaining by health care professionals similar to employees under the NLRA. Proponents of the QHCCA argued that the bill would positively affect the quality of health care by increasing the leverage and bargaining position of doctors who could then force MCOs to improve the level of patient care. The legislation would help to ensure that all MCO contracts signed by health care professionals are fair and equitable.

89. A committee or subcommittee has the option to "table" a bill, or postpone action on it indefinitely. See generally How Our Laws Are Made, VI: Consideration By Committee, available at http://thomas.loc.gov/home/lawsmade.bysec/considbycomm.html (last modified July 23, 2000) [hereinafter How Our Laws Are Made] (describing the structure of the committee process). The practical effect of this system is that bills fail to move out of the committee or subcommittee until the end of the legislative session, which is two years long. Id. In the case of the Quality Health-Care Coalition Act of 1998, it failed to move out of committee before the end of the 105th Congress and expired at the end of that Congress in 1998. Kopit, supra note 45, at 104-05.


92. H.R. 1304, § (2)(a). The substantive portion of the bill, in its entirety, read:

Any health care professionals . . . engaged in negotiations with a health plan regarding the terms of any contract . . . [for] health care items or services for which benefits are provided . . . shall, in connection with such negotiations, be 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 in connection with such collective bargaining.

Id.

93. Id.

94. Brewbaker, supra note 7, at 550-51 (stating the argument "that unionization will benefit consumers by strengthening the hand of doctors in protecting consumer interests against HMO interference").

95. See Statement of the AMA, supra note 91. Indeed, the terms and conditions of a health plan can be unreasonable enough to cause harm to patients. Id.; see supra note 45 and accompanying text (explaining how contracts with the MCOs were generally one-sided in favor of the health plan).
Opponents of the QHCCA quickly pointed out that the bill increased physician incomes above competitive levels. Additionally, opponents expressed doubts about whether the quality of patient care would be improved under such a system. They pointed out that in the era before managed care, local groups of physicians were the first to suppress private cost-containment efforts and resist price competition. Any mechanism that gave physicians back this power, QHCCA opponents argued, would undoubtedly reintroduce these tactics into the health care industry.

The FTC and DOJ were particularly vocal in their criticism of the QHCCA. Both Robert Pitofsky, Chairman of the FTC, and Joel I. Klein, Assistant Attorney General, DOJ Antitrust Division, testified before a House committee, regarding QHCCA, to reiterate their agencies’ opposition to the bill. According to these agencies, the QHCCA would result in higher prices for consumers without any guarantee of improved patient care. The FTC and DOJ provided data indicating that health plan markets vary widely and that MCOs typically face considerable competition from other MCOs. Thus, most MCOs do not have sufficient monopsony power in most areas to warrant a

96. See generally Kopit, supra note 45, at 110-12 (discussing potential increase of income for physicians and cost of health care system). The Congressional Budget Office’s estimates on the bill stated that it would increase physician incomes by 4.5%. Id. at 111. In response to this figure, the Health Insurance Association of America also commissioned a study which claimed that the national medical costs could rise as much as $80 billion a year. Id. at 112.

97. See Brewbaker, supra note 7, at 551. Opponents viewed the argument that patients would benefit from the unionization of doctors as “highly suspect” because “unions generally achieve their goals at the expense of employers and consumers.” Id. (emphasis added).

98. Id. (noting that “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”).

99. Id.


102. Id. at 31-32 (statement of Chairman Pitofsky).

103. Id. at 45-46 (statement of Assistant Attorney General Klein). Furthermore, managed care markets are constantly changing, and more than 150 new MCOs were licensed to operate in the United States between 1994 and 1997. Id. (statement of Assistant Attorney General Klein).
need for physicians to collectively bargain.\textsuperscript{104} Essentially, the FTC and DOJ were concerned that the QHCCA’s goal to equalize bargaining power rested on theoretical assumptions that did not accurately describe the majority of health care markets.\textsuperscript{105} Therefore, the QHCCA did not provide assurance that its enactment would decrease health care costs.\textsuperscript{106}

Judiciary Committee Chairman Henry Hyde of Illinois also expressed concern regarding the potential costs of the QHCCA legislation.\textsuperscript{107} Accordingly, he persuaded the House Judiciary Committee to limit the duration of the QHCCA by amending the bill with a sunset provision.\textsuperscript{108} The Hyde Amendment also called for a government study, to be conducted by the FTC during the final six months of the sunset provision, to evaluate whether or not the legislation should be reauthorized.\textsuperscript{109}

After the bill was amended, the Judiciary Committee reported the bill favorably to the House floor.\textsuperscript{110} The House of Representatives subsequently passed the QHCCA.\textsuperscript{111} Despite this success in the House, the bill never reached the floor of the Senate.\textsuperscript{112} Instead, Senate Majority Leader Trent Lott of Mississippi chose to stall the bill in committee\textsuperscript{113} over concerns that it would interfere with the successful

\textsuperscript{104} Kopit, \textit{supra} note 45, at 103 ("In fact, in testimony before the House Judiciary Committee, a representative of the Chamber of Commerce and the Antitrust Coalition for Consumer Choice in Health Care, testified that in large metropolitan statistical areas . . . there may be more than eight managed care companies operating.").

\textsuperscript{105} H.R. REP. NO. 106-625, at 39 (statement of Chairman Pitofsky). Data on HMOs for example, show that HMOs face competitions from other HMOs as well as other types of health plans. \textit{Id.} at 38 (statement of Chairman Pitofsky).

\textsuperscript{106} \textit{Id.} at 39 (statement of Chairman Pitofsky).

\textsuperscript{107} Kopit, \textit{supra} note 45, at 106-07. Indeed, Chairman Hyde was unwilling "to support the bill until the Congressional Budget Committee estimates of its costs were known." \textit{Id.}

\textsuperscript{108} This sunset provision causes the legislation to expire, without an affirmative act by Congress, after three years. \textit{See id.} This was done because of Chairman Hyde’s disagreement and uncertainty as to how the bill would work under actual market conditions. \textit{Id.} at 107.

\textsuperscript{109} \textit{Id.} The Hyde Amendment established the FTC as the responsible agency to conduct the study. \textit{Id.} However, an additional amendment shifted responsibility for the study to the General Accounting Office. \textit{Id.}

\textsuperscript{110} \textit{Id.} at 106. The Judiciary Committee voted favorably 26-2 to send the bill to the House floor. \textit{Id.}

\textsuperscript{111} \textit{Id.} at 108. The United States House of Representatives passed H.R. 1304, the Quality Health-Care Coalition Act of 2000, on June 30, 2000, by a vote of 276-136. \textit{Id.}

\textsuperscript{112} Berman, \textit{supra} note 38, at 697 ("Due to opposition from Senate Majority Leader Trent Lott and other Senate Republican leaders, the [QHCCA] remained bottled up in a Senate committee for the remainder of the 106th Congress.").

\textsuperscript{113} \textit{See supra} note 89 (explaining how postponing action on a bill can keep it from getting out of a legislative session); \textit{see generally} How Our Laws Are Made, \textit{supra} note 89 (describing the structure of the committee process).
passage of another important health care policy priority, the Patients’ Bill of Rights.\footnote{See Kopit, supra note 45, at 109. The Patients’ Bill of Rights was a series of healthcare reforms focusing on the relationship between patients and HMOs that did not include the Quality Health-Care Coalition Act of 2000. See id.} The Quality Health-Care Coalition Act has not been reintroduced during the 107th Congress and, in the face of continued health care policy debates, its fate at the federal level is unclear.\footnote{Berman, supra note 38, at 697 (noting that proponents of the QHCCA will likely reintroduce the legislation during the 107th Congress).}

3. The FTC/DOJ Statements and Their Guidelines for Antitrust Enforcement Policy in Health Care

The FTC and DOJ based their opposition to the QHCCA not only on data, but also on their experience investigating previous instances of collective bargaining by health care practitioners.\footnote{H.R. REP. NO. 106-625, at 32 (2000) (statement of Chairman Pitofsky). For example, the FTC “has taken enforcement actions in cases in which provider groups sought to impede” other practices by denying, delaying, or limiting hospital privileges of non-physician providers. See id. at 33 (statement of Chairman Pitofsky).} Even before the Quality Health-Care Coalition Act of 2000 debate, the agencies’ position was that measures designed to increase the power of consumer choice, rather than physician choice, would better serve patients.\footnote{Id. at 32 (statement of Chairman Pitofsky).} This position was articulated in the agencies’ Statements of Antitrust Enforcement Policy in Health Care ("Guidelines").\footnote{U.S. Dep’t of Justice & Federal Trade Comm’n, Statements of Antitrust Enforcement Policy in Health Care, Apr. 7, 2000, at 1, available at http://www.ftc.gov/reportslhlth3s.htm [hereinafter Guidelines]. The Guidelines were introduced by the agencies in 1993. Id. at 2. Although the Guidelines are not law, they are nonetheless important because they spell out the thoughts of the two federal agencies most responsible for law enforcement. See Monroe & Seitz, supra note 100, at 71-72.}

The Guidelines established “antitrust safety zones” for nine specific areas of the health care industry.\footnote{See Remis, supra note 44, at 119-21 (evaluating an earlier version of the Guidelines, which included six specific areas). The nine specific areas are listed in the table of contents of the Guidelines:

Statement 1 - Mergers Among Hospitals
Statement 2 - Hospital Joint Ventures Involving High Technology Or Other Expensive Health Care Equipment
Statement 3 - Hospital Joint Ventures Specialized Clinical Or Other Expensive Health Care Services
Statement 4 - Providers’ Collective Provision Of Non-Fee-Related Information To Purchasers Of Health Care Services
Statement 5 - Providers’ Collective Provision Of Fee-Related Information To Purchasers Of Health Care Services
Statement 6 - Provider Participation In Exchanges Of Price And Cost Information}
to industry participants by describing conduct that the agencies would not challenge under the antitrust laws absent extraordinary circumstances. Moreover, the conduct falling outside of these safety zones would not immediately be considered per se unlawful. Rather, the agencies would evaluate the conduct under the “rule of reason” to determine whether the joint venture was likely to have procompetitive benefits that outweigh the anticompetitive potential. Essentially, if procompetitive gains could be shown and physicians operated their joint ventures within the Guidelines, they could avoid antitrust liability.

C. Attempts at State Regulation Through the State Action Doctrine

1. The State Action Doctrine

Attempts have been made at the state level to give physicians the right to collectively bargain through the judicially created state action doctrine. This doctrine, first articulated by the Supreme Court in Parker v. Brown, gives states the authority to supplant competition with state regulation. This doctrine originally exempted state and local government regulations from federal antitrust liability, even if the

Statement 7 - Joint Purchasing Arrangements Among Health Care Providers
Statement 8 - Physician Network Joint Ventures
Statement 9 - Multiprovider Networks

Guidelines, supra note 118, at 1 (Table of Contents).

120. Guidelines, supra note 118, at 3. The agencies anticipate that extraordinary circumstances warranting a challenge to conduct that falls inside the safety zone will be rare. Id. at 4 n.1.

121. Id. at 3. The individual statements themselves note the analysis that the agencies will use in reviewing conduct that falls outside of the safety zone. Id.

122. Id. This flexible rule of reason approach takes into account the relevant market, the remaining competition in the market, effect of exclusivity and non-exclusivity of venture, a determination of the efficiencies, and other similar factual matters. See Monroe & Seitz, supra note 100, at 89; see also Chi. Bd. of Trade v. United States, 246 U.S. 231, 238 (1918) (holding that the rule of reason test is whether the restraint promotes or suppresses competition).

123. See Guidelines, supra note 118.

124. Kopit, supra note 45, at 118. It is important to note that many state attempts were originally based on AMA model legislation. See Editorial, A right to talk in Texas, AMEDNEWS.COM (Apr. 26, 1999), at http://www.ama-assn.org/sci-pubs/amnews/amn_99/edit0426.htm.

125. Parker v. Brown, 317 U.S. 341 (1943). In Parker, the Supreme Court held that an anticompetitive marketing program that “derived its authority and its efficacy from the legislative command of the state” was not a violation of the Sherman Act. Id. at 350.

126. Id. at 360 (holding that the Commerce Clause does not remove from the states “the authority to regulate commerce with respect to matters of local concern, on which Congress has not spoken”).
regulation was a clear violation of the federal antitrust laws. Thus, the doctrine stood for the proposition that federal antitrust laws should not be used to intrude too deeply into the state regulatory process.

In 1980, the Supreme Court in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.* extended the state action doctrine to give private actors immunity from the federal antitrust laws when they were acting pursuant to state regulatory programs designed to supplant competition with state regulation. In *Midcal*, the Court invalidated a state-authorized resale price maintenance scheme for wine pricing because there was no state monitoring of market conditions after its implementation. The Court arrived at this result by establishing two requirements that state regulatory programs must meet before antitrust immunity can be conferred upon private actors. First, the state must clearly articulate and firmly express its reasons for supplanting competition with state regulation. Second, the policy must be actively supervised by the state itself.

Most state statutes meet the *Midcal* "clear articulation" standard by making an express statement of the state's intent to displace competition with regulation. Compliance with the "active supervision" prong of the *Midcal* test, however, is often the subject of debate. This second requirement ensures that a private party's anticompetitive conduct

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127. *Id.* at 350-51 (noting that nothing in the Sherman Act or its history suggests that the purpose was to restrain a state or its officers from activities directed by its legislature); see generally *Herbert Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice* § 20 (1994).
131. While the state policy was clear, the state neither established the prices nor reviewed the price schedules used by private parties. *Midcal*, 445 U.S. at 105-06. Thus, the policy failed because it was not actively supervised by the state. *Id.* at 106.
132. *Id.* at 105.
133. *Id.* (noting that "[t]he legislative policy is forthrightly stated and clear in its purpose to permit resale price maintenance").
134. *Id.* Here the Court was more skeptical because the "[s]tate simply authorized price setting and [then] enforce[d] the prices established by private parties." *Id.* As a result, the Court held that this prong of the articulated test was not met. *Id.* at 106.
135. Vance, *supra* note 130, at 421. States can also choose to speak in more general policy terms and should still pass the clear articulation requirement. *Id.*
promotes state policy rather than the party’s individual interest.\footnote{Patrick, 486 U.S. at 100-01. In Patrick, the Court held that the state action doctrine did not protect physicians in the state of Oregon from federal antitrust liability for their activities on a hospital peer-review committee. \textit{Id.} at 105. Like \textit{Midcal}, the Court here found that the state regulatory agency did not review the private decisions rendered in the committee meetings to determine if the decisions comported with state policy. \textit{Id.} at 101. As a result, the physicians were liable under the federal antitrust laws. \textit{Id.} at 105.} It further mandates that the state exercise ultimate control over the challenged anticompetitive conduct.\footnote{Id. at 101. Perhaps the best way for states to show “ultimate control” is for a state to actually use their review authority on an ongoing basis. \textit{See, e.g.}, DFW Metro Line Servs. v. Southwestern Bell Tel. Corp., 988 F.2d 601 (5th Cir. 1993); Sandy River Nursing Care Ctr. v. Nat’l Council on Comp. Ins., 798 F. Supp. 810 (D. Me. 1992), \textit{aff’d sub nom.}, Sandy River Nursing Care v. Aetna Cas., 985 F.2d 1138 (1st Cir. 1993).} In other words, state officials must have and exercise the power to review particular anticompetitive acts of private parties and declare void those that fail to comply with the state policy.\footnote{Patrick, 486 U.S. at 101.}.

In \textit{Federal Trade Commission v. Ticor Title Insurance Co.},\footnote{Ticor, 504 U.S. at 621.} “the Supreme Court took its active supervision analysis a step further.”\footnote{Vance, supra note 130, at 413. Notably, the Court held that state action immunity is “disfavored.” Ticor, 504 U.S. at 636.} The Supreme Court in \textit{Ticor} held that the active supervision prong of the \textit{Midcal} test could not be met simply by empowering a state agency.\footnote{Ticor, 504 U.S. at 638. In \textit{Ticor}, private title insurance companies fixed rates in Connecticut, Arizona, Wisconsin, and Montana through a private ratings bureau, in accordance with state legislation. \textit{Id.} at 628. The bureaus then filed their rates with the state insurance office. \textit{Id.} at 629. In Montana and Wisconsin, the rates became effective unless the state rejected them within the specified period. \textit{Id.} at 638. The Court stated that each state had a “negative option” system. \textit{Id.}} The potential for active supervision is not enough, instead the state must actually exercise this authority.\footnote{Id. at 638. With a negative-option type system, conduct by private parties acting under a state regulatory regime can become effective unless it is rejected within a set time. \textit{See id.} at 629. Therefore, inaction by the state can actually constitute substantive approval by default. \textit{See id.}} Specifically, if a regulation is operating through a “negative-option” system,\footnote{Id. at 638. The rate increase received a cursory examination by the State Insurance Commissioner but was not objected to even though no one in the agency inquired into the expense. \textit{Id.} The rate increase subsequently went into effect because the state did not object. \textit{Id.}} private parties claiming immunity must establish that state officials have “in
fact” actively supervised the specifics of the price-fixing scheme.145 Without this comprehensive supervision by the state, private actors participating in a state program will not be immune under the state action doctrine from federal prosecution.146

One positive aspect of the state action doctrine is that a state legislature can regulate the anticompetitive conduct of private actors free from federal intrusion.147 The downside is that, if done incorrectly, private actors participating in a state program will not be immune from federal prosecution.148 Furthermore, the recent modifications to the active supervision requirement developed in Ticor could potentially deter private actors from participation in any state regulatory program.149 It is against this backdrop that some state legislatures attempted to establish a right for physicians to collectively bargain.150

2. The Texas Experience: Untested Legislative Changes

Texas was the first state to pass legislation under the state action doctrine that allowed physicians to collectively bargain with MCOs through third parties.151 The Joint Negotiations by Physicians with Health Benefit Plans Act152 sought to restore fair negotiations between physicians and health care plans by allowing physicians to collectively bargain with health care plans.153

145. Id. at 638 (“The mere potential for state supervision is not an adequate substitute for a decision by the [s]tate.”); see also Vance, supra note 130, at 413-14 (noting that state officials must in fact have taken necessary steps to determine the specifics of the price-fixing scheme). But see Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46 n.10 (1985) (noting in dicta that “[i]n cases in which the actor is a state agency, it is likely that active state supervision would also not be required, although we do not here decide that issue”).

146. Ticor, 504 U.S. at 640. Indeed, private actors participating in state programs operating under the state action doctrine are likely to be exposed to greater liability after Ticor than before it because they fear prosecution. See Vance, supra note 130, at 416. In Washington State, for example, the state medical association has been unable to induce any health plans to negotiate with physicians over fees or pricing information because the regulating statute warns broadly against anticompetitive practices. See Rugg, supra note 37, at 34.


148. Ticor, 504 U.S. at 640-41 (Scalia, J., concurring); see also infra Part II.C.3 (discussing how health care plans are not bargaining under the Washington statute).

149. Ticor, 504 U.S. at 640-41 (Scalia, J., concurring) (“[T]his standard will be a fertile source of uncertainty and (hence) litigation, and will produce total abandonment of some state programs because private individuals will not take the chance of participating in them.”).

150. See infra Part II.C.2 (discussing Texas legislation passed after the Ticor decision).


153. Id. § 29.01. The Texas Legislature’s purpose was to achieve fair negotiations between physicians and the health plans. See id. Fair negotiations are unable to occur when MCOs
Under the provisions of the Act, physicians can negotiate jointly with MCOs over any non-financial terms and conditions of a contract.\textsuperscript{154} Joint negotiation of fees, discounts, or fixed payments, however, is limited to instances in which the health benefit plan has substantial market power that either has affected or threatens to affect the quality and availability of patient care.\textsuperscript{155} Furthermore, when negotiations of these financial items do occur, only ten percent of the competing physicians in the involved MCO's geographic service area can be represented in the negotiations.\textsuperscript{156}

The power to enforce the entire Texas Act is vested with the Office of the Texas Attorney General, who, along with the Insurance Commissioner, is given the authority to promulgate any rules necessary to implement the provisions of the Act.\textsuperscript{157} The Attorney General also makes the determination regarding what constitutes substantial market power\textsuperscript{158} and is vested with the power to approve or disapprove filings, proposed contracts, and requests to enter into joint negotiations.\textsuperscript{159} The failure of the Attorney General to approve or reject joint negotiations

\begin{quote}
"dominate the market to such a degree that fair negotiations . . . are unobtainable absent any joint action on behalf of physicians." \textit{Id.}
\end{quote}

\textsuperscript{154} \textit{See id.} §§ 29.04-29.05. "Competing physicians within the service area of a health plan may meet and communicate [to jointly negotiate non-financial terms and conditions]." \textit{Id.} Examples of these non-financial terms and conditions include practices and procedures to encourage early detection of illnesses in children, clinical criteria for effective cost-efficient disease management programs, and patient referral procedures. \textit{See id.} § 29.04.

\textsuperscript{155} \textit{Id.} § 29.06(a). Specifically, the items excluded from negotiation are: (1) the fees or prices for services, (2) the conversion factors in a reimbursement methodology or similar methodology, (3) the amount of any discount on the price of services, and (4) the dollar amount per patient or fixed payment for health services rendered by physicians to health benefit plan patients. \textit{Id.} § 29.05.

\textsuperscript{156} \textit{Id.} § 29.09(b). The joint negotiation shall represent "no more than 10 percent of the physicians in a health benefit plan's defined geographic service area . . . ." \textit{Id.} The Texas Attorney General may adjust this percentage. \textit{Id.} A licensed physician's representative carries out all joint negotiations between physicians and the health care plans. \textit{Id.} § 29.08.

