The Corporate Transformation of Medical Specialty Care: The Exemplary Case of Neonatology

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I. Introduction

With new, effective, and expensive health care services, the American health care sector has become an even greater source of business and wealth opportunities. All kinds of health care providers and suppliers are competing for patients and dollars. The key to wealth in today's health care sector is the physician. Only physicians can certify to third-party payers that health care services, medical devices, or pharmaceutical products are necessary for patient care. That certification initiates the process by which the item, service, or treatment modality is ordered, delivered, and paid for. Thus, organizations that can exert control over physicians stand to gain financially.

Increasingly, more entrepreneurial physician specialists are organizing their practices in for-profit corporations and employing other physicians. Focusing on the example of neonatology, this article describes the prevailing business model of these for-profit medical specialty groups as controlling their employed physicians through restrictive employment contract provisions. This article examines how the prevailing business model of for-profit medical specialty groups for the employment of physicians enables them to eliminate competition for specific specialty services to the detriment of patients and consumers.

II. For-Profit Medicine

Physicians have always had economic as well as professional motives in deciding what health care services should be provided to their patients. However, consolidation and employment of physicians into for-profit medical groups is different — a difference with important implications for American health care.

A. For-Profit Medical Specialty Groups and Their Business Model

For-profit medical groups have evolved particularly in the technology-intensive, hospital-based specialties such as radiology, anesthesiology, emergency medicine, and neonatology.[1] Several for-profit medical groups are on the Fortune 500 list of most profitable companies in the United States. Specifically, US Oncology, ranked 684th on the Fortune 500 in 2006,[2] is the nation's leading health care services network dedicated exclusively to cancer treatment. US Oncology is affiliated with over 900 physicians practicing in approximately 460 locations, including 85 outpatient cancer centers in 32 states.[3] Similarly, the Renal Care Group, ranked 937 on the Fortune 500 list for 2006,[4] operates renal dialysis units around the country and employs nephrologists and other physicians to staff them. The Renal Group operates 450 outpatient dialysis facilities and also provides acute dialysis services at more than 200 hospitals in a 34-state network.[5] In addition, Pediatrix Medical Group is the largest provider of pediatricians for hospital-based neonatal intensive care units and one of the fastest growing corporations in the nation.[6]

A major concern about for-profit medical groups is how they organize physicians through restrictive employment contract provisions.[7] Although employment contracts vary, contracts generally include the following provisions:

- Multi-year covenants-not-to compete in any hospital in which the for-profit medical group has a

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practice and within a specified distance from such a hospital.

- Covenants to use private arbitration to resolve any dispute with the for-profit medical group.

The employed physicians generally have little voice in the management of the corporation. Indeed, some physicians employed by corporations have complained about being commodities in the business of health care. As one physician observed:

> A progressively increasing number of physicians are employed by large medical groups, hospitals, managed care organizations, or health maintenance organizations. Progressively fewer physicians ever become partners in or owners of these corporations. More often than not these organizations are run by businessmen, at times physician-MBA's, but rarely by actively practicing physicians. Healthcare has become first and foremost a business, and physicians are now seen as a resource to be exploited and profited from if possible. In the world of business, any resource that ceases to be profitable becomes a liability. As I see it, physicians have become the newest healthcare commodity and the practice of medicine as a profession has been replaced by a business model driven by profit or loss.[8]

These contract provisions are legal and widely used.[9] Indeed, they are included in employment contracts throughout the economy and not just in physician employment contracts. Their use has raised questions about the appropriateness of limiting employees from invoking the protections of state and federal law in employment disputes.[10]

In most states, a covenant not-to-compete is reasonable and thus enforceable if it is no broader than necessary to protect a legitimate interest of the employer and does not unduly burden the employee nor harm the public.[11] The American Medical Association (AMA) had historically banned covenants-not-to-compete as unethical in the 1930s, only to reverse this policy in 1960.[12] Since then, AMA ethics have permitted such covenants but have always expressed a sense of concern about their harm to the public.[13] Of note, there has been much concern expressed about the impact of these covenants on physicians and their mobility,[14] and the particular hardships imposed when physician practice management groups fail.[15] At least one court refused to enforce a restrictive covenant on grounds that enforcement would have created at least a temporary monopoly even though the covenant itself was valid under state law.[16]

Agreements to arbitrate have long been part of the landscape of dispute resolution schemes at both the state and federal level. The Federal Arbitration Act allows for an alternative forum for litigants of equal bargaining power and preempts state law that would preclude enforcement of agreements to arbitrate in state court.[17] Today, agreements to arbitrate are included in a wide array of contracts from rental car agreements to employment contracts.[18]

Further, arbitrators have great latitude in making decisions. Because of the extraordinarily low standard of review given to arbitration awards, legal and factual errors in arbitration may not be reversed on appeal even though the identical errors would cause reversal in a trial court.[19] Consequently, an ultimately binding arbitration agreement may not be consistent with the law of the relevant jurisdiction.

B. The Evolution of For-Profit Medical Care

The health care sector today is very different than in the 1980s, the twilight years of lucrative provider payment by third-party payers that rewarded physicians and hospitals for the charges providers set for their services. Indeed, the third quarter of the 20th century could be characterized as a period of physician dominance of health care delivery in the United States. Physicians and hospital medical staffs dominated the management of hospitals. Both public and

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private third-party payers were deferential to physicians' judgments as to what was reasonable and necessary care warranting reimbursement. Also, rising academic medical centers fueled the growth of medical specialties and the advances in medical technology that have transformed medical care.[20]

However, health sector costs rose sharply and steadily, and large proportions of the U.S. population had no health insurance. After the federal government became involved with the provision of health insurance for the elderly, poor, and disabled through the Medicare and Medicaid programs in 1965 and considered public programs for universal coverage, the federal government and states became very interested in health reform. Private payers were increasingly interested in controlling health care expenditures as well.[21]

Of interest, the number of physicians in practice who are employees jumped from 24 percent in 1983 to 43 percent in 1997.[30]

Finally, under the radar screen, state and federal courts along with state and federal policymakers retreated from the corporate practice of medicine prohibition in its various incarnations. The corporate practice of medicine doctrine is a principle of state law established in case law or state medical practice statutes that forbids corporations to employ physicians and engage in medical practice.[31] In recent years, believing that it inhibited rational reorganization of the health care sector, many states have abandoned or sharply limited the doctrine.[32]

Federal antitrust orthodoxy seems powerless to address the anticompetitive conduct of physicians, hospitals, and other players that damage competition in the health care sector. Indeed, the current antitrust orthodoxy seems to facilitate the organization of physicians into for-profit medical groups and enables these groups to consolidate monopoly power.

1. THE FALL OUT OF FAILED PUBLIC HEALTH REFORM INITIATIVES

In the 1980s, third-party payers changed the way they paid providers in ways that shifted the financial risk of inefficient and excessively costly care onto the provider rather than the payer.[22] In response, individual hospitals became multi-hospital systems and combined with other collaborative arrangements to achieve efficiencies and increased revenues through expanded control over their medical staffs.[23] Hospital systems took greater interest in economic performance of physicians in credentialing decisions.[24]

Due to the pressures of managed care in the 1990s, health care providers have become much more commercial in the way they do business and have often joined in ways to bargain more effectively with third-party payers.[25] As health care delivery became more integrated, physicians joined HMOs or formed their own organizations to compete more effectively for health care dollars.[26] These organizations include practice management organizations[27] and for-profit medical groups.[28] One observer aptly described the phenomenon this way: "As a result, many specialists are joining single-specialty organizations, creating monopolies for specialists' services within regional markets and gaining a better price for their services."[29]

2. THE INADEQUACY OF HEALTH CARE ANTITRUST ORTHODOXY

In the 1980s, the Supreme Court eliminated the historical immunity of health care providers from the application of the federal antitrust laws[33] and thereby imposed commercial competition rules on health care providers.[34] However, the application of federal antitrust laws to medical care markets is incomplete. Physicians moved quickly to blunt the application of the federal antitrust laws in the Health Care Quality Improvement Act of 1985.[35] And judicial decisions and federal policy limited the role of antitrust laws in the reorganization of the health care sector.[36] Consequently, federal antitrust orthodoxy seems powerless to address the anticompetitive conduct of physicians, hospitals, and other players that damage competition in the health care sector. Indeed, the current antitrust orthodoxy seems to facilitate the organization of physicians into for-profit medical groups and enables these groups to consolidate monopoly power.

Exclusive Contracting under the Antitrust Law. One useful vehicle for consolidating power over a market for specialty care services is exclusive contracting with hospital systems. Given the green light by the United States Supreme Court in *Jefferson Parrish Hospital District No. 2 v. Hyde*[37] — in which an anesthesi-

ologist unsuccessfully challenged an exclusive contract between a hospital and an anesthesiology group as an illegal tying arrangements under the federal antitrust laws — exclusive contracting arrangements between hospital systems and medical specialty groups have prevailed throughout the country.[38]

Since the seminal *Hyde* decision, courts have disfavored antitrust lawsuits brought by individual physicians under the antitrust laws.[39] The federal antitrust laws, designed to protect free competition in the market place, appear to offer little protection to competition in the market for medical services when the requisite antitrust conspiracy is between a multi-hospital network and a for-profit medical practice group.

With physicians as employees bound by restrictive contracts, for-profit medical groups are well positioned to enter lucrative exclusive contracts with hospital systems to provide specialty services within the hospital system. Because they employ physicians, the for-profit medical groups can provide services more cheaply than physicians organized in traditional medical practices. The hospital systems are willing to work closely with the corporate medical practice groups because they value the low price and efficient delivery of the services of the corporate medical group.

The Health Care Quality Improvement Act of 1985 (HCQIA). Another aspect of the antitrust orthodoxy that contributes to the dominance of corporate medical groups is the Health Care Quality Improvement Act of 1985.[40] HCQIA requires that professional review actions be taken only in "the reasonable belief that the action was in the furtherance of quality health care," and also "after a reasonable effort to obtain the facts of the matter," and with adequate and fair notice and process.[41] Courts have interpreted this language quite strictly, making it extremely difficult for a physician to establish non-compliance with these provisions.[42] However, only litigation by the targeted physician is available to ensure compliance with HCQIA's protections. In litigation, however, physicians are confronted with the HCQIA provision that professional review actions "shall be presumed to have met the statutory standards unless the presumption is rebutted by a preponderance of the evidence."[43]

Of interest, the HCQIA was enacted following a successful $2.28 million verdict for treble damages in a federal antitrust suit brought by a physician who had left a practice and opened a competing practice.[44] Members of the peer review committee that revoked his privileges at the community hospital were his competitors. Following this verdict, medical and hospital associations lobbied Congress hard to obtain immunity under the federal antitrust laws for physicians engaged in peer review activities.[45] The Federal Trade Commission, the Department of Justice, and the House committees overseeing the federal antitrust laws vigorously opposed.[46] The HCQIA also established the National Practitioner Databank to which serious malpractice judgments and settlements as well as disciplinary actions by hospital peer review committees against physicians and dentists must be reported to and maintained by the federal government.[47]

The HCQIA and similar state laws that accord civil immunity in antitrust and other legal actions to participants in peer review proceedings may encourage abuse by effectively shielding peer review participants

Figure 1

Cost and Economic Burden of Neonatal Care in the United States, 2005

Item	Amount
Total Annual Societal Economic Burden	$26.2 billion
Annual Societal Economic Burden per Preterm Newborn	$51,600
Total Annual Cost of Medical Services	$16.9 billion
Annual Cost of Medical Services per Preterm Newborn	$33,200
Total Annual Maternal Delivery Costs	$1.9 billion
Annual Maternal Delivery Costs per Preterm Newborn	$3,800
Total Annual Early Intervention Services Costs	$611 million
Annual Early Intervention Services Costs per Preterm Newborn	$1,200
Total Annual Special Education Services Associated with a Higher Prevalence of Four Disabling Conditions, Including Cerebral Palsy, Mental Retardation, Vision Impairment, and Hearing Loss	$1.1 billion
Annual Special Education Services per Preterm Newborn	$2,200
Annual Lost Household and Labor Market Productivity Associated with Those Disabling Conditions	$5.7 billion
Annual Lost Household and Labor Market Productivity per Preterm Newborn	$11,200

Source: Behrman & Butler, footnote 54.

from legal liability. Much evidence suggests that hospital peer review proceedings have been used to punish competitor physicians or physicians who have objected to hospital policies on grounds of safety and quality concerns.[48] One journalist has described numerous sham peer review proceedings around the nation in a notable series of newspaper articles.[49] The problem of sham peer review was featured in *Time* magazine,[50] and a recent editorial in the *Journal of the American College of Cardiology* decried this phenomenon.[51] There have also been a few spectacular jury verdicts and court decisions in favor of physicians damaged by inappropriate peer review proceedings.[52]

in more economically well-off population groups. Specifically, in 2003, according to the Centers for Disease Control and Prevention, the highest rates were for non-Hispanic African Americans (17.8%), and the lowest were for Asians or Pacific Islanders (10.5%).[56] Additionally, from 2001 to 2003, the most prominent increases were for Hispanic groups as well as white non-Hispanics and American Indians.

This high rate of premature births in the United States constitutes a public health concern that costs society.[57] The Institute of Medicine estimated that the cost of prematurity in the United States was $26.2 billion in 2005.[58] A major proportion of these expenses

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are associated with the lifetime care of seriously disabled survivors.[59] Figure 1 shows the estimates of the Institute of Medicine on the cost of neonatal care in its seminal report. Of note, in 1992, the *Wall Street Journal* reported on the high cost of neonatal care.[60]

III. The Exemplary Case of Neonatal Intensive Care

Neonatal intensive care provides an excellent example of the potential problems with for-profit corporate medical specialty groups, and their business model for organizing physicians can pose for American health care. The nature of neonatal care, the characteristics of the people most in need of these services, and the ethical issues associated with these services dramatically demonstrate the issues associated with for-profit corporate medical care. As noted by one observer:

> A notable example of the conspicuous and eventually unsustainable disconnect between input and outcome is found in neonatal medicine. This relatively new specialty invented itself in the 1960s and grew very rapidly, particularly in the United States, with no thought given to overall limits and goals.[53]

There is plenty of business for a for-profit corporate provider of a hospital-based neonatal care. According to the Institute of Medicine, 12.5 percent of births in the United States were preterm (less than 37 weeks gestation) in 2005[54] and rate of low term births is increasing.[55] The incidences of low-term births is higher in more disadvantaged populations and lower

Neonatal care routinely poses unique clinical, economic, and ethical considerations because outcomes of neonatal intensive care are highly unpredictable, particularly for the smallest babies.[61] Because of this uncertainty, medical decision-making in the management of severely premature infants is often problematic and includes difficult issues of whether to initiate care[62] and to terminate care.[63] Very low weight babies often incur serious, lifelong disabilities that require care for many years.[64] Specifically, empirical research suggests that approximately 30 to 50 percent of surviving children who weighed less than 750 g at birth or whose gestational age was less than 25 weeks had a moderate or severe disability, including blindness, deafness, or cerebral palsy, and many had more than one such disability.[65]

Poor decisions can result in incredible burdens for these infants and their parents. Neonatal care can be catastrophically expensive for families.[66] Many families do not have adequate or any health insurance to pay for neonatal intensive care and are strapped with large medical bills that take years to pay off.[67] Of note,

unlike many other health care services, Medicaid, a publicly funded welfare program for the poor and disabled, pays the expenses for 41.3 percent of all live births in the United States.[68]

Yet parents are not always in an ideal position to participate in the decision-making process that affects them so profoundly. Empirical evidence also suggests that parents and neonatologists have very different views on whether to proceed with care in questionable cases.[69] One commentator eloquently describes the dilemma for many parents and their babies:

> [P]arents, struggling to rear severely retarded children born after extreme prematurity, protest that they were "made to feel like criminals for questioning" heroic medical treatment. Doctors are "out of touch with the harsh realities of our children's lives," they complain. "Where," they ask, "is a description of the months or years of grueling hospitalization with the associated gastrostomy tubes, jejunostomy tubes, and fundoplications; the tracheostomies, shunts, orthopedic, eye, and brain surgeries; hyperalimentation, oxygen tanks, and ventilators?" Similarly, medical accounting fails to recognize the frequency of emotional and financial breakdown in families caused by the extreme burdens of caring for developmentally retarded children with superimposed severe medical problems.[70]

Yet neonatal intensive care is a great source of revenue for hospitals as well as physicians. Many hospitals, even non-tertiary hospitals in rural areas, have established neonatal intensive care nurseries.[71] Some evidence suggests that there may be more neonatal intensive care units and neonatologists than are needed to prevent the death of high-risk newborