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Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority

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INTRODUCTION

The decline of organized medicine as a political force in the latter half of the twentieth century is well known. Reasons for the decline include government subsidization of health care and the corresponding growth of commercial enterprise, the application of the antitrust laws to the "learned professions," and the consumer challenge to medical authority and self-regulation. Medicine's downfall created a power vacuum for others to fill. Government seemed the logical choice based on models advanced in other countries, such as Canada and Great Britain, but the timing was poor for the type of regulation that characterized the New Deal era and the administrative state. Policy makers eschewed centralized authority in favor of market competition to stem rising costs. Corporate medicine emerged the victor, thanks in no small part to legislative enactments,¹ court rulings,² and the support of government agencies such as the Federal Trade Commission.³

²See, e.g., Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (horizontal agreement among participating physicians to fix maximum prices for medical services violated the antitrust laws).
³See, e.g., In the Matter of The American Medical Association, et. al., 94 F.T.C. 701 (1979) (ethical restrictions on physician advertising, solicitation and contract practice were in restraint of trade); In the Matter of Michigan State Medical Society, 101 F.T.C. 191 (1983) (the
Though organized medicine is "just a player" in health politics at the present time,⁴ there are clear signs that physicians and their professional associations are regaining some of their lost political clout and economic leverage.⁵ These signs include: (1) collaborative efforts between organized medicine and consumer groups at the state and local levels to advance common interests, such as patient protection legislation; (2) the recent Supreme Court decision in California Dental Association v. FTC (1999)⁶ that reinforces professional values; (3) liberalization of the rules on physician efforts to organize in response to managed care organizations (MCOs); and (4) structural changes in the private market that indicate that physicians are adapting to a competitive environment. Collectively, these events signal a new framework for the exercise of political and economic authority within a reconfigured and fragmented professional landscape. This article will examine the evidence, will explore why physicians are regaining power, and will assess the significance for health policy.

Gaining Leverage Through Collaboration
The medical profession acquired political power, in large part, by controlling the institutions and individuals that provided health care in local communities.⁷ The mechanisms of institutional control included credentialing and privileging committees of hospitals, medical staff by-laws and procedures, and private accrediting bodies; the mechanisms of Michigan State Medical Society illegally conspired to boycott the cost containment programs of Michigan Medicaid and Blue Cross/Blue Shield of Michigan).


⁵Recent studies lend support to my thesis. M. Schlesinger, A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession, 80 THE MILBANK QUARTERLY 190 (2002); Stevens, supra note 4. Schlesinger's data show that public confidence in medical authority "rebounced" in the mid-1990s following a decline that began in the 1960s. Stevens questions the historical portrayal of a profession in decline. She notes that today's "environment requires collaborative planning, management, and policymaking rather than conflicts," and that "it is easier to see than it was 10 years ago that public interest and professional self-interest are not necessarily, or even usefully, antagonistic." Id. at 337, 347.


individual control included professional associations, medical schools, licensing boards, and the ethical principles they enforced. Though professional control undoubtedly enhanced competence and quality, the effect was to exclude competing practitioners (chiropractors, podiatrists, etc.) and to restrict the corporate practice of medicine.\(^8\) Those lacking access to private institutions and to the closed referral and fee-generating systems asserted that quality was a guise for economic self-interest.\(^9\) But until the federal government enacted Medicare and Medicaid and health care costs rose dramatically in the 1970s, there was no concerted effort to undermine the medical establishment.

The erosion of professional power at the local level began with the introduction of rules and regulations at the federal level. The political scientist E. E. Schattschneider wisely observed that "inevitably the outcome of a contest is controlled by the level at which the decision is made."\(^10\) What Schattschneider meant was that weak contestants in a political battle must seek to "expand the scope of conflict" in order to gain leverage with more powerful opponents. One way to expand conflict is to "nationalize" it,\(^11\) just as chiropractors, insurers, and HMOs did throughout the 1980s and 1990s when they appealed to federal authorities to protect them from anticompetitive practices of local and state medical societies and other professional groups.\(^12\) So long as federal rules prevailed and independent practitioners could not organize competitively, corporate providers dominated at the state and

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\(^9\)See Trial Brief of Counsel Supporting the Complaint [of the FTC against the AMA], Docket No. 9064 (filed 18 April 1977), 53-78. See also *Federal Trade Commission Reauthorization: Hearing Before the Congress, House, Subcomm. on Commerce, Transportation, and Tourism, Comm. on Energy and Commerce, 97th Cong. (2nd Sess. 1982)* (statements of the American College of Nurse-Midwives, the American Optometric Association, the American Chiropractors Association, the Association for the Advancement of Psychology, and the American Nurses' Association).


\(^11\)Id. at 10.

local levels. As Clark Havighurst has noted: "Few things could have had as revolutionary an effect on the health care sector as the abrupt overturning of the deep-seated policy of trusting medical interests to make and enforce industry rules and set standards for the health care field."

These events might seem at odds with the decentralizing and deregulating trends in American government over the past thirty years. They are not. In order to enhance efficiency through market competition, government sought to break up the medical monopoly. Despite an overall decrease in federal antitrust actions during the Reagan administration, filings actually increased against professional and trade associations. In addition, the federal government enacted laws and regulations, such as fraud-and-abuse statutes and HMO legislation, that fostered market competition while encouraging physicians to integrate with institutional providers and health insurers.

After the Clinton administration failed to fashion a national health plan that cobbled public oversight with private delivery, the federal government again retreated to the sidelines, leaving it to MCOs and professional associations to police the private sector. Though diminished federal involvement enhanced opportunities for state regulation and professional control, managed care now was a key participant in the private sector. Having declined politically, a much-weakened medical profession lacked the clout to oppose MCOs and insurers on its own. Seeking assistance, physicians cultivated ties with

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consumers by asserting that many of the devices that corporate managers used to control physicians (utilization review, gag clauses, financial incentives, etc.) were bad for patient care. Physicians were effective in their campaign, fueling a public backlash against the managed care industry.

Consumers also were searching for new allies. According to Louise Trubek, the movement of authority downward from federal to state and local government, outward to the private sector, and outside the "regulatory box" reconfigured the political landscape, fostering "collaboration among previously antagonistic actors." She argues that in an uncertain regulatory environment, consumer advocates sought help from groups that shared an interest in the quality of health care. A weakened medical profession was a likely candidate because of the perception that doctors were advocates for their patients against MCOs. Trubek relates that physician and consumer groups in Wisconsin founded the Collaboration for Healthcare Consumer Protection (CHCP) to promote legislation and other initiatives that advanced patients' rights.

Trubek's findings are consistent with my own study of advocacy coalitions in Wisconsin politics. After conducting numerous interviews with legislative staff and with leaders and lobbyists from

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20 Id.


22 Id.


24 CHCP comprises the Center for Public Representation, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, Wisconsin AARP, the Wisconsin Nurses Association, and the Wisconsin Society of Podiatric Medicine. Letter from CHCP to Governor McCallum, Representative Jensen, and Senator Chvala (Feb. 16, 2001).

consumer groups, the managed care industry, and professional societies, I also found that groups with past differences were now working together to fashion legislation. Of particular note, I learned that the state medical society in Wisconsin had altered its strategy to emphasize "patient advocacy" over "doctor advocacy" in the pursuit of professional goals. Still, medical societies conceded little in promoting the interests of consumers. An agenda that furthered patients' rights countered federal policies that sought to streamline medical practice in order to reduce costs.

These findings suggest that collaborative activities between physicians and consumers at the state level, combined with growing public distrust of managed care during the 1990s, furthered the political agenda of organized medicine. Congress thus far has failed to pass comprehensive legislation or an antitrust exemption for physicians.

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26The events were more complex, of course, than this brief summary suggests. The advocacy coalitions that I identified represented a broad spectrum of beliefs and values from professional and public interest groups to managed care organizations. Moreover, groups and coalitions were divided among themselves on certain issues. For example, the Milwaukee County Medical Society disagreed with the State Medical Society on data collection legislation, and preferred provider organizations in Wisconsin broke ranks with HMOs over patient protection legislation.


28A good example is the distinction between state insurance regulation and the Employee Retirement Income Security Act of 1974 (ERISA). State laws ("any willing provider" legislation, mandated benefits, emergency room coverage, etc.) promote individual access to medical services with little regard for cost. ERISA, on the other hand, limits the rights of plan beneficiaries in the attempt to preserve scarce resources. See B.R. Furrow et al., Health Law: Cases, Materials, and Problems 624-625 (American Casebook Series, West Group, 4th ed., 2001).

29Some evidence exists that physicians are better organized at the state and local levels than at the federal level relative to their managed care counterparts. Physician membership in state medical societies surpasses that of the AMA. Interview with A. O'Connor, Vice President, Advocacy and Policy, Wisconsin State Medical Society (Aug. 15, 2001). Moreover, an increasing number of doctors are running for political office, particularly at the state level where 30 state legislatures had physician members in 2001. T. Albert, W.Va. Liability Crisis Motivates Doctors to Become Candidates, AM. MED. NEWS, June 17, 2002. Further, the managed care industry has concentrated its political resources on Congress where it has contributed enormous sums to defeat consumer rights' initiatives. L. Berger et al., Holding Patients Hostage: The Unhealthy Alliance Between HMOs & Senate Leaders, Public Citizen's Congress Watch (2000); Congress, House, Committee on the Judiciary, The Quality Health-Care Coalition Act of 1999: Hearing Before the Congress, House, Comm. on the Judiciary, 106th Cong., (1st Sess. 1999) [hereinafter House Hearings (1999)].
Most states, on the other hand, have enacted some form of patient protection legislation that favors physicians in the form of any-willing-provider laws, restrictions on gag clauses in contracts, state licensure requirements for medical directors of HMOs, and prompt payment laws. Even a few states (Washington, Texas, and New Jersey) have authorized independent practitioners to bargain collectively with MCOs under certain circumstances. In state legislatures, at least, professional goals and interests have trumped those of managed care.

The Revitalization of Medical Ethics
For much of the twentieth century, the medical profession argued that the commercialization of medicine would be bad for patient care, and, for a long time, the courts agreed. Faced with a physician-led boycott of hospital associations in Oregon over prepaid medical care, the Supreme Court in United States v. Oregon Medical Society (1952) upheld a lower court decision that found insufficient evidence to support a conspiracy. Perhaps the Court’s own values and beliefs colored its decision. In the words of the Court: "There are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

Before the Court’s historic turnaround in Goldfarb v. Virginia State Bar (1975), the AMA Principles of Medical Ethics restricted advertising, solicitation, and contract practice. Constraints on advertising and solicitation prevented physicians from competing based on price or quality of service. The prohibition on contract practice, which precluded certain types of compensation, such as capitation, and certain arrangements between physicians and non-physicians, adversely

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30 See Marsteller, supra note 19.
32 See Starr, supra note 7.
33 43 U.S. 326 (1952).
34 Id. at 336.
36 94 F.T.C. at 801.
affected HMOs and alternative providers. Though the Court in *Goldfarb* exposed the "learned professions" to antitrust scrutiny, it expressed some ambivalence over the reach of the antitrust laws, stating in footnote 17 that professional activities might merit special treatment because of their "public service aspect and other features of the professions." When the Federal Trade Commission sued the AMA in 1975 in an attempt to alter the AMA's restrictions on advertising, solicitation, and contract practice, the AMA invoked footnote 17, asserting that such restrictions were reasonable attempts to prevent consumer deception and inferior medical care.

In the first of many rulings against organized medicine and various professional groups, the FTC in 1979 dismissed the AMA's claims, observing that the restrictions went "far beyond anything that might reasonably be related to the goals" of protecting consumers from deceptive advertising or patients from poor medical care. Subsequent FTC and Supreme Court rulings narrowed the scope of footnote 17. In *Federal Trade Commission v. Indiana Federation of Dentists* (1986), the Court circumscribed the so-called "patient care defense," holding that dentists could not keep x-rays from insurers on the grounds that such information, unaccompanied by a full dental examination, might lead to inadequate care and treatment. Relying on its earlier decision in *National Society of Professional Engineers v. United States* (1978), the Court employed a truncated rule-of-reason analysis to quickly dismiss the dentists' assertions.

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37 421 U.S. at 788-789, n. 17. The complete quotation is as follows:
The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.


39 94 F.T.C. at 1011-1012.


At the time of the Court's ruling in *California Dental Association v. Federal Trade Commission* (1999), legal scholars, for the most part, believed that professional associations could not rely on the underlying public policy implications of footnote 17 to advance restrictive trade practices, except in very limited circumstances. *California Dental* resurrected footnote 17. In *California Dental*, the Supreme Court reversed the findings of the FTC and the Ninth Circuit on the grounds that "the rule of reason requires a more thorough enquiry into the consequences" of certain restrictions on advertising. The ethical provisions at issue prohibited members of the state dental society from advertising discounts for dental work and for extolling the quality of their dental services. Using a "quick look" rule-of-reason analysis, the Ninth Circuit found that the anticompetitive tendencies of the restrictions were intuitively obvious, but a bare majority (5 to 4) of the Supreme Court did not agree. Instead, the Court held that the facts justified a "full-bore" analysis because "the restrictions on both discount and nondiscount advertising are, at least on their face, designed to avoid false or deceptive advertising in a market characterized by striking disparities between the information available to the professional and the patient." The Court's holding in *California Dental* affirmed the role of professional societies in regulating certain forms of advertising, even non-deceptive advertising, so long as the avowed goal was to avoid the dissemination to consumers of false or misleading information. This is a role that the Court arguably foreclosed in *Professional Engineers* and in *Indiana Federation of Dentists*. Further, in relying on footnote 17 to bolster their decision, a majority of the Justices signaled their willingness to view favorably professional norms and values in future cases involving ethical restrictions on business practices. Critics of the Court's decision are wary. Indeed, Clark Havighurst claims that, "by

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44526 U.S. at 759.
45*Id.* at 763-764, 784.
46*Id.* at 771.
47*Id.* at 771, n. 10.
raising the burden of proof facing anyone challenging certain professional restraints of trade, the Court has created a new risk that professionals will once again be empowered to control their economic environment in their own interests, potentially reversing much of the progress in antitrust enforcement against professionals in the quarter century since Goldfarb.49

Though physicians are unlikely to regain monopoly powers, particularly with the advent of managed care, California Dental has broad implications for organized medicine. Specifically, the ruling bolsters (and may even expand) professional oversight in the sensitive area of economic self-regulation. As discussed in the next section, the FTC has relaxed its position on physician-network joint ventures, but has been reluctant to cede control over professional practices that impinge on market competition.50 Whether California Dental will have a "chilling effect" on the Commission's enforcement activities remains to be seen. Some believe that it already has, though the FTC was proceeding in other directions even before California Dental.51 Still, the Court's decision and the Ninth Circuit's subsequent dismissal of the case, without remanding it to the FTC for further proceedings,52 might deter future lawsuits for restraints of trade.

Collective Actions in Response to MCOs
Physicians have sought to remove constraints on their concerted economic activity ever since the application of the antitrust laws to the "learned professions." The AMA petitioned Congress for relief from FTC jurisdiction beginning in 1980. After securing passage of a bill in the House placing a moratorium on FTC prosecutions, the AMA lost in the Senate in 1982.53 Following the AMA's defeat, the Commission,


49Havighurst, supra note 14, at 949.


51See Greaney, supra note 48, at 186.

52224 F.3d 942 (9th Cir. 2000).

53Senate Record Vote Analysis, vote no. 428, 97th Cong., (2d Sess. 1982).
the Department of Justice, and state attorneys general brought numerous lawsuits charging health care professionals with price fixing, boycotts, and restraint of trade; the FTC pursued at least 27 of these cases, most of them against the medical profession.\(^5^4\)

During the 1990s, organized medicine continued to press for Congressional relief from the antitrust laws. The Medicare Preservation Act of 1995 sought broad immunity for collaborative activities related to the setting of quality standards, and limited immunity for fee-setting among certain provider networks.\(^5^5\) Similar legislation to ease restrictions on provider networks surfaced again in 1996.\(^5^6\) Each of these attempts was unsuccessful. Finally, in 1996, the FTC and the Department of Justice issued joint guidelines that established "antitrust safety zones" and otherwise clarified the standards for financial risk-sharing and the clinical integration of physicians' groups.\(^5^7\)

Despite some easing of the restrictions on physician integration, many doctors remained unhappy with the perceived disparity in negotiating leverage between them and the insurance industry.\(^5^8\) According to the AMA's general counsel, Edward Hirshfeld, "this leverage has enabled health plans to assume substantial control over medical decision making, to drive down the incomes of many physicians, and to threaten the viability of physician practices that will not cooperate with them."\(^5^9\) Though the number of doctors in group practices increased substantially after 1965, most self-employed physicians remained in solo-or small-group practices (2 to 4 physicians) as of 1998.\(^6^0\) These physicians, in particular, continued to press for

