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Report on AThe Quality Health-Care Coalition Act of 1999≅ by the Section of Antitrust Law of the American Bar Association

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Introduction

On March 25, 1999, Representatives Campbell, Conyers and others introduced the Quality Health-Care Coalition Act of 1999 (AAct≅), H.R. 1304. The Act is virtually identical to H.R. 4277, introduced by Rep. Campbell in 1998. Like its predecessor, the Act would amend federal and state antitrust law by conferring on health care professionals engaged in negotiations with a health plan, the same treatment under antitrust laws as collective bargaining units recognized under the National Labor Relations Act (ANLRA≅). The Act also would limit penalties or damages for actions taken in good faith reliance on this protection.

The Antitrust Section disfavors antitrust exemptions directed at specific industry categories or conduct, and such exemptions rarely have been enacted. The antitrust laws are designed to provide general standards of conduct for the operation of our free enterprise system. Special exemptions from these standards rarely are justified -- they often are not necessary to eliminate the risk of antitrust liability for procompetitive conduct, and the goals for such protection often can be achieved in a manner consistent with established antitrust principles and enforcement policy.

The Antitrust Section opposes the Act because it is both unwise and unnecessary. The Act would protect price fixing, group boycotts, and market or customer allocations which occur through negotiations with health plans, and which otherwise could be deemed illegal per se under established antitrust principles. This broad protection from antitrust law has not been shown to be necessary to protect procompetitive conduct, it may result in higher prices and diminished consumer choices without improving quality or achieving other important goals in the delivery of health care, and it would not advance the policies underlying existing labor exemptions from antitrust law.

Summary of the Act

The Act has two main provisions. The first states that health care professionals who are engaged in negotiations with a health plan regarding the terms of a contract to provide health care items or services covered by the plan, shall be entitled to the same treatment in connection with such negotiations as are bargaining units recognized under the NLRA in connection with such collective bargaining. A health care professional will be treated as an employee engaged in

concerted activities in connection with such negotiations, and shall not be regarded as an employer, independent contractor, managerial employee or supervisor.

The second main provision states that actions taken in good faith reliance on the first provision shall not be subject to criminal sanctions, civil damages, fees, or penalties under antitrust law, beyond actual damages incurred. The Act also provides, by way of limitation, that the first provision shall not confer any right to participate in any collective cessation of services to patients not otherwise permitted by law.

The Act defines Ahealth care professional≅ as an Aindividual≅ who provides patients with health care items or services, treatment, assistance with activities of daily living, or medications and, to the extent required by law, who possesses specialized training that confers expertise in the provision of such items or services. The Act defines Ahealth plan≅ as a group health plan within the meaning of the Employee Retirement Income Security Act of 1974, or an organization offering a Medicare+Choice Plan or Medicaid managed care benefits in accordance with the Social Security Act.

The Act states as findings that (i) the delivery of health care through managed care plans has increased substantially in recent years; (ii) health care plans have experienced increased concentration in recent years; (iii) the McCarran-Ferguson Act has created an enhanced opportunity for market power of insurance companies in health care, and has given such companies significant leverage over health care providers and patients; (iv) permitting health care professionals to negotiate collectively with health care plans will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care; and (v) allowing such collective negotiations will not change the ethical duties of health care professionals to continue to provide medically necessary care to their patients.

Competition in Health Care Is Essential to Promote Efficiency and Consumer Welfare

Health care markets have experienced rapid and far-reaching changes in recent years, not only in the increased use of managed care arrangements to finance and deliver services, but also in the extent of consolidation among both payers and providers through mergers, joint ventures and other collaborative arrangements. Health care markets still vary widely, however, in the number, size and quality of managed care plans and provider organizations, as well as in prices and price trends. Notwithstanding these differences, competition among health plans, and among providers and provider networks, has been the operative force which determines prices, and the range and quality of services offered to consumers.

The Act ignores important differences in health care markets and presumes that health plans in all areas now have the ability to impose terms on health care professionals which could not be achieved in a competitive market. The Act focuses in particular on horizontal consolidation among health plans as a perceived threat to competition and quality of care, and seeks to address this by promoting a Acountervailing≅ consolidation among health care professionals into Abargaining units≅ to gain leverage in negotiating with health plans. Accordingly, although health care markets are complex and are affected by a wide range of market forces and government policies, these comments are directed primarily at horizontal consolidation among health plans or providers and its effects on competition.

Consolidation among direct rivals is a common and often procompetitive business strategy in many industries and markets, and has been widely observed in health care in recent years. In a competitive market, a rational firm pursues consolidation only where this is expected to achieve cost savings and other efficiencies through the integration of operations and services. This, in turn, enables the firm to increase its sales by offering customers lower prices, new services, improved quality or other attributes they value.

Health care professionals have engaged in varying degrees of consolidation in response to market forces in recent years. Some have engaged in direct mergers to form large practice groups, either independently or as a part of health systems which include hospitals and other providers. Others have sought to achieve marketing and operating efficiencies associated with larger scale organizations through joint ventures among themselves, or with hospitals and other providers. Many of these organizations are large and sophisticated, and individually may have significant influence over prices or other terms in negotiating with health plans due to their size, reputation, or quality or range of services, and the desires of consumers and employers for health plans to include them as participating providers.

Many other health professionals still practice as individuals or in small practice groups. They may prefer the autonomy and other attributes of a smaller practice setting, but many perceive that they have little or no influence in negotiating with health plans on prices or other terms for their services. These practitioners frequently seek to facilitate contracting with health plans through local independent practice associations and other collaborative arrangements. The degree of actual integration in services or financial risk reflected by these organizations varies widely. Organizations which achieve no meaningful change in how participants provide or are paid for their services are unlikely to benefit consumers through lower costs, improved quality or in other respects.

As drafted, the Act could be interpreted to protect only Aindividual≅ health care professionals, and not professional corporations or other organizations through which they enter into contracts with health plans or provide services. If so, the Act=s coverage may be so narrow that it would have little or no effect on negotiations with health plans. More importantly, however, this would encourage health care professionals to remain in or revert to individual proprietorships to qualify for protection under the Act, thereby depriving consumers of efficiencies which otherwise may be achieved through consolidation in response to normal market forces.

The Act would encourage health care professionals to form large new Abargaining units≅ without regard to whether this will achieve efficiencies through a meaningful integration of their services, or whether the benefit of such efficiencies will be passed on to consumers. There would be no limit on the size of such organizations. This would substantially eliminate the normal incentives for health care professionals to consolidate only to achieve efficiencies which enhance their ability to compete, and thereby benefit consumers. In fact, the Act would protect Abargaining units≅ which act solely to increase provider income. This, in turn, could result in fewer options and higher prices for professional services provided under health plans, including

Medicare and Medicaid managed care plans, without any offsetting benefits in quality of care or other attributes of service.

Antitrust Law Promotes Procompetitive Joint Contracting by Health Care Professionals with Health Plans

The basic objective of antitrust law is to encourage and protect the competitive process by inhibiting practices that unreasonably interfere with free competition. This enhances consumer welfare by ensuring the most efficient allocation of resources so as to offer consumers low-priced, high-quality and accessible goods and services. Exemptions or immunities from antitrust law may insulate some market participants from competitive pressures which otherwise may lead to the most advantageous allocation of resources, and thereby promote consumer welfare.

The Antitrust Section -- consistent with its opposition to other proposed antitrust exemptions -- strongly endorses continued competition in health care, and regards continued application of antitrust law as being essential to maintain competitive and efficient health care markets. *See, e.g.*, Reports of the Antitrust Section on the Antitrust Health Care Advancement Act of 1997, the Television Improvement Act of 1997, the Major League Baseball Antitrust Reform Act of 1997 and the Curt Flood Act of 1997, and the Major League Baseball Antitrust Reform Act of 1995 (available at http://www.abanet.org/antitrust). In February 1989, at the urging of the Section of Antitrust Law, the ABA House of Delegates adopted a policy that urged the repeal of the McCarran-Ferguson Act, which provides an antitrust exemption for the business of insurance:

> The ABA urges repeal of the current McCarran-Ferguson exemption to the antitrust laws . . . ; and recommends that states retain the authority to regulate the business of insurance, and that the federal government defer to state regulation except in unusual circumstances where the regulatory objective can only be effectively accomplished through federal involvement.

In April 1989, the Section testified before Congress on behalf of the ABA in support of repealing the McCarran-Ferguson exemption. In addition, the Section has published a book entitled *Identification and Description of Antitrust and Competitive Issues Raised by Key Health Care Reform Bills* (1994), in which the Section analyzed the positive effects of competition on reform of the health care system, favored antitrust enforcement against anticompetitive conduct affecting health care by both providers and health plans, opposed regulations that impaired competition, and opposed exemptions and implied repeals of the antitrust laws.

The analytical principles embodied in antitrust law have evolved through numerous applications across a broad array of markets and conduct, including significant applications in recent years to joint contracting activities in health care. *See, e.g., North Lake Tahoe Medical Group*, FTC File No. 981-0261, 64 Fed. Reg. 14730 (March 26, 1999) (analysis of proposed consent order to aid public comment); *Asociacion de Farmacias Region de Arecibo*, FTC File No. 981-0153, 63 Fed. Reg. 70407 (Dec. 21, 1998) (analysis of proposed consent order to aid public comment); *Dentists of Juana Diaz, Coamo and Santa Isabel, Puerto Rico*, FTC File No. 981-0154, 63 Fed. Reg. 50573 (Sept. 22, 1998) (analysis of proposed consent order to aid public comment); *M.D. Physicians of*

Southwest Louisiana, FTC File No. 941-0095, 63 Fed. Reg. 33423 (June 24, 1998) (analysis of proposed consent order to aid public comment); *Mesa County Physicians Independent Practice Association,* FTC Dkt. No. 9284, 63 Fed. Reg. 9549 (Feb. 25, 1998) (analysis of proposed consent order to aid public comment); *FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, Trade Reg. Rep. (CCH) & 24,335 (D.P.R. 1997) (consent order); *Montana Associated Physicians, Inc.*, FTC Dkt. No. C-3704, 62 Fed. Reg. 11201 (March 11, 1997) (consent order); *United States v. Federation of Certified Surgeons and Specialists,* Civ. No. 99-167-CIV-T-17F, 64 Fed. Reg. 5831 (Feb. 5, 1999) (stipulations, proposed final judgment and competitive impact statement); *United States v. Federation of Physicians and Dentists, Inc.*, Civ. No. 98-475 (D. Del., Aug. 12, 1998) (complaint); *United States v. Health Choice of Northwest Missouri,* 1996-2 Trade Cas. (CCH) & 71,606 (W.D. Mo. 1996) (final judgment and competitive impact statement); *United States v. Women=s Hospital Foundation,* 1996-2 Trade Cas. (CCH) & 71,561 (M.D. La. 1996) (final judgment and competitive impact statement); *United States and State of Connecticut v. Healthcare Partners, Inc.*, 1996-1 Trade Cas. (CCH) & 71,337 (D. Conn. 1996) (final judgment and competitive impact statement); *United States v. Lake Country Optometric Society,* Trade Reg. Rep. (CCH) & 45,095 at 44,781 (W.D. Tex., Dec. 15, 1995) (criminal plea).

In most of these cases, federal and state antitrust enforcement agencies have brought actions against health care providers who collectively resisted cost containment efforts by managed care firms, thereby enhancing income of providers while producing higher prices and reduced services for both health plans and consumers. *See, e.g., Mesa County Physicians Independent Practice Ass=n*, FTC Dkt. No. 9284, 63 Fed. Reg. 9549 (Feb. 25, 1998) (85% of physicians in Mesa County, Colorado, established a single agent to bargain on their behalf with managed care plans). In some extreme cases, physicians have refused to provide services to patients in efforts to maximize their own income at the expense of their patients. *See, e.g., FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, Trade Reg. Rep (CCH) & 24,335 (D.P.R. 1997) (to achieve their goals, physicians called for an eight day strike during which they ceased providing non-emergency services to patients). No enforcement actions have involved collective efforts by providers to improve patient welfare rather than provider income.

Antitrust principles are founded on preserving competitive rivalry as the underlying force by which consumer welfare is enhanced. Courts and government enforcement agencies, however, have sought to accommodate the special interests and concerns associated with joint contracting and other collaborative arrangements among health care providers within the context of established antitrust principles. *See, e.g., U.S. Department of Justice & Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996), reprinted in* 4 Trade Reg. Rep. (CCH) & 13, 153 (AStatements of Enforcement Policy≅)*; All Care Nursing Service v. High Tech Staffing Services,* 135 F.3d 740 (11th Cir. 1998) (rejecting antitrust claims challenging joint bidding and contracting program to facilitate hiring of temporary nurses by twelve hospitals operating in the same county); *Levine v. Central Florida Medical Affiliates,* 72 F.3d 1538 (11th Cir. 1996) (rejecting price-fixing claim challenging physician hospital organization=s joint contracting and exclusive referral arrangements used to facilitate contracts with health plans); *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d 1406 (7th Cir. 1995) (rejecting, inter alia, price fixing claim challenging HMO=s use of Amost favored nations≅ price provision in contracts with physicians who compete with physician group which owns HMO).

Analytical principles have been developed to evaluate whether these arrangements threaten to harm competition and consumer welfare, or rather have a meaningful prospect of benefiting consumers through cost savings, better management of utilization, and/or enhanced quality and coordination in the delivery of health care services. These principles have evolved substantially in recent years, primarily through issuance of the Statements of Enforcement Policy and their predecessors by the Department of Justice and Federal Trade Commission in 1993, 1994 and 1996, and by numerous applications of these enforcement policies to provider joint ventures in Business Review Letters of the Department of Justice and in Advisory Opinions of the FTC Staff. These enforcement policies also are reflected in a series of government consent decrees (many of which are cited above), resolving antitrust claims against joint conduct by providers in their dealings with health plans.

Antitrust law recognizes that joint ventures among competing health care professionals often are a lawful means of achieving efficiencies which promote competition, and that participants may jointly negotiate prices and other competitive terms of contracts with health plans where this is reasonably necessary to achieve the venture=s procompetitive goals. Importantly, antitrust law requires careful consideration of the procompetitive benefits which joint contracting by a provider network or joint venture among competing health care professionals is expected to produce. Where there is no procompetitive integration of services (i.e., a meaningful prospect for improving efficiency in the delivery of care, reducing costs, better managing the utilization of services, or improving quality of care), the only likely result of joint contracting by providers will be to increase or maintain prices for their services. Such conduct ordinarily is regarded as horizontal price fixing which is illegal per se under established antitrust principles.

The Act, in contrast, makes no distinction between joint negotiations by health care professionals which simply would benefit the providers through higher prices, and those which would benefit consumers through lower costs, improved quality or expanded services. Thus, the Act would protect all collective negotiations, even those whose sole purpose and effect is to maintain or increase providers= income without integrating their services in an efficient and procompetitive manner.

Antitrust law also recognizes that even legitimate provider networks are not permitted to achieve market power by consolidating the negotiating leverage of a substantial percentage of competing providers into a single Abargaining unit.≅ Rather, participation must be limited so competing networks can form, or participants must remain free to join multiple networks or to contract directly with health plans. For example, the Statements of Enforcement Policy provide a safety zone for nonexclusive provider networks with up to thirty percent of competing providers in a market, thereby allowing at least three totally separate networks to form.

The Act, in contrast, would encourage and permit health care professionals to organize Abargaining units≅ which are not limited in size and participation to prevent the exercise of market power. In fact, all competition could be eliminated because the providers could form a single Abargaining unit≅ without fear of antitrust challenge. The Act, for example, would permit all physicians in New York or Dallas to form one bargaining unit to demand a significant increase in their fees, thereby substantially increasing health care costs. This would eliminate competitive options not only for consumers and health plans, but also for health care professionals themselves

(where bargaining units demand and achieve exclusive dealing restrictions with health plans), and would materially distort the normal market forces and rivalry on which our competitive system is based.

There could be no assurance that joint negotiations carried on under the protection of the Act would promote competition and benefit consumers. The Act provides for no federal or state regulatory scheme to ensure this, but rather presumes that all collective actions by providers either would be beneficial or benign with no mechanism to police their conduct.

A variety of joint ventures among competing health care professionals now are operating successfully -- and without immunity from antitrust law -- in a wide array of health care markets, and many engage in joint negotiations with health plans on behalf of participating providers. Antitrust law is inherently flexible in that it focuses on actual market conditions and competitive effects, and its application will ensure that such joint conduct furthers legitimate procompetitive goals as health care markets change and new methods are introduced to deliver and finance care. Thus, although the analytical standards used to evaluate such conduct should be subject to continuing review and refinement, antitrust enforcement will do far more to preserve competition and enhance consumer welfare than the broad antitrust exemption set forth in the Act.

No Compelling Need Has Been Shown for Broad Antitrust Immunity for Health Care Professionals Who Jointly Negotiate with Health Plans

Neither the findings in the Act nor other general observations about trends in health care markets demonstrate a compelling need for the broad antitrust immunity proposed in the Act. The Act expressly seeks to alter the dynamics of contract negotiations between health care professionals and health plans, but the broad generalizations about health care markets expressed therein not only are inconsistent with particular market settings where providers now have significant influence over prices and other terms in their negotiations with health plans, they also would not merit a broad exemption from antitrust law even if true.

The findings state that mergers among health plans have resulted in a significant increase in concentration in markets for health care financing which, together with the protection afforded to health plans by the McCarran-Ferguson Act, enables them to exercise market power over health care professionals in contract negotiations. Contrary to this suggestion, however, courts generally have held that the McCarran-Ferguson Act provides no exemption from antitrust law for an insurance company=s agreements with third parties that supply goods or services to policyholders. *See, e.g., Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979); *Rozema v. Marshfield Clinic*, 1997-1 Trade Cas. (CCH) & 71, 796 (W.D. Wis. 1997). In fact, federal and state antitrust enforcement authorities have asserted jurisdiction over provider contracts and health plan mergers notwithstanding the McCarran-Ferguson Act, including Aetna=s pending acquisition of Prudential=s health plans. *See, e.g., United States v. Medical Mutual of Ohio*, 1999-1 Trade Cas. (CCH) & 72,465 (N.D. Ohio 1999) (final judgment and competitive impact statement, prohibiting health plan=s use of Amost favorable rates≅ provisions in contracts with hospitals). Moreover, the McCarran-Ferguson Act reflects deference to the primary role of state regulation over the business of insurance, whereas under the Act there would be no comparable regulation of health care professionals. The Antitrust Section has supported repeal of the McCarran-Ferguson Act=s

exemption from federal antitrust law, and this would better serve to promote competition than would the broad antitrust immunity proposed in the Act.

The findings also state that permitting collective negotiations by health care professionals will create a more equal balance in negotiating power, promote competition and enhance the quality of patient care. The Act, however, makes no distinction between markets where health plans arguably may have a degree of market power over health care professionals, and others where the converse may be true or where neither has such leverage. Thus, the Act may enable health care professionals to jointly negotiate, and thereby enhance their negotiating leverage, in market settings where many health plans operate and none possesses market power over providers. This would not be warranted even by the findings set forth in the Act.

Consolidation among health plans admittedly has been observed in many areas, but this does not warrant a special exemption from antitrust law to enhance the negotiating position of health care professionals with whom they contract. Although there have been few direct antitrust challenges to date against mergers between health plans, federal and state antitrust law, as well as state regulation over the business of insurance, provide significant enforcement authority to monitor such transactions and prevent undue concentration among health plans which threatens competition. *See, e.g., Proposed Acquisition of Metlife Healthcare Network of Kansas City, Inc.*, No. 95-07-13-0006 (Mo. Dep=t. of Ins., Sept. 18, 1995) (order approving consent agreement requiring divestiture of St. Louis HMO); *Matter of Harvard Community Health Plan*, No. 95-0331 (Suffolk Super. Ct., Mass., Jan. 18, 1995) (assurance of discontinuance approving health plan merger subject to restrictions on future pricing and provider contracts); *Agreement between New Hampshire Department of Justice, Harvard Pilgrim Health Care, Inc., Matthew Thorton Health Plan, Inc., The Hitchcock Clinic and Darthmouth Hitchcock Health Systems* (Oct. 16, 1995) (approving health plan merger subject to restriction on exclusive contracts with primary care physicians).

Health plan mergers should continue to be subject to careful antitrust review by federal and state enforcement officials, as well as by private parties. The Antitrust Section fully supports such efforts. Mergers among health plans are -- and should be -- subject to scrutiny to avoid the concerns with health plan market power stated in the Act. At the same time, courts and enforcement agencies have recognized that consolidation in a broad range of markets -- including markets for health care services and health care financing -- may be procompetitive and enhance consumer welfare. These judgments, however, are properly made based on a careful analysis of market data for individual transactions, not through broad and unsupported findings such as those set forth in the Act.

The Act Would Not Advance the Policies Underlying
Existing Labor Exemptions from Antitrust Law

The Act would grant to health care professionals in their negotiations with health plans, the same protection from antitrust law under the Astatutory≅ and Anon-statutory≅ labor exemptions that is available to employees in collective bargaining with their employers through legitimate labor organizations under federal labor law. Importantly, however, the Act would not require that providers actually become employees of a common employer, or achieve any efficiencies by integrating their practices. Nor would the Act subject such negotiations or the Abargaining units≅ formed for this purpose to the jurisdiction of the NLRB or the requirements of federal labor law. Extending these exemptions to conduct which is not subject to the collective bargaining requirements of federal labor law would be inconsistent with federal labor policy, and would not advance the main purposes for those exemptions -- to allow restraints on competition within and limited to the labor market (i.e., wages, hours and conditions of employment), and to accommodate and give deference to the primary role of federal labor law in the collective bargaining process.

The statutory labor exemption is derived from Section 6 of the Clayton Act, which declares that Athe labor of a human being is not a commodity or article of commerce,≅ and from the Norris-LaGuardia Act, 29 U.S.C. ∋101 et seq., which prohibits federal courts from issuing an injunction growing out of a Alabor dispute.≅ The statutory exemption protects unilateral union conduct, and requires that the entity seeking the exemption (1) must be a bona fide labor organization; (2) must be acting in its self-interest (i.e., pursing a labor market objective); and (3) must not have combined with a non-labor group. *United States v. Hutcheson*, 312 U.S. 219 (1941).

The nonstatutory labor exemption is an implied immunity developed through court decisions, which protects a labor union=s collective bargaining with an employer over wages, hours and other terms and conditions of employment, as well as resulting agreements regarding these matters. Courts also have extended the nonstatutory labor exemption to other concerted activity and agreements between labor groups and other parties. In doing so, courts generally have required that the concerted activity or agreement (i) arise in a collective bargaining setting; (ii) be intimately related to a mandatory subject of bargaining; and (iii) not have the potential for restraining competition in a business market in ways that would not follow naturally from elimination of competition over wages and working conditions. *See, e.g., Connell Construction Co. v. Plumbers & Steam Fitters Local Union No. 100*, 421 U.S. 616, 635 (1975).

Courts have recognized the nonstatutory labor exemption in order to accommodate and give deference to important policies in federal labor statutes, Awhich set forth a national labor policy favoring free and private collective bargaining. . . which require good faith bargaining over wages, hours and working conditions. . . and which delegate related rulemaking and interpretive authority to the National Labor Relations Board.≅ *Brown v. Pro Football, Inc*, 116 S. Ct. 2116, 2120 (1996). Federal labor law delegates to the NLRB the Aprimary responsibility for policing the collective bargaining process. And one of their objectives was to take from antitrust courts the authority to determine, through application of the antitrust laws, what is socially or economically desirable collective-bargaining policy.≅ *Id.* at 2123.

Both the statutory and non-statutory labor exemptions apply only to activity arising out of a labor dispute, i.e., a dispute which involves a bona fide labor organization of employees, and which promotes legitimate labor interests rather than entrepreneurial or other non-labor interests. AOf course a party seeking refuge in the statutory exemption must be a bona fide labor organization, and not an independent contractor or entrepreneur.≅ *H.A. Artists & Associates, Inc. v. Actors=Equity Assn.*, 451 U.S. 704, 717 n.20 (1981). *See also, Columbia River Packers Ass=n v. Hinton*, 315 U.S. 143 (1942). These exemptions apply only to employees and their collective bargaining units, not to independent contractors or business entities engaged in collective contract negotiations. *See* 29 U.S.C. ∋152(3) (stating that the term Aemployee≅ as used in the NLRA shall not include any individual having the status of an independent contractor).

Unlike the existing exemptions, the Act would not accommodate federal labor policy by preserving the jurisdiction and regulatory authority of the NLRB over health care professionals= joint negotiations with health plans. Indeed, unlike all other groups covered by the labor exemptions, health care providers would be exempt both from antitrust law and from federal labor law. Thus, the Act would not further the policies under federal labor law on which these exemptions are based.

In fact, these exemptions already apply to health care professionals, but most are not traditional employees of health plans. Rather, they provide service to numerous health plans under separate commercial contracts. The existing labor exemptions, however, do not extend beyond the labor market into the realm of commercial competition.

The Act would address this by expressly abrogating the requirement that collective bargaining by health care professionals pertain to an employment relationship. Thus, even if the Act provided for application of existing federal labor law and regulations, it would extend the labor exemptions significantly beyond collective bargaining over wages, hours or other terms of an employment relationship (i.e. physicians employed by a multi-specialty physician group, hospital or health plan), to cover any joint negotiations regarding the terms for items or services provided under a health plan. Federal labor law, however, reflects no fundamental policy favoring collective bargaining over terms and conditions for such health care contracts. Thus, the Act cannot be justified as an extension of federal labor law and policy.

Furthermore, the objectives of the Act differ significantly from the objectives embodied in federal labor statues and the exemptions that flow from these statutes. These exemptions seek to balance Athe inherent tension between national antitrust policy, which seeks to maximize competition, and national labor policy, which encourages cooperation among workers to improve the conditions of employment.≅ *H.A. Artists*, 451 U.S. at 713. By contrast, the stated purpose of the Act is to Apromote competition≅ and Aenhance the quality of patient care.≅ Engrafting these conflicting procompetitive objectives onto existing labor statutes, particularly when limited to a single industry, will jeopardize over sixty years of generally applicable jurisprudence under federal labor law.

The Act also would conflict with the nonstatutory labor exemption in that it provides no express protection for health plans which negotiate and contract collectively with health care professionals. In *Brown,* 116 S. Ct. at 2121, the Court recognized that, where application of the

nonstatutory labor exemption Ais necessary to make the statutorily authorized collective bargaining process work as Congress intended, the exemption must apply both to employers and employees.≅ Section 3(b) of the Act limits damage awards for actions taken in good faith reliance on the Act=s antitrust immunity, but even this limitation does not apply expressly to health plans. Moreover, awards of actual damages and injunctive relief would not be prohibited. Accordingly, health plans which enter into contracts through joint negotiations with health care professionals still would be subject to price fixing and other antitrust claims by employers, enrollees or government enforcement agencies.

Conclusion

Health care markets continue to experience profound change in many areas. It is difficult to predict the nature and extent of future change in the structure of health care markets and the preferred methods for delivering and financing health care. Nevertheless, competitive rivalry among health plans, and among providers and provider networks, should continue to serve as the primary vehicle by which consumers are assured of receiving the best and most cost-effective health care services possible. Continued application of antitrust law is essential to preserve this competitive process, which will assure that health care markets respond in a dynamic and efficient manner to consumer preferences, advances in health care, and the many other factors which influence cost and benefits under health plans. For these reasons, the Antitrust Section opposes the exemption from antitrust law proposed in the Act.