\textsuperscript{157} \textit{Id.} § 29.11. On June 2, 2000, the Attorney General promulgated the final rules with respect to the Act. \textit{See Mayo, supra note 151, at 1117 n.115.}

\textsuperscript{158} \textit{TEX. INS. CODE ANN.} § 29.06(a). The term "substantial market power" is not defined in the statute. \textit{Id.} Presumably, the Attorney General will use market share as proxy for market power in their evaluation. \textit{See supra note 70 and accompanying text} (defining market share as "the percentage of the market for a product that a firm supplies").

\textsuperscript{159} \textit{TEX. INS. CODE ANN.} § 29.09. Under the provisions of the Act, these joint negotiations are approved if the "applicants have demonstrated that the likely benefits . . . outweigh the disadvantages attributable to a reduction in competition . . . ." \textit{Id.} § 29.09(b).
for any reason within the statutory time period provides an applicant the right to petition a district court for a mandamus order.\textsuperscript{160} 

Under the Texas Act, the Attorney General has the power to bind physicians to the terms of the statute by approving their request for collective bargaining.\textsuperscript{161} The physicians are subject to penalties for anticompetitive behavior if their collective action falls outside the bounds of the statute.\textsuperscript{162} Furthermore, physicians who decide to enter into joint negotiations under the Act are prohibited from jointly coordinating a cessation, limitation, or reduction of their health care services, and arguably, from striking.\textsuperscript{163}

The Texas Act was enacted into law on June 6, 2000.\textsuperscript{164} Since then, only a few physicians filed for collective bargaining approval.\textsuperscript{165} The Texas Act is subject to a sunset provision and is set to expire on September 1, 2003.\textsuperscript{166}

3. Other States Introduce Legislation

By the year 2000, seventeen states had considered physician collective bargaining legislation.\textsuperscript{167} While Texas remains the only state

\textsuperscript{160} Id. § 29.09(d). It is interesting to note that the petition can only be filed in a specific district court, Travis County. \textit{Id.} A mandamus order would compel the Attorney General to approve or reject the joint negotiations. \textsc{See} BLACK'S LAW DICTIONARY 973 (7th ed. 1999).

\textsuperscript{161} \textit{See} TEX. INS. CODE ANN. § 29.09(c). "An approval of the initial filing by the attorney general shall be effective for all subsequent negotiations between the parties specified in the initial filing." \textit{Id.}

\textsuperscript{162} Id. § 29.10. "The [licensed physician's representative] . . . shall warn physicians of the potential for legal action against physicians who violate state or federal antitrust laws when acting outside the authority of [the Act]." \textit{Id.}

\textsuperscript{163} \textit{Id.} The specific language states that physicians are not authorized to "jointly coordinate any cessation, reduction, or limitation of health care services." \textit{Id.} Physicians are also not permitted to tie their participation to all areas of the health plan as a condition for participation in any particular plan offering. \textit{Id.} While this provision is a little unclear, it may be an attempt by the state legislature to discourage physicians from striking. \textsc{See} Kopit, \textit{supra} note 45, at 106; Mayo, \textit{supra} note 151, at 1116.


\textsuperscript{165} \textit{See AG Grants MDs Permission to Jointly Negotiate With Texas Blues}, ST. HEALTH MONITOR, Oct. 1, 2001, \textit{available at} 2001 WL 8996343. Two years after passage, the Texas Attorney General gave the first antitrust waiver to eleven Henderson, Texas based physicians to conduct joint negotiations with Blue Cross and Blue Shield of Texas. \textit{Id.}

\textsuperscript{166} TEX. INS. CODE ANN. § 29.14. This sunset provision causes the legislation to expire without an affirmative act by the Texas legislature after three years. \textsc{See} Kopit, \textit{supra} note 45, at 119; \textit{see also supra} note 108 and accompanying text (discussing the similar sunset provision in the federal QHCCA bill).

\textsuperscript{167} \textsc{See} Kopit, \textit{supra} note 45, at 120. The states that have considered legislation include: Alaska, Arizona, California, Connecticut, Delaware, Florida, Hawaii, Illinois, Michigan, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Tennessee, and
to provide physicians with the express right to collectively bargain, other states used the state action doctrine to exempt similar conduct in certain situations.\textsuperscript{168} For example, in 1995, the State of Washington gave physicians the right to negotiate collectively, as long as they do not negotiate fees or pricing.\textsuperscript{169} In addition, the measure warns against anticompetitive practices that would constitute per se violations of federal antitrust laws.\textsuperscript{170} Because this broad warning fails to provide specific guidance to either physicians or MCOs, Washington state has not enjoyed much success in inducing health plans to enter into joint negotiations.\textsuperscript{171}

Oregon provides a more limited exemption than the State of Washington because Oregon only displaces competition among health care providers in the heart and kidney transplant market.\textsuperscript{172} Since these health care providers exercise no control over supply,\textsuperscript{173} the Oregon legislation allows providers to form cooperative programs with each other and with specific health care plans to ensure that transplant centers offer high-quality services.\textsuperscript{174} Unlike the Texas and Washington legislation, which allows doctors to collectively negotiate the terms and conditions of their own supply of labor, the Oregon legislation is more
limited because physicians exercise no control over supply, and high-quality transplant services will likely result.\textsuperscript{175}

III. DISCUSSION

During the 91st Illinois General Assembly, Representatives Skip Saviano, Sara Feigenholtz, and Kay Wojcik of the Illinois House introduced House Bill 4478 (H.B. 4478), the Health Care Services Contract Joint Discussions Act.\textsuperscript{176} After this bill failed to pass during the 91st General Assembly, Saviano reintroduced the legislation as House Bill 3086 (H.B. 3086) in the 92nd General Assembly.\textsuperscript{177} Saviano also introduced House Bill 2115 (H.B. 2115), the Fairness in Health Care Services Contracting Law, during the same legislative term.\textsuperscript{178} An alternative to H.B. 3086, H.B. 2115 endeavors to increase fairness for all parties involved in physician-MCO contracting.\textsuperscript{179}

A. Illinois House Bill 3086

Illinois House Bill 3086, the Health Care Services Contract Joint Discussion Act, is the second bill introduced in the Illinois General Assembly designed to ensure that health care plans and providers work together to provide quality health care services to MCO enrollees.\textsuperscript{180} The primary sponsor of the bill, Representative Skip Saviano, found

\textsuperscript{175} OR. REV. STAT. § 442.705. Displacing competition in a marketplace with limited supply would be beneficial to the public because the duplication of services in a competitive market would be eliminated. Remis, supra note 44, at 131. This would, in turn, decrease prices for consumers and eliminate the waste of a limited supply of organs. \textit{Id.}


\textsuperscript{178} Fairness in Health Care Services Contracting Law, H.B. 2115, 92nd Gen. Assem., Reg. Sess. (Ill. 2001). Similar legislation was passed in the Senate. S.B. 1340, 92nd Gen. Assem., Reg. Sess. (Ill. 2001). While H.B. 3086 and H.B. 2115 both have the same goal of alleviating the situations that independent physicians face, H.B. 2115 is more direct in that it calls for reasonable standardization and simplification of the terms and conditions of contracts between health care professionals and health care plans. \textit{See infra} Part III.B (discussing H.B. 2115 in greater detail).

\textsuperscript{179} Ill. H.B. 2115, § 351E-5 ("The purpose of this [bill] is to provide reasonable standardization and simplification of terms and conditions of... health care professional or health care provider service contracts...'); \textit{see infra} Part III.B (providing a detailed discussion of H.B. 2115).

\textsuperscript{180} Ill. H.B. 3086, § 5(a).
that the health care market lacked plan and provider cooperation because health care plans dominate the market and do not enter into fair discussions with health care providers.\textsuperscript{181}  Furthermore, he found that contracting organizations, including physician hospital organizations ("PHOs"),\textsuperscript{182} independent practice associations ("IPAs"),\textsuperscript{183} and typical large group practices did not give health care providers an adequate voice when discussing contract terms and conditions.\textsuperscript{184}  As a result, H.B. 3086 calls for joint discussions between health care plans and collective groups of health care providers.\textsuperscript{185}

Similar to the legislation in Texas, H.B. 3086 allows physicians to bargain collectively with health plans through regulated third party representatives.\textsuperscript{186}  These third parties can represent no more than twenty percent of all physicians in the geographic service area of the health care plan with whom they are negotiating.\textsuperscript{187}  H.B. 3086 permits joint discussions on non-fee related terms and conditions, such as practices and procedures, clinical criteria and practices, administrative

\textsuperscript{181}  Id. § 5(b). The impetus for the bill was that, in some instances, health care plans dominate the "market to such a degree that fair discussions \ldots are unobtainable absent any joint action on behalf of health care providers."  \textit{Id.}  The term "health care provider" is statutorily defined as a "physician, dentist, podiatrist, hospital, facility, or person that is licensed or otherwise authorized to deliver health care services."  \textit{Id.} § 10.


\textsuperscript{183}  An independent practice association (IPA) is a physician or group of physicians that operate like a preferred provider organization (PPO), except that an IPA is usually under contract to an HMO.  Murray S. Monroe, \textit{Health Care: Current Antitrust Issues}, 20 N. KY. L. REV. 365, 380 (1993).  A PPO "is a group of physicians and/or hospitals that contracts with employers, insurance companies, and other third-party payors to provide medical services to an employee group at reduced fees."  Gary B. Wilcox, \textit{Preferred Provider Organizations: Can the Doctors Do the Price Fixing?}, 37 OKLA. L. REV. 733, 733 (1984).

\textsuperscript{184}  Ill. H.B. 3086, § 5(c). "The General Assembly finds \ldots that current mechanisms that bring health care providers together into contracting organizations \ldots do not provide health care providers with an adequate voice in discussing contract terms and conditions."  \textit{Id.}

\textsuperscript{185}  \textit{Id.} § 5(f). "It is the intention of the General Assembly to authorize health care providers to hold joint discussions with health care plans and to qualify those joint discussions and related joint activities for the State-action exemption to the federal antitrust laws \ldots."  \textit{Id.}

\textsuperscript{186}  \textit{Id.} § 35(a). These joint discussion representatives must be licensed annually.  \textit{Id.} § 65(a). Notably, physicians who decide to enter into joint negotiations and are approved by the Attorney General are not authorized to engage in any group boycott or strike.  \textit{Id.} § 25(e).

\textsuperscript{187}  \textit{Id.} § 20(c). "The joint discussions shall represent no more than 20\% of any type of health care providers \ldots except in cases where in conformance with the other provisions of this Act conditions support the approval of a greater or lesser percentage."  \textit{Id.}  The term "types of health care providers" is defined based on the licenses held by the health care providers.  \textit{Id.}
procedures, and patient referral procedures. The negotiation of fees, discounts, or fixed payments is also authorized under the bill, but is limited to situations in which the health benefit plan has substantial market power. Substantial market power exists when a health care plan has the power to set the fee-related terms and conditions in a manner that affects or threatens to affect the quality and availability of patient care. Substantial market power also exists when the market share of the health care plan exceeds fifteen percent of the patients in the geographic area of the affected health care providers.

Under H.B. 3086, the Illinois Attorney General is responsible for overseeing compliance with the bill’s requirements. If the Attorney General determines that a joint discussion representative adequately demonstrates that the benefits of joint negotiations outweigh the disadvantages attributable to a reduction in competition, he may allow a joint discussion to occur between the representative and the health care plan. Likewise, the Attorney General may object to any aspect prior to the start of joint discussions.

188. Id. § 25(a).
189. Id. § 25(b), (c). “The Attorney General shall make the determination of what constitutes substantial market power.” Id. § 25(c); see also supra note 70 and accompanying text (discussing how courts use market share as a proxy for market power).
190. Ill. H.B. 3086, § 25(c)(1).
191. Market share is “the percentage of market for a product that a firm supplies.” BLACK’S LAW DICTIONARY 985 (7th ed. 1999). See supra note 70 and accompanying text (explaining that market share is traditionally a proxy for market power).
192. Ill. H.B. 3086, § 25(c)(2). H.B. 3086 vests the Illinois Attorney General with the power to determine if this latter type of substantial market power exists. Id. When calculating this type of market power the Attorney General should take into account “all policies and products offered by a subsidiary, parent, and affiliate health care plans . . . .” Id.
193. Id. § 20(a). “It shall be the responsibility and duty of the Attorney General to license, supervise, and regulate joint discussion representatives.” Id. The bill also creates an advisory “Health Care Services Contracting Board,” to be housed within the office of the Attorney General. Id. § 15(a). This Board makes recommendations concerning the duties of the Attorney General under the act. Id. § 15(e). Ultimately, however, the Attorney General has the authority to adopt rules necessary to implement the provisions of the act. Id. § 95.
194. Id. § 20(c). Upon the request of one or more of its affected members, a joint discussion representative may send a written communication to its members asking if they are interested in having the representative review, comment upon, advise, or discuss the terms and conditions of a contract. Id. § 30(a). Before engaging in any joint discussions with a health care plan, however, the representative must furnish an initial report to the Attorney General. Id. § 30(c). Once the Attorney General approves this, the representative can enter into joint discussions with a health care plan. Id. § 30(f). The Attorney General is responsible for the approval of all joint discussion material, written communications, and proposed contracts. Id. § 50(d).
195. Id. § 50(c). Once the Attorney General objects to any type of written communication, the joint discussion representative works with the physicians that he represents to arrive at a resolution. Id. If a resolution is reached, the Attorney General may require the joint discussion representative to send members an additional written notice confirming this resolution. Id.
Once joint negotiations have been approved, all written communications between the joint discussion representative and the health care plan must be filed with the Attorney General for review.\textsuperscript{196} If the Attorney General finds any terms or conditions within a contract to be anticompetitive, he may object to the proposed contract.\textsuperscript{197} Conversely, if the proposed contract will result in procompetitive gains for consumers, the contract will be approved.\textsuperscript{198} Finally, the Attorney General has the discretion to investigate compliance with H.B. 3086 after the approval of the joint negotiation.\textsuperscript{199}

From start to finish, H.B. 3086 operates under a "negative-option" scheme\textsuperscript{200} for approval of the items submitted to the Attorney General.\textsuperscript{201} The Attorney General’s office must notify the parties to the negotiation within twenty days if it objects to a communication.\textsuperscript{202} Approval is granted to the negotiating parties if the Attorney General fails to take action within this period of time.\textsuperscript{203}

After the introduction of H.B. 3086, the Illinois House referred the legislation to the House Committee on Rules.\textsuperscript{204} The bill was then

\begin{itemize}
\item \textsuperscript{196} \textit{Id.} § 50(a). The Attorney General must also review all items of negotiation, such as proposed contracts, to ensure that they do not contain any terms or conditions prohibited by the bill. \textit{Id.} § 50(b).
\item \textsuperscript{197} \textit{Id.} An indication of excessive and unfair payments from one side to another or an escalation of the cost of health care are indicative of anticompetitive harm arising from the transaction. \textit{Id.} § 50(e). If such an item is disapproved during joint negotiations, the Attorney General must provide a written explanation to the parties as to how to correct the deficiency. \textit{Id.} § 50(b). If the deficiency is not able to be corrected, the objection is a final administrative decision and is subject to appeal under the provisions of the Administrative Review Law. \textit{Id.} § 50(c).
\item \textsuperscript{198} \textit{Id.} § 50(d). Procompetitive effects include, but are not limited to, restoration of a competitive balance in the market, protections of access to quality patient care, promotion of the health care infrastructure, and improved communications between health care providers and health care plans. \textit{Id.} § 50(e).
\item \textsuperscript{199} \textit{Id.} § 90. “The Attorney General, at any time after a written communication or proposed contract . . . is filed or approved . . . may . . . [investigate] compliance with this Act.” \textit{Id.}
\item \textsuperscript{200} With a negative-option type system, conduct by private parties acting under a state regulatory regime can become effective unless it is rejected within a set time. Fed. Trade Comm’n v. Ticor Title Ins. Co., 504 U.S. 621, 629 (1992). Therefore, inaction by the state can actually constitute substantive approval by default. \textit{Id.;} see also supra note 144 and accompanying text (explaining in detail a negative-option type scheme).
\item \textsuperscript{201} Ill. H.B. 3086, § 50(a). The same system operates in respect to the approval and review of proposed contracts. \textit{Id.} § 55(a).
\item \textsuperscript{202} \textit{Id.} § 50(a). “Approval of the written communication shall be deemed to have been granted if the Attorney General does not take any action within the 20 day period.” \textit{Id.}
\item \textsuperscript{203} \textit{Id.}
\item \textsuperscript{204} \textit{Status of H.B.3086}, http://www.legis.state.il.us/scripts/imstran.exe?LBSINCBHB3086 (last visited Jan. 28, 2002). After its introduction on February 28, 2001, the bill was referred to the House Committee on Rules. \textit{Id.}
assigned to the House Committee on Labor one day later.\footnote{Id.} On March 16, 2001, H.B. 3086 was re-referred to the House Committee, where it is still being debated.\footnote{Id.}

A few months after H.B. 3086 was introduced, Representative Saviano introduced Illinois House Bill 2115, the Fairness in Health Care Services Contracting Law, in the House as an alternative to H.B. 3086.\footnote{Fairness in Health Care Services Contracting Law, H.B. 2115, 92nd Gen. Assem., Reg. Sess. (Ill. 2001).} Legislators designed H.B. 2115 to alleviate the difficulties that independent physicians face in the health care industry.\footnote{Physicians perceived that they were being handed “take-it-or-leave-it” contracts by the dominant MCOs in the health care industry. \textit{See supra} note 45 and accompanying text (discussing the one-sidedness of “take-it-or-leave-it” contracts in favor of the MCOs).} H.B. 2115 calls for the reasonable standardization and simplification of the terms and conditions of contracts between health care professionals, such as physicians and health care plans.\footnote{Ill. H.B. 2115, § 351E-25. For instance, some of these provisions include: a “medically necessary” and “medical necessity” term that gives the physician the right to prescribe reasonable treatment to patients; a “direct responsibility” provision making the physician’s right to payment a direct responsibility of the health care plan; and a “noncovered services” provision that gives physicians} Furthermore, H.B. 2115 aims to eliminate contract provisions that may be unfair, deceptive, misleading, or unreasonably confusing in connection with the services covered, reimbursement, or payment to health care providers for those services.\footnote{Id.}

H.B. 2115 prevents unilateral changes by health care plans to the terms and conditions of their contracts with health care providers.\footnote{Id. § 351E-15(h). “A contract, term, condition, or policy . . . may not be unilateral concerning termination, indemnification, or arbitration.” \textit{Id.}} The bill prohibits a health care plan from mandating that a physician serve on, or accept reimbursement from, another health care plan as a condition of a contract.\footnote{Id. § 351E-15(b). “A contract term . . . may not mandate or require a health care professional . . . as a condition of participation . . . to also serve on another professional or provider panel or accept reimbursement for another plan or contract of the company.” \textit{Id.}} Furthermore, H.B. 2115 requires that certain provisions be included in every contract between a health care provider and a physician.\footnote{Id.} In addition, terms and conditions related to

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  \item \footnote{Id.} \item \footnote{Id. § 351E-5. “A contract, term, condition, or policy . . . may not be unilateral concerning termination, indemnification, or arbitration.” \textit{Id.}} \item \footnote{Id. § 351E-25. For instance, some of these provisions include: a “medically necessary” and “medical necessity” term that gives the physician the right to prescribe reasonable treatment to patients; a “direct responsibility” provision making the physician’s right to payment a direct responsibility of the health care plan; and a “noncovered services” provision that gives physicians}
termination, indemnification, or arbitration must apply equally to both
the health care plan and the health care professional.\textsuperscript{214}

H.B. 2115 was incorporated into Senate Joint Resolution 33.\textsuperscript{215} This
resolution calls for a joint task force to investigate the ultimate impact
of H.B. 2115 and similar legislation on patients in Illinois.\textsuperscript{216} It also
calls for public input to determine if any modifications must be made to
H.B. 2115 before the bill becomes law.\textsuperscript{217} In addition, the resolution
has established a task force to study H.B. 2115 and charged this group
to examine the entire health plan and professional services contracting
process.\textsuperscript{218} At this time it is unclear what impact task force meetings
will have on the current form of the legislation.\textsuperscript{219}

\textbf{IV. \textit{ANALYSIS}}

Providing an exemption to the federal antitrust laws through the state
action doctrine is not the best solution for a constantly evolving industry
like health care. At a minimum, there are serious concerns as to
whether H.B. 3086 comports with both requirements of the state action
exemption.\textsuperscript{220} The mere possibility that the state may fail to comply
with the active supervision requirement of the state action doctrine
could deter private actors from risking participation in Illinois’ health
care joint discussion program.\textsuperscript{221} Moreover, Illinois’ blanket exemption
from the federal antitrust laws is overly broad in terms of policy.\textsuperscript{222}
Current federal guidelines provide an adequate sword for physicians to

\footnotesize{the right to bill and collect payments from patients if the services rendered are not covered as part of the contract. \textit{Id.}}

\textsuperscript{214} \textit{Id.} § 351E-15(h). “A contract term, condition, or policy, either formal or informal, may
not be unilateral concerning termination, indemnification, or arbitration. These provisions shall
all apply equally to both the company and [the] health care professional or health care provider.”
\textit{Id.}

\textsuperscript{215} See S.J. Res. 33, 92nd Gen. Assem. (Ill. 2001) (creating the Illinois Legislative Task
Force on Fairness in Health Care Services Contracting).

\textsuperscript{216} See \textit{id.}

\textsuperscript{217} \textit{Id.}

\textsuperscript{218} \textit{Id.} Included in this task force are not only the General Assembly members sponsoring
the bill, but also members of physician organizations, MCOs, and patient care representatives. \textit{Id.}

\textsuperscript{219} This task force will hold meetings and make recommendations to the General Assembly
by January 15, 2002. \textit{Id.}

\textsuperscript{220} See \textit{infra} Part IV.A.1–2 (analyzing whether H.B. 3086 comports with the requirements of
the state action doctrine).

\textsuperscript{221} See \textit{infra} Part IV.A.2 (examining whether private actors would risk the liability for
participation in joint negotiations when the state regulation may not comport with the active
supervision requirement of the \textit{Midcal} test).

\textsuperscript{222} See \textit{infra} Part IV.B (arguing that H.B. 3086 is overly broad from a policy standpoint
because the FTC/DOJ Guidelines do an adequate job of ensuring that patients receive quality care
and countervailing power is difficult to constrain).
use in negotiating with both small and large MCOs. With this blanket exemption, it is the physicians who gain the upper hand in negotiations, particularly when dealing with smaller MCOs in many areas of the state. Indeed, this shift in power is antithetical to the purpose of the legislation, which is to ensure that patients receive quality health care coverage in the state. In contrast, H.B. 2115 is a direct solution to the problems plaguing the health care industry and is a better solution for Illinois to adopt.

A. Illinois House Bill 3086 Does Not Comply with the State Action Doctrine

It is not clear whether H.B. 3086 meets both requirements of the Midcal test. As discussed previously, the state must not only articulate a clear and affirmative policy, but it must also actively supervise the anticompetitive conduct of private actors to satisfy the doctrine. H.B. 3086 meets the clear articulation requirement. However, the bill does not meet the active supervision requirement as set forth in Ticor.

1. The Clear Articulation Requirement

Illinois House Bill 3086 meets the clear articulation requirement of the Midcal test. Section 5 of the bill promulgates various reasons that Illinois wishes to displace competition with state regulation.

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223. See infra Part IV.B.1 (discussing how the FTC/DOJ Guidelines do an adequate job of ensuring that patients receive quality care).
224. See infra Part IV.B.2 (exploring how countervailing power is difficult to constrain).
225. Health Care Services Contract Joint Discussions Act, H.B. 3086, 92nd Gen. Assem., Reg. Sess. § 5(a) (Ill. 2001); see also infra Part IV.B.2 (explaining that H.B. 3086 would result in higher prices for patients without any guarantee of increased quality).
226. See H.B. 2115, 92nd Gen. Assem., Reg. Sess. (Ill. 2001); see also infra Part IV.B.2 (explaining that H.B. 2115 is a more direct approach to the problems facing the health care industry).
228. Midcal, 445 U.S. at 105; see also supra Part II.C.1 (discussing the clear articulation and active supervision requirements of the state action doctrine).
229. See infra Part IV.A.1 (noting that H.B. 3086 complies with the clear articulation requirement of the Midcal test).
231. Health Care Services Contract Joint Discussions Act, H.B. 3086, 92nd Gen. Assem., Reg. Sess. § 5 (Ill. 2001). Specifically, section 5 notes that the purpose of the legislation is to empower competing health care providers to hold joint discussions with health care plans and to help restore the competitive balance. Id. § 5(d).
Moreover, H.B. 3086 specifically mentions the state action doctrine twice in the actual text of the bill.\textsuperscript{232} Accordingly, H.B. 3086 adequately articulates that the state intends to supplant competition with regulation.\textsuperscript{233} However, the active supervision requirement must also be considered.\textsuperscript{234}

2. The Active Supervision Requirement

Illinois House Bill 3086 does not meet the active supervision prong of the \textit{Midcal} test.\textsuperscript{235} In \textit{Ticor}, the Supreme Court tightened the active supervision requirement set forth in \textit{Midcal}, holding that state regulators must both possess and exercise their authority against potential anticompetitive conduct.\textsuperscript{236} Compared to Illinois, the Texas collective bargaining legislation provides for this active supervision by requiring that the Attorney General either approve or disapprove of the work product of collective negotiations.\textsuperscript{237} In the event that this authority is not exercised, the only way for the private parties to go forward is to obtain a writ of mandamus from the district court.\textsuperscript{238}

Unlike the Texas legislation, H.B. 3086 proposes a negative-option scheme.\textsuperscript{239} Under the bill, automatic approval of the work product of a

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\item\textsuperscript{232} \textit{Id.} In section 5 of H.B. 3086, the General Assembly states its intent to “qualify . . . joint discussions and . . . joint activities for the State-action exemption to the federal antitrust laws through the articulated State policy and active supervision . . . in th[e] Act.” \textit{Id.} § 5(f). In section 80, the General Assembly again states its intent to operate under the “State-action immunity under federal antitrust laws.” \textit{Id.} § 80(b).
\item\textsuperscript{233} \textit{See id.} § 5.
\item\textsuperscript{234} \textit{See infra} Part IV.A.2 (discussing how H.B. 3086 does not meet the active supervision requirement of the \textit{Midcal} test).
\item\textsuperscript{235} Cal. Retail Liquor Dealers Ass’n v. \textit{Midcal} Aluminum, Inc., 445 U.S. 97, 105 (1980); \textit{see also supra} Part II.C.1 (discussing the active supervision requirement of the \textit{Midcal} test).
\item\textsuperscript{236} Fed. Trade Comm’n v. \textit{Ticor} Title Ins. Co., 504 U.S. 621, 634 (1992). In \textit{Ticor}, the Court held that “[t]he mere potential for state supervision is not an adequate substitute for a decision by the State.” \textit{Id.} at 638; \textit{see also supra} notes 145-46 and accompanying text (emphasizing the active supervision requirement).
\item\textsuperscript{237} \textit{Tex. Ins. Code Ann.} § 29.09(d) (Vernon Supp. 2002). In Texas, a joint discussion representative “shall have the right to petition a district court for a mandamus order requiring the attorney general to approve or disapprove the contents of the filing forthwith.” \textit{Id.; see also supra} note 160 and accompanying text (noting that a petition can be filed only in district court in Travis County and explaining the effect of a mandamus order).
\item\textsuperscript{238} \textit{Tex. Ins. Code Ann.} § 29.09(d). A mandamus order from the district court of Travis County would compel the Attorney General to either approve or disapprove of the filing. \textit{Id.; see also supra} note 160 and accompanying text (noting that a petition can be filed only in district court in Travis County and explaining the effect of a mandamus order).
\item\textsuperscript{239} \textit{See Health Care Services Contract Joint Discussions Act, H.B. 3086, 92nd Gen. Assem., Reg. Sess.} § 50(a) (Ill. 2001). In a negative-option system, conduct by private parties acting under a state regulatory regime can become effective unless the conduct is rejected within a set time. \textit{See \textit{Ticor}}, 504 U.S. at 629. Accordingly, inaction by the state can actually constitute
\end{enumerate}
\end{footnotesize}
joint discussion occurs within twenty days, if the Illinois Attorney General does not take any action against it. This negative-option scheme mirrors the one at issue in *Ticor*, where the Supreme Court held that private parties claiming immunity must establish that state officials have taken affirmative steps to determine the specific details of the price-fixing scheme.

In addition, it is not clear what level of ongoing supervision is required under the new guidelines set forth in *Ticor*. Because this level of supervision is an open question, Illinois should establish monitoring guidelines as part of its legislation. However, H.B. 3086 dictates only that the Attorney General has the option to investigate compliance with the act after approval of the joint negotiation; thus, investigation does not appear to be mandatory. Likewise, it is not clear that the Attorney General has the authority to either rescind approval or void the contract. If Illinois fails to monitor the negotiation scheme, it will not meet the requirements articulated in *Ticor*.

It is not clear that H.B. 3086 comports with the active supervision requirement of *Midcal* and *Ticor*. Therefore, many health care providers will simply choose not to participate in joint negotiations for fear that the state’s supervision will be inadequate thereby potentially

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240. Ill. H.B. 3086, § 50(a); see * supra* note 202 and accompanying text (noting that approval is "deemed to have been granted if the Attorney General does not take any action within the [twenty] day period").

241. *Ticor*, 504 U.S. at 638; see * supra* notes 142-46 and accompanying text (discussing the Court’s holding in *Ticor*).

242. Compare David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 210 (1994) (noting that "there remains serious doubt whether the private parties' ongoing conduct will be insulated by the initial state authorization if the state regulators do not actively oversee the parties' transactions"), with *Vance*, * supra* note 130, at 428 (noting that the Court in *Ticor* did not use terminology to indicate that ongoing supervision was required).

243. *Vance*, * supra* note 130, at 428. For example, the FTC has interpreted *Ticor* as requiring ongoing supervision. Id. at 419. Courts have yet to rule on the issue, however. Id.

244. Ill. H.B. 3086, § 90; see * supra* note 199 and accompanying text (discussing the Attorney General’s discretion to review filed or approved contracts or communications under H.B. 3086).

245. See Ill. H.B. 3086, § 90; see * supra* note 199 and accompanying text (noting that section 90 provides only that the Attorney General has the power to investigate a written communication or proposed contract’s compliance once it has been filed or approved).

246. See *Vance*, * supra* note 130, at 428 (noting that states that do not monitor in fact fail to meet the *Ticor* requirement).

exposing participants to liability under federal antitrust laws.\textsuperscript{248} If this is the case, H.B. 3086, if passed, will lie dormant as similar legislation has in the State of Washington.\textsuperscript{249} Any potential that the legislation has will go unrealized, and the disproportionate status quo will be maintained in the health care industry.\textsuperscript{250}

\textbf{B. H.B. 3086 is Too Broad from a Policy Standpoint}

Even if Illinois' joint negotiation legislation satisfied the state action doctrine requirements, it is still too broad from a policy standpoint. Under H.B. 3086, Illinois wants to ensure that the quality of services increases for all interested parties in the industry.\textsuperscript{251} However, the creation of a specific and complex scheme of collective bargaining will increase both the time spent negotiating and the cost of those negotiations.\textsuperscript{252} Instead, physicians should utilize the current FTC/DOJ Guidelines to their fullest potential in place of adopting a scheme rife with the "red tape" of bureaucracy.\textsuperscript{253} The use of the Guidelines will adequately ensure that benefits result for patients.\textsuperscript{254} Furthermore, creation of a countervailing power in the health care marketplace will not serve to benefit either patients or less dominant health care plans.\textsuperscript{255} Indeed, without the proper constraints, physicians, armed with the knowledge of what their competitors charge, can use this leverage against small health care plans as well as against larger ones.\textsuperscript{256}

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\item \textsuperscript{248} \textit{Id.} at 641 (Scalia, J., concurring); see \textit{supra} note 146 and accompanying text (noting that private actors participating in state programs operating under the state action doctrine are likely to be exposed to greater liability after \textit{Ticor} than before it).
\item \textsuperscript{249} See \textit{WASH. REV. CODE ANN.} § 43.72.300 (West 2000); see \textit{supra} note 169 and accompanying text (discussing the aim of the Washington legislation).
\item \textsuperscript{250} See Kopit, \textit{supra} note 45, at 102 (noting that "[t]here can be little question that individual physicians . . . feel powerless to negotiate with large [MCOs]"); see also \textit{supra} Part II.A (discussing the current situation in the health care industry).
\item \textsuperscript{251} Health Care Services Contract Joint Discussions Act, H.B. 3086, 92nd Gen. Assem., Reg. Sess. § 5(d) (Ill. 2001) (stating that the purpose of the legislation is to ensure that "benefits [result] for consumers, health care providers, and less dominant health care plans").
\item \textsuperscript{252} See Meyer & Rule, \textit{supra} note 242, at 201 (noting that most efforts to codify narrow scopes of immunity simply substitute a set of complex definitional uncertainties).
\item \textsuperscript{253} See \textit{infra} Part IV.B.1 (discussing how the established Guidelines do an adequate job of ensuring that patients receive quality health care).
\item \textsuperscript{254} See \textit{infra} Part IV.B.1 (stating that the Guidelines, if used to their fullest potential, protect physicians and ensure that benefits result for patients).
\item \textsuperscript{255} See \textit{infra} Part IV.B.2 (examining how countervailing power is difficult to constrain).
\item \textsuperscript{256} See \textit{infra} Part IV.B.2 (noting that collective bargaining gives knowledge to all participants who then use this knowledge to squeeze profits from smaller, less competitive MCOs).
\end{itemize}
1. The FTC/DOJ Guidelines Ensure That Patients Receive Quality Health Care

In contrast to H.B. 3086, the current FTC/DOJ Guidelines are flexible enough to adapt to a changing health care system.\(^{257}\) If utilized to their fullest potential, the Guidelines can also ensure that patients receive quality health care.\(^{258}\) First, private collaborators who wish to achieve high-quality patient care can utilize the Guidelines to their advantage.\(^{259}\) For example, federal antitrust enforcers will not challenge physicians who jointly discuss with health care plans non-economic issues, such as the collection of outcome data, suggested practice parameters, and even suggested assurances from MCOs that they will not second-guess physicians about the care of patients.\(^ {260}\)

Second, the Guidelines allow groups of physicians and hospitals to form networks to negotiate with insurers through a third party messenger.\(^{261}\) Such “messenger models” can pass muster only if they provide objective or empirical information about the terms of an offer, are not coercive, and allow physicians to make their own decisions as to whether to sign the contract with a provider.\(^{262}\)

Third, the FTC/DOJ Guidelines implicitly state that physician network joint ventures\(^{263}\) (“PNJVs”) that are structured with regard to the antitrust rules are even less likely to receive antitrust scrutiny.\(^{264}\) A

\(^{257}\) See generally Guidelines, supra note 118.

\(^{258}\) Id.; see also supra Part II.B.3 (providing a general explanation of the Guidelines).

\(^{259}\) See Meyer & Rule, supra note 242, at 171 (stating that the federal antitrust laws are aimed at achieving a more efficient and less costly delivery of health care services).

\(^{260}\) Guidelines, supra note 118, at 14-15 (stated in section “Providers’ Collective Provision Of Non-Fee-Related Information To Purchasers Of Health Care Services”).

\(^{261}\) Lutsky, supra note 3, at 85. The Guidelines allow groups of independent physicians and hospitals to form negotiation networks through third party “messengers.” Id. These messengers are not allowed to share information with member physicians or to collectively bargain on behalf of them. See id. They can, however, be valuable because messengers who represent large numbers of physicians can use their leverage to gain higher rates from the health care plans. Id.

\(^{262}\) Id. at 86. Indeed, physicians could “unionize” to the extent of this messenger model as long as the model does not interfere with physicians’ own independent decision on whether to sign a contract with the MCOs. Id.

\(^{263}\) A physician network joint venture (PNJV) is any organization of doctors designed to market their services to health plans. Guidelines, supra note 118, at 22. PNJVs can take the form of IPAs or PPOs. Id. A preferred provider organization “is a group of physicians and/or hospitals that contracts with employers, insurance companies, and other third party payors to provide medical services to an employee group at reduced fees.” Wilcox, supra note 183, at 733. An independent practice association (IPA) is a physician or group of physicians that operate like a preferred provider organization (PPO), except that an IPA is usually under contract to an HMO. Monroe, supra note 183, at 380.

\(^{264}\) Meyer & Rule, supra note 242, at 192 (“Indeed, the [FTC and DOJ] have long encouraged parties to consider joint ventures as a procompetitive alternative to outright merger.”);
PNJV is allowed to collectively bargain with MCOs under the Guidelines if (1) the PNJV participants share a substantial financial risk in the operation and (2) the size of the operation falls within one of two safety zones for PNJVs.²⁶⁵ A PNJV will be evaluated under the rule of reason²⁶⁶ if it falls outside of these safety zones.²⁶⁷

A properly structured preferred provider organization ("PPO")²⁶⁸ is but one example of a PNJV that avoids challenge as a violation of the antitrust laws.²⁶⁹ A PPO is beneficial to physicians because it allows physicians to retain the autonomy and authority provided by the historical doctor-patient relationship.²⁷⁰ Likewise, consumers, insurers, and employers are also attracted to PPOs.²⁷¹ Indeed, competitive PPOs can motivate financially vested physicians to work from within to seek a

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²⁶⁵ Guidelines, supra note 118, at 23. If the PNJV is exclusive (i.e. the network’s physician participants are restricted in their ability to individually contract or affiliate with other PNJVs or MCOs), then it will qualify for the safety zone if it does not constitute more than twenty percent of the “physicians in each physician specialty . . . who practice in the relevant geographic market.” Id. A non-exclusive PNJV, however, cannot constitute more than thirty percent of the same market group. Id.; see also supra note 119 and accompanying text (describing the general principles of safety zones).

²⁶⁶ Analysis under the “rule of reason” test considers market conditions, procompetitive justifications, effects of the agreement, and other relevant facts. See Monroe & Seitz, supra note 100, at 89; see also supra note 62 and accompanying text (describing how the rule of reason test evaluates whether competition is procompetitive or anticompetitive).

²⁶⁷ Guidelines, supra note 118, at 25 (stated in section “Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under the Rule Of Reason”). In fact, some commentators note that the agencies’ articulated standards are “arguably more restrictive than the realities of the agencies’ enforcement practices.” Meyer & Rule, supra note 242, at 204.

²⁶⁸ A preferred provider organization is “a group of physicians and/or hospitals that contracts with employers, insurance companies, and other third party payors to provide medical services to an employee group at reduced fees.” Wilcox, supra note 183, at 733.

²⁶⁹ Guidelines, supra note 118, at 31. Still, there is no general immunity for the health care marketplace. Arizona v. Maricopa County Med. Soc’y, 457 U.S. 332, 348 (1982). Therefore, physicians must structure their PPOs within the Guidelines and within the general antitrust laws to avoid being challenged. See generally Wilcox, supra note 183, at 743-52 (discussing how physician-sponsored preferred provider organizations can be an effective cost-reduction delivery system).

²⁷⁰ Wilcox, supra note 183, at 733; see also supra note 31 and accompanying text (discussing the doctor-patient relationship under the fee-for-service system).

²⁷¹ Wilcox, supra note 183, at 733.

Consumers are attracted to PPOs because they are not locked-in to a specific group of providers as they are with HMO memberships. Insurers obviously favor dealing with PPOs over traditional indemnity arrangements because of the discounts granted. Employers view PPOs as a means for influencing the delivery of medical care to better provide for their insured employees.

Id. at 734 (footnotes omitted).
return on capital by lowering prices, reducing costs, and providing other pro-consumer efficiencies. In short, properly structured PPOs can act as a vehicle for collective negotiation with MCOs while also benefiting the industry because they encourage both competition and cost-effectiveness.

In contrast to the FTC/DOJ Guidelines, Illinois’ joint negotiation legislation is so structured and complex that it does not provide for an alternative to MCOs. Physicians authorized to jointly negotiate with health care providers under H.B. 3086 would have no incentive to enter into more beneficial joint ventures because competition would not exist to make that choice necessary. H.B. 3086’s attempt at fixing the problem would inevitably protect conduct that poses legitimate threats to the benefits of competition. Because H.B. 3086 would hamper the expansion of new industry models and maintain the status quo, it is not flexible enough to be introduced into such a dynamic industry.

Moreover, portions of H.B. 3086 are simply a more stringent codification of the existing FTC/DOJ Guidelines. For example, the Guidelines allow physicians to jointly negotiate with health care plans regarding non-fee related information because these types of negotiations do not raise anticompetitive concerns. Indeed, the Guidelines require a showing of the negotiation’s procompetitive nature.

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272. See Guidelines, supra note 118, at 26 (stated in section “Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under the Rule Of Reason”).

273. See Segars, supra note 37, at 1317; Wilcox, supra note 183, at 734.

274. See Meyer & Rule, supra note 242, at 198. Flexibility is important in antitrust analysis because the application of the antitrust laws is an inherently fact-intensive process. See id. Sweeping too broadly in either direction, as static legislation might do, “would occasion excessive harm to the competitive process.” Id.

275. Id. at 184. Conversely, “both the FTC and the Antitrust Division [of the DOJ] have acted on several occasions to . . . encourage rather than prohibit or chill the formation of efficient provider networks.” Id.

276. Id. at 201.


278. See Guidelines, supra note 118, at 14-15 (stated in section ‘Providers’ Collective Provision of Non-fee Related Information to Purchasers of Health Care Services’). Generally, disclosure of non-fee related information to competitors is procompetitive because it may improve a health care purchaser’s resolution of issues relating to the mode, quality, or efficiency of treatment. Id.
only if the negotiations are challenged.\textsuperscript{279} Similarly, H.B. 3086 authorizes health care providers to meet collectively with health care plans to discuss practices and procedures that do not focus on fee-related terms and conditions.\textsuperscript{280} In contrast, H.B. 3086 authorizes these types of joint discussions with the caveat that the Attorney General must approve them.\textsuperscript{281} This process is unduly burdensome to both parties and may actually increase the transactional cost of negotiations, which will ultimately be passed on to consumers.\textsuperscript{282}

The proposals in H.B. 3086 increase the safety zones for collaboration to untested levels in the health care industry.\textsuperscript{283} Joint discussions might also expand to untested levels when the allocated percentage of twenty percent is exceeded.\textsuperscript{284} Conversely, the FTC/DOJ Guidelines are time-tested and have been revised to ensure that they adequately meet the needs of a changing marketplace.\textsuperscript{285} In short, the safety zones provided in the Guidelines are the result of FTC and DOJ action in monitoring the health care market through its many complex changes.\textsuperscript{286} These efforts should be relied upon to encourage innovation and benefit consumers in the health care marketplace.

Finally, H.B. 3086 is not subject to a sunset provision.\textsuperscript{287} The Illinois General Assembly is not required to revisit the legislation to determine

\textsuperscript{279} Id. at 15. This is because, generally, a provider’s collective provision of certain types of information to a purchaser is likely either to raise little risk of anticompetitive effects or to provide procompetitive benefits. Id.

\textsuperscript{280} Health Care Services Contract Joint Discussions Act, H.B. 3086, 92nd Gen. Assem., Reg. Sess. § 25 (Ill. 2001); see supra note 188 and accompanying text (discussing how H.B. 3086 permits joint discussions on items such as procedures and clinical criteria).

\textsuperscript{281} Ill. H.B. 3086, § 50(d). Indeed, the codification of the Guidelines as rules is likely to “increase the likelihood that conduct outside the scope of immunity will be regarded as raising more serious antitrust risks.” See Meyer & Rule, supra note 242, at 202.

\textsuperscript{282} See H.R. REP. No. 106-625, at 37-38 (2000) (statement of Chairman Pitofsky (“[E]conomic theory predicts that a significant industry-wide increase in input costs will ordinarily raise the price of the final product.”)).

\textsuperscript{283} Compare TEX. INS. CODE ANN. § 29.09 (Vernon Supp. 2002) (noting that joint negotiation can only represent 10% of the physicians in an MCO’s geographic area), with Ill. H.B. 3086, § 20(c) (noting that joint negotiation can be carried out with 20% of the physicians in the geographic area).

\textsuperscript{284} Ill. H.B. 3086, § 20(c); see supra note 187 and accompanying text (explaining that joint discussions may involve no more than 20% of any type of health care provider).

\textsuperscript{285} See Meyer & Rule, supra note 242, at 186 n.60 (discussing how safe harbors for PNJVs have been revised under the Guidelines). Originally, a safety zone was instituted for PPOs at 20% in the mid-1980s. Id. The safe harbor was increased to 35% a few years later. Id. The 1996 Guidelines reinstated the standard 20% safety zone. See Guidelines, supra note 118.

\textsuperscript{286} See Meyer & Rule, supra note 242, at 186 n.60.

\textsuperscript{287} See Kopit, supra note 45, at 119-20. A sunset provision causes the legislation to expire without an affirmative act by a legislative body after a set amount of time. Id.; see also supra note 108 and accompanying text (defining a sunset provision).
whether the bill resulted in efficiencies in the industry or in anticompetitive harm to the consumer. In contrast, the FTC/DOJ Guidelines are revised periodically. 288 H.B. 3086 also differs from the legislation adopted in Texas, which requires the legislature to revisit the provisions of the bill three years from the date of its enactment. 289 A similar sunset provision also appeared in the QHCCA, which failed at the federal level. 290

Ultimately, the FTC/DOJ Guidelines are a flexible approach to the issues that arise in a dynamic industry. 291 The two principal antitrust enforcement agencies, the FTC and the DOJ, recognize that a dynamic industry should follow guidelines, instead of rules, to minimize the uncertainty facing participants in the health care market. 292 When conduct crosses the line from being procompetitive to anticompetitive, courts can use the Guidelines as persuasive authority and evaluate the conduct under the rule of reason, a fact-intensive and fair standard for both parties to a joint venture. 293 Indeed, with sound advice from experienced antitrust counsel, the Guidelines provide a more appropriate framework than H.B. 3086 for all types of collaborative ventures among physicians. 294

2. Countervailing Power is Difficult to Constrain

H.B. 3086 inadequately addresses the problems facing the health care industry for a second reason. Specifically, H.B. 3086 fails to take into account the fact that countervailing power 295 is difficult to constrain. Once small sellers are able to join together and exercise countervailing power against a dominant buyer, total power in the industry may shift to

288. See Meyer & Rule, supra note 242, at 186 n.60 (discussing the changes made to the FTC/DOJ Guidelines).

289. TEX. INS. CODE ANN. § 29.14 (Vernon Supp. 2002); see supra note 166 and accompanying text (discussing the sunset legislation of the Texas legislation).

290. See Quality Health-Care Coalition Act of 2000, H.R. 1304, 106th Cong.; see also supra note 108 and accompanying text (discussing the sunset provision in the QHCCA).

291. Varney, supra note 277, at 1 (noting that the revised health care guidelines address her concerns for an industry undergoing rapid change).

292. See Meyer & Rule, supra note 242, at 198.

293. See id. at 209 ("A mere desire to substitute the judgment of state regulators concerning the proper application of competitive principles for that of the federal courts and enforcement agencies [is not enough] . . . to supplant the federal antitrust laws.").

294. Id. at 184.

295. The term "countervailing power" refers to power that the legislature could grant to physicians to exert force against a dominant MCO. See supra note 8 and accompanying text (defining countervailing leverage as the exertion of force against an opposing force or influence).
the sellers.\textsuperscript{296} This shift pushes costs higher than the rate at which the market would dictate if neither side possessed market power.\textsuperscript{297}

Moreover, physicians who join together can wield their collective power against small or weak MCOs.\textsuperscript{298} Clearly, this collective power cannot be exercised through the negotiations themselves.\textsuperscript{299} It can occur unilaterally because H.B. 3086 requires that information regarding a joint negotiation’s terms and conditions be distributed to the health care providers involved in the transaction.\textsuperscript{300} Thus, physicians armed with the knowledge of their competitors’ negotiated prices can leverage this information against smaller health care plans in the geographic area. Accordingly, higher prices for patients are a likely consequence when physicians are allowed to exercise countervailing power against smaller MCOs.\textsuperscript{301}

Higher prices produced by the exercise of this countervailing power by physicians also come without a guarantee of increased quality in health care.\textsuperscript{302} The information that the FTC and DOJ provided to the House Committee reviewing the Quality Health-Care Coalition Act of 2000 is applicable to this issue as well.\textsuperscript{303} Specifically, it is likely that the number of market participants per region in Illinois varies as widely as it does all across the country.\textsuperscript{304} Therefore, Illinois’ joint negotiation legislation rests on theoretical assumptions that fail to accurately

\begin{itemize}
\item \textsuperscript{296} See Grimes, supra note 45, at 200 ("Collective action to create countervailing power may create power beyond what is necessary to confront a power buyer or seller; that power may be indiscriminately exercised against the small and vulnerable as well as the power player.").
\item \textsuperscript{297} Id. For all practical purposes, market share is an adequate proxy for market power. See supra note 70 and accompanying text (explaining that courts use market share as proxy for market power in their evaluation).
\item \textsuperscript{298} See Grimes, supra note 45, at 200.
\item \textsuperscript{299} See H.B. 3086, 92nd Gen. Assem., Reg. Sess. § 20(c) (Ill. 2001). In order for negotiations to occur, an MCO must have a substantial market share. \textit{Id.} It is unlikely that small buyers will have a "substantial market share" \textit{Id.}
\item \textsuperscript{300} \textit{Id.} § 35(a); see supra note 194 and accompanying text (noting that joint discussion representatives can informally resolve disputes among those whom they represent).
\item \textsuperscript{301} Grimes, supra note 45, at 210. The direct consequence of countervailing power in the hands of small sellers is to increase the price paid by buyers, at least some of which is passed on to the buyer’s customers. \textit{Id.}
\item \textsuperscript{302} See \textit{id.} (noting that higher prices are only bad when they do not come with an increase in choice or quality).
\item \textsuperscript{303} See H.R. REP. No. 106-625, at 30 (2000) (statement of Chairman Pitofsky); \textit{Id.} (statement of Assistant Attorney General Klein); see also supra notes 100-05 and accompanying text (examining the testimony that the FTC and DOJ presented to the House Judiciary Committee reviewing the Quality Health-Care Coalition Act of 2000).
\item \textsuperscript{304} See, e.g., H.R. REP. No. 106-625, at 45-46 (statement of Assistant Attorney General Klein) (noting that managed care markets are constantly changing and that more than 150 new MCOs were licensed to operate in the United States between 1994 and 1997).
\end{itemize}
describe most health care markets in the state.\textsuperscript{305} Furthermore, managed care markets are constantly changing.\textsuperscript{306} Thus, it seems likely that H.B. 3086 would result only in higher prices for patients, who would bear the increase in physicians’ costs without a guarantee of increased quality.\textsuperscript{307} This outcome does not accomplish the goal of H.B. 3086, which is to increase the quality of patient care throughout Illinois.\textsuperscript{308} Instead, H.B. 3086 simply provides physicians with a countervailing force to use in negotiations in which they must prove to the Attorney General that an MCO has a substantial market share.\textsuperscript{309}

C. Illinois House Bill 2115 is a Positive and Direct Solution to the Problems in the Health Care Industry

H.B. 2115, the Fairness in Health Care Services Contracting Act,\textsuperscript{310} stands in stark contrast to H.B. 3086 as a more appropriate and direct form of managed care reform.\textsuperscript{311} Instead of giving physicians a blanket exemption from the federal antitrust laws, H.B. 2115 alleviates a physician’s contracting concerns by simplifying his contracts with health care plans.\textsuperscript{312} The legislation further endeavors to make contracts that are unfair, misleading, or deceptive unlawful.\textsuperscript{313} Moreover, it protects physicians by not allowing a health care plan to unilaterally decide when alteration or termination of a contract will

\textsuperscript{305} See Kopit, supra note 45, at 103 ("[T]here are a few markets where individual managed care plans have monosony [sic] power."). "Monopsony power refers to a buyer’s ability or power to depress the price of a good or service below competitive levels." Segars, supra note 37, at 1322.

\textsuperscript{306} Kopit, supra note 45, at 103.

\textsuperscript{307} See Grimes, supra note 45, at 210.

\textsuperscript{308} See supra note 180 and accompanying text (stating that H.B. 3086 was designed to ensure that health care plans and providers work together to provide quality health care to MCO enrollees).

\textsuperscript{309} See generally Grimes, supra note 45, at 210-12. This condition is similar to when successive oligopoly conditions are present. \textit{Id}. In both situations, costs will be passed on to buyers without the added quality. \textit{Id}.


\textsuperscript{311} See Kopit, supra note 45, at 121.

\textsuperscript{312} Ill. H.B. 2115, § 351E-5 (noting that H.B. 2115 calls for the simplification of contracts between health care professionals and health care plans); see supra note 209 and accompanying text.

\textsuperscript{313} Ill. H.B. 2115, § 351E-5; see supra note 210 and accompanying text (noting that H.B. 2115 intends to eliminate provisions contained in contracts that are unfair, misleading, or unreasonably confusing in connection with services covered and reimbursement to health care providers).
occur. In short, H.B. 2115 addresses many of the problems confronted by independent physicians and is a first step toward making “take-it-or-leave-it” contracts in the health care industry a thing of the past.

With a few slight modifications to H.B. 3086, Illinois could provide a relatively unfettered antitrust exemption for physicians to collectively bargain with health care plans while complying with the state action doctrine at the same time. However, whether or not parties would wish to collectively bargain under the terms of the bill remains to be seen. H.B. 3086 is also too broad from a policy standpoint. First, it is too rigid and complex for use in a rapidly changing industry. The bill also does nothing to constrain the knowledge gained by physicians of their competitors’ business. Conversely, H.B. 2115 is a more appropriate and direct version of managed care reform. Its terms protect physicians from onerous “take-it-or-leave-it” contracts and simplify the contracting process. Clearly, the results under H.B. 2115 are more favorable than under H.B. 3086. As a result, the Illinois General Assembly should pass H.B. 2115 and let H.B. 3086 languish into oblivion.

V. PROPOSAL

Rather than pursuing the complex course of action outlined in H.B. 3086, Illinois should adopt less drastic solutions to deal with the current problems plaguing the health care industry. As noted above, Illinois is


316. See supra Part IV.A.2 (discussing how H.B. 3086 does not currently meet the active supervision requirement of the Midcal test).

317. See supra Part IV.A.2 (examining how likely it is that competitors will risk increased liability for participation in H.B. 3086).

318. See supra Part IV.B (analyzing how H.B. 3086 is too broad from a policy standpoint).

319. See supra Part IV.B.1 (examining how the FTC/DOJ Guidelines can be used to their fullest potential to protect independent physicians and increase the quality of health care in the industry).

320. See supra Part IV.B.2 (discussing countervailing power theory and its impact on the health care industry).

321. See supra Part IV.C (discussing H.B. 2115 as a more direct version of managed care reform).

322. See supra Part IV.C (discussing how H.B. 2115’s terms protect physicians and simplify their process of contracting).
already working towards this goal by incorporating House Bill 2115 into Senate Joint Resolution 33, which calls for a joint task force to investigate what the likely impact of H.B. 2115 will be to patients in Illinois.\(^{323}\)

Alternatively, Illinois can decide not to pass any new legislation and work within the status quo to regulate the potential monopsony power of the MCOs when it actually arises.\(^{324}\)

Finally, Illinois could pass legislation to displace competition only in specific areas of the health care industry, where the link between regulation and increased patient care does not involve a physician having to function on behalf of his patients with the MCOs.\(^ {325}\)

Indeed, these solutions could achieve a better result than H.B. 3086 for health care consumers in the state.

A. State and Federal Antitrust Agencies Must Become More Involved

The Sherman Act's prohibition on contracts, combinations, and conspiracies in restraint of trade applies equally to buyers and sellers.\(^{326}\)

Consequently, an aggressive approach, which attacks the monopsony power of MCOs at the state and federal level, will result in a direct benefit to consumers and reduce the need for physicians to have countervailing power. Indeed, state and federal antitrust enforcement agencies do not require new legislation to become more involved in the antitrust scrutiny of MCOs.\(^ {327}\)

Federal and state antitrust enforcement over the monopsony power of MCOs has been lax in the past.\(^ {328}\)

However, as the industry has grown, the federal court system has stepped in to make public enforcement easier by modifying the test of market share. Namely, federal courts have determined that an MCO may have a substantial market share even though it consists of a small

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\(^{323}\) See supra Part III.B (discussing the history of H.B. 2115).

\(^{324}\) See infra Part V.A (arguing that state and federal antitrust enforcement agencies should scrutinize MCO mergers).

\(^{325}\) See infra Part V.B (proposing that Illinois adopt less broad solutions to remedy the situation in the health care industry).

\(^{326}\) Sherman Act, 15 U.S.C. § 1 (2000); see Segars, supra note 37, at 1323; see also supra notes 59-60 and accompanying text (discussing how the Sherman Act blocks combinations formed with the purpose or effect of restraining trade).

\(^{327}\) See Glassman, supra note 59, at 106-07. As the health care market matures, antitrust enforcers could successfully challenge HMOs under the antitrust laws. Id. at 107.

\(^{328}\) See id. at 106-07 (noting that courts and regulators have viewed HMO markets as transitional, allowing them to develop free from close antitrust scrutiny). Yet another potential reason for this lack of close antitrust scrutiny is the fact that MCOs are often natural monopolies. See generally Segars, supra note 37, at 1323. Such natural monopolies occur in markets where a single purchaser creates efficiencies due to economies of scale. Id. As it is more efficient for subscribers to purchase health care services jointly rather than individually, such natural monopolies exist free from antitrust scrutiny. Id.
share of the market. Under this new approach, federal and state antitrust enforcement agencies are more likely to prevail when taking legal action against a monopsonist who uses its power to acquire nonprice advantages over a physician through "take-it-or-leave-it" contracts. Indeed, under the new test, these contracts may be sufficient to subject MCOs to the antitrust laws.

In addition, as the MCO concept matures, federal and state antitrust enforcement agencies must be on the lookout for mergers between health care plans that would have a direct, negative effect on consumers. This oversight could be accomplished by promulgating guidelines that specifically address the merger of MCOs or by incorporating such a set into the existing FTC/DOJ Guidelines. Likewise, federal and state agencies could carefully scrutinize and bring enforcement actions against managed care plans that injure or threaten to injure competition by creating monopsony power through MCO consolidation. Ultimately, this type of enforcement would have a deterrent effect on future violators and would keep monopsonies to a minimum in the marketplace.

B. Illinois Must Adopt Discrete Solutions to the Problematic Health Care Situation

It is within Illinois' power under the state action doctrine to intervene and displace competition in specific areas of the health care industry where there is a direct link between state regulation and the increased

329. Glassman, supra note 59, at 129 (noting that emerging economic factors in the health care financing market could lead courts to find that HMOs possess market power despite their small share of the market); see also supra note 70 and accompanying text (discussing how courts use market share as a proxy for market power).

330. See Segars, supra note 37, at 1325. Such provisions might even allow antitrust enforcers to bring actions against natural monopsonies who contract with physicians. Id.

331. Id. (noting that contracts seeking to gain "exclusive access" to physician services may be an antitrust violation under the Supreme Court's holding in United States v. Griffith, 334 U.S. 100 (1948)).

332. See id. at 1327-28 (noting that pre-merger scrutiny may provide adequate mechanisms for regulation).

333. Id. at 1326. By specifically addressing the merger of MCOs, the agencies could adequately prevent future monopsonies. Id.

334. Robert Pitofsky, Thoughts on Leveling the Playing Field In Health Care Markets, address before the National Health Lawyers Association (Feb. 13, 1997), at http://www.ftc.gov/speeches/pitofsky/nhla.htm (noting that as agencies review consolidations of managed care plans, they consider whether the transaction is likely to injure competition through the creation of buyer power).

335. See Segars, supra note 37, at 1328. "An agency enforcement policy implementing these provisions could correct any existing market distortions and deter potential abuses of monopsony power." Id.
quality of patient care. This type of regulation affects only a portion of the industry and will certainly be more manageable to a state agency charged with active supervision of the program.

As described previously, Oregon successfully displaced competition in specific areas of the health care industry. Moreover, in its testimony to the House Judiciary Committee, the FTC highlighted several proposals introduced at the state and federal levels that require MCOs to present consumers with "comparative quality and performance information" to help their decision-making. Legislation such as Oregon's and the potential proposals highlighted by the FTC provide a direct link between regulation and the resultant benefit to consumers. These regulations and proposals are exemplary responses to the demands of the public that will use these services to increase the quality of care in the industry.

Similarly, the FTC has called for regulations that would offer consumers a choice of health care coverage. Because most consumers obtain health care coverage through their employers, Illinois could make it easier for small employers to participate in purchasing pools, thus offering individuals a choice of health plans. This type of regulation would have a direct effect on the quality of

336. See, e.g., OR. REV. STAT. §§ 442.700-442.760 (2000 & Supp. 2001) (defining a state regulation under the state action doctrine that only affects the transplant market); see also supra note 169 and accompanying text (discussing a Washington statute that displaced competition in situations where the physician faced disincentives in competing with MCOs).

337. OR. REV. STAT. §§ 442.700-442.760; see supra Part II.C.3 (discussing the Oregon legislature's success in eliminating waste and duplication in the heart and kidney transplant market).


339. Id. at 40-41. An increase in consumer information is certainly a resultant benefit to consumers. Id. at 41; see also OR. REV. STAT. §§ 442.700-442.760. Displacing competition in the health care market for heart and kidney transplants to cut duplication and waste is also of direct benefit to consumers. OR. REV. STAT. §§ 442.700-442.760; see also supra note 172 and accompanying text (discussing Oregon's exemption).

340. H.R. REP. No. 106-625, at 40-41. "Offering consumers a choice can help make health plans more responsive to consumer preferences." Id. at 41.

341. Id. at 40.

342. Id.

Consumers have different views about many aspects of health care service delivery, including the types of settings in which they want to receive health care, the kinds of services and health practitioners to which they want access, how much they are willing to pay for health insurance, and the value they attach to broader choices among providers. Id. at 40-41.
health care for consumers and would increase the autonomy of physicians over their practices.³⁴³

As these examples illustrate, Illinois' joint negotiation legislation is not necessary to achieve parity among physicians and health plans. Instead, there are more manageable solutions, which already exist and adequately deal with the current problems plaguing the health care industry. These solutions include passing a version of Illinois House Bill 2115, bringing enforcement actions against MCOs that truly have monopsony power over the health care industry, and narrowly tailoring state action immunities from the antitrust laws to areas where they are needed most. The best result for health care consumers in Illinois is one in which the state provides for direct increases in the quality of care to consumers and does not assume that physicians with countervailing power will act in the best interests of their patients.

VI. CONCLUSION

Illinois' Health Care Services Contract Joint Discussions Act, House Bill 3086, should not become law in the state. H.B. 3086 does not comply with the requirements of the state action doctrine. Moreover, physicians frustrated by the impact of recent changes to their autonomy and income levels, should realize that lobbying for a broad exemption to the federal antitrust laws will do their patients more harm than good.

Instead, physicians should concentrate their efforts on working within the confines of the current FTC/DOJ Guidelines. They should seek relief from the so-called "take-it-or-leave-it" contracts by joining properly structured physician network joint ventures, which require a physician to accept a small reduction in autonomy. In addition, they should lobby the federal and state legislatures and other state agencies to increase enforcement of antitrust laws against MCOs, which have true monopsonistic power. Finally, physicians can endorse legislation that would have a direct impact on the quality of care for their patients. Ultimately, the health care industry is dynamic and flexible. The rules that govern the industry should reflect its nature and be dynamic and flexible as well.

³⁴³ Id. at 41. "Increased consumer choice among health plans also would be good for doctors." Id. Because patients can choose among doctors, physicians will not be required to contract with multiple MCOs to keep their existing patient base. See id; see also supra note 47 and accompanying text (discussing how the current situation in the health care market required physicians to turn away established and new patients because they were insured by an MCO).