\(^{5^4}\)See House Hearings (1999), supra note 29, at 24-30.
\(^{5^5}\)H.R. 2425.
\(^{5^7}\)See DOJ/FTC Statement, supra note 50.
\(^{5^9}\)Id. appendix A, at 29.
\(^{6^0}\)Self-employed physicians comprised 52.4% of practicing physicians in 1998. Of these, 21.7% or 134,802 were in practice by themselves and 13.2% or 81,802 physicians were in practices numbering less than five physicians. D. Emmons and P. Kletke, The Practice Arrangements of Patient Care Physicians, 1998 (AMA Center for Health Policy Research 1999).
They supported legislation sponsored by Tom Campbell, a Republican Congressman from California, that would allow them to bargain collectively with insurers and HMOs.\textsuperscript{62}

Originally introduced in 1998, the Campbell bill targeted self-employed physicians, not employees of insurers or HMOs. Reintroduced in 1999 and 2000, the proposed legislation passed by a vote of 276 to 136 in the House of Representatives, but failed to gain a sponsor in the Senate.\textsuperscript{63} Though physicians lost at the federal level, they enjoyed some success at the state level. Texas, Washington, and New Jersey enacted modest forms of collective bargaining legislation on behalf of doctors, most recently in 2002.\textsuperscript{64} Moreover, Congress is again considering antitrust relief in the current legislative session.\textsuperscript{65} The so-called Barr-Conyers bill would require the FTC to apply "rule of reason" analysis to collective negotiations by independent physicians and would establish at least six demonstration projects to study the effects of such arrangements on competition.\textsuperscript{66}

Advocates of market competition in the health care industry have expressed concern over this recent legislative activity. According to Thomas Greaney, "legislators' newfound interest in exempting collective bargaining is startling not only because it represents a substantial reversal of long-standing policy and legal precedent,...but also because of the thin justifications on which exemption rests."\textsuperscript{67} Among the "thin justifications" that Greaney disputes is the assertion that enhancement of physicians' bargaining position bolsters quality-of-care.

Organized medicine often has conflated quality concerns with medical ethics and economic self-interest. During the debate over the Campbell bill, for instance, the AMA argued that "the role of physician as patient advocate never has been more critical than in the current...
environment. Ironically, the antitrust laws—which were intended to protect the Davids of the world against the Goliaths—are having the opposite effect in the health care market, and are making it virtually impossible for many physicians to have any leverage with health plans over patient care issues. In *American Medical Association*, the AMA asserted that restrictions on advertising, solicitation, and contract practice were necessary to protect consumers and to ensure quality medical care; in *Michigan State Medical Society*, professional leaders justified their boycott of Blue Cross/Blue Shield and Michigan Medicaid, in part, because reduced fees would limit access and impair patient care; and in *Wilk v. American Medical Association*, the AMA claimed that concerns for patient safety warranted its boycott of the chiropractic profession.

As I discovered in my research concerning the passage of patient protection legislation in Wisconsin, political coalitions mirror the relative importance that groups place on the goals of access, cost, and quality. Because the public most closely associates physicians with quality care and MCOs with cost control and efficiency, the political clout of organized medicine, and its corresponding role in the governing framework, depends, to some extent, on the location of quality on the national agenda. The release of the Institute of Medicine's report on medical errors in late 1999, coupled with the perception that health care costs were under control and the public was unhappy with managed care, triggered consideration of reform legislation, including the Campbell bill. The emergence of quality care on the national agenda alongside access to care and cost containment bodes well for organized medicine. Physicians and their
professional associations will regain some of their political stature so long as quality is a key concern. But organized medicine must adhere to professional norms and values. Because the political fortunes of physicians depend on successful collaborations with other actors, they risk losing "goodwill" if the public perceives that economic interests predominate.

**Increasing Leverage in Contract Negotiations**

In the early 1990s, many experts believed that independent physicians, hospitals, and insurers eventually would merge or consolidate, forming integrated systems that delivered health care in an efficient manner at a reasonable cost. They also believed that physician-hospital organizations (PHOs), independent practice associations (IPAs), and management services organizations (MSOs) were transitional means for accomplishing this objective. But vertical or centralized forms of integration (i.e., asset purchases and employment relationships) did not transpire as predicted, and there are strong indications that the entire process has reversed course. Some point to disintegration, while others postulate more complex arrangements that feature contractual linkages rather than ownership of physicians' practices.

There are two important reasons why integrated delivery systems did not materialize as predicted. First, full integration did not give health plans the flexibility to succeed in markets characterized by diverse consumer preferences and provider entities. Health plans could ensure consumer choice and could respond to market change and innovation if they did not enter into exclusive contracts with or own provider groups.

Second, most physicians were not comfortable with corporate arrangements and management practices that reduced their independence or interfered with their clinical autonomy. Many physician practice management corporations (PPMCs) failed during the

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76 Furrow, supra note 28, at 878-884.
77 Id.
78 Bazzoli, supra note 75, at 191.
79 See Furrow, supra note 28, at 879.
80 Bazzoli, supra note 75, at 195; Robinson, supra note 15, at 79-80.
81 Robinson, supra note 15, at 79-83.
82 Id. at 174; Budetti, supra note 17, at 208.
1990s, and, more recently, IPAs and PHOs also have faltered. Though poor management may have contributed to the demise of some of these entities, medical practice appears ill-suited to global capitation and bureaucratization. In the words of David Blumenthal, director of the Institute for Health Policy, MGH/Partners Health Care System, Inc.: "Investors assumed the work of physician offices could be standardized and franchised, but the complexity of clinical decision making and physicians' natural distrust of outside managers have made that difficult." 

Health markets, in general, remain in flux, and instability among provider groups is a common feature. Instability occurs when doctors and hospitals leave, or threaten to leave, a particular health plan, creating uncertainty and confusion for consumers. Upon visiting twelve communities throughout the United States, researchers associated with the Center for Studying Health System Change (HSC) found that in more than half of the communities (Boston, Greenville, S.C., Miami, Northern New Jersey, Orange County, Calif., Phoenix, and Seattle) hospitals and physicians were embroiled in contract disputes with managed care organizations. The same is true in Northeastern Wisconsin where Oshkosh physicians, affiliated with Aurora Health Care, based in Milwaukee, recently severed ties with Touchpoint Health Plan, located in Appleton. In most of these cases, disputes typically involved "payment levels, financial risk-sharing arrangements and accuracy or timeliness of payments." 

Some observers believe that these events signal a shift in the
balance of power from health plans to providers. Among them are the HSC's director of site visits, Cara Lesser. She concludes that "a number of market forces--including the managed care backlash, consumer demand for broad choice of physicians and hospitals, rising medical costs, increased provider consolidation and newly emerging inpatient capacity constraints--are converging to give many providers the upper hand in contract negotiations." According to Lesser, "Managed care as we knew it in the early and mid-1990s appears to be in retreat in both the commercial market and public programs. With growing provider clout and increasing resistance to risk-based contracting, there seems to be a move 'back to the future' in the financing and delivery of health care." 

In addition to these observations, there are other indications that physicians are regaining their competitive edge. First, there is growing recognition that "locally-owned, physician-run, and rationally-sized" organizations are best able to survive in a competitive market. Indeed, in many communities that HSC surveyed, including Syracuse, N.Y., Greenville, S.C., Lansing, MI, and Miami, solo or small-group practices predominated, just as larger entities organized to manage physicians' practices faltered because capitated contracts with health plans failed to pay dividends. Second, doctors are building ambulatory surgery centers (ASCs) and specialty hospitals that garner higher profits for them and compete directly with traditional hospitals for patients. In Phoenix, for example, many specialists own ASCs and demand high fees from hospitals in order to provide emergency services.

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92Lesser, supra note 84, at 4.
98Lesser, supra note 84, at 3.
99Id.
room care. Third, some doctors are leaving managed care altogether and are starting so-called "concierge practices" that cater to patients who can afford to pay out-of-pocket in exchange for more personalized care (house calls, etc.).

Finally, as health costs increase, yet physicians remain unwilling to negotiate with health plans to share risk or reduce fees, large employers may bypass HMOs altogether and enter into contracts with provider groups. These so-called "disintermediated plans" permit employees free choice of provider under financing arrangements similar in nature to medical savings accounts. Disintermediated plans represent the antithesis of HMOs and, in effect, would foster a return to fee-for-service medicine and provider control of service delivery.

CONCLUSION

The evidence supports the belief that physicians and their professional associations are regaining political clout and economic leverage. Because it is likely that doctors will have a strong stake in the emerging market for health care services, decision makers must consider their interests, as well as those of consumers, insurers, and MCOs. Many prominent researchers and analysts now believe that health plans often have overlooked or have paid inadequate attention to issues of importance to physicians in discussions concerning integration. The implications are that physicians are resisting pressures to merge with health plans and institutional providers, and they increasingly are vocal in their disputes with MCOs.

Two central themes resonate in this context. The first is that the devolution of policy making from federal to state and local governments, outward to the private sector, and outside the regulatory box strengthens the authority of the medical profession. Absent a national health policy that favors corporate medicine, physicians will collaborate with consumers to promote patient-focused, rather than population-based, care; absent public pressures to integrate,

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101 D. Friedman, Dr. Levine's Dilemma, N.Y TIMES MAG. (May 5, 2002).
102 J.V. Jacobi & N. Huberfeld, Quality Control, Enterprise Liability, and Disintermediation in Managed Care, 29 J.L., MED. & ETHICS 311 (2001).
103 Budetti, supra note 17, at 208.
independent physicians and small group practices will flourish; absent federal resistance, physicians will collaborate among themselves to further self-regulation and to oppose managed care.

Medical practice and corporate management are uneasy partners. The health care industry is labor intensive, information is imperfect and asymmetrical, patient care often is of an emergency or semi-emergency nature, results are ambiguous, there is a high degree of specialization, and physicians are difficult to control. Physicians and consumers have resisted corporate bureaucracy, not only because physicians distrust external oversight, but also because consumers value personalized care.

The second theme concerns the emergence of quality on the health care agenda. Though health systems instituted treatment protocols, practice guidelines, and other devices to enhance quality, patients reacted adversely to perceived threats concerning their choice of provider and interference with medical judgment. Most of these concerns, often fueled by physicians, stemmed from utilization review, gatekeeper strategies, and financial incentives placed on doctors to limit medical services. Patients viewed physicians as their advocates against cost-conscious and profit-hungry HMOs. The so-called "managed care backlash" that gained momentum during the 1990s led to legislation that was intended to protect consumers, but also favored physicians, such as any-willing-provider laws, restrictions on gag clauses in managed-care contracts, and prompt payment laws. Capitalizing on this momentum, physicians and their professional associations backed an antitrust exemption that would allow independent practitioners to bargain collectively with MCOs. Though most attempts to enact such legislation thus far have failed, federal and state agencies have relaxed their regulatory restrictions on forming physician networks, as well as their efforts to enforce existing laws.

Concerns about the commercialization of medical practice also have augured court opinions. Though the Supreme Court rejected the "learned professions" exemption in Goldfarb, it indicated in footnote 17 that professions might receive special treatment under the antitrust laws. But until the norm of quality achieved prominence on the

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national agenda, the courts rarely invoked professional norms and values to justify anticompetitive activities. The Supreme Court's decision in *California Dental* resurrects footnote 17 and, at least, bolsters the claim that ethical restrictions on commercial practices deserve special consideration for reasons related to quality of care.

The resurgence of professional power and authority has broad implications for future health policy. Despite a more fragmented profession than existed in the era before managed care, physicians and their professional associations have acquired the capacity to respond to political and economic challenges to their interests and beliefs. They are more sophisticated in their business dealings, they are more effective in their political collaborations with consumer groups, and they have gained bargaining leverage with MCOs. By the same token, MCOs are not in the same position that they once were. They are no longer a novelty; their techniques have been tried and tested--some work and some do not; much of the savings from managed care already has been extracted from the health care system in the form of reduced duplication and fees, and the standardization of certain clinical protocols and procedures; finally, the public is less tolerant of high corporate earnings at the expense of patient care.

But enhanced professional authority should not eclipse the economic principles that managed care represents. As Rosemary Stevens asserts, "making managed care the 'fall guy' for necessary (and overdue) rationalization of the medical marketplace seems misguided, even counterproductive, as a long-range strategy for any actual or would-be policy group." Many physicians, moreover, are owners and managers of MCOs. Rather than counter managed care, medicine should collaborate and participate in a health-policy debate that frequently has neglected professional values and concerns. Because the federal government and business again must stem rising costs and decreasing access to care, medicine has a fresh opportunity to engage in the policy-making process.

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105 Stevens, *supra* note 4, at 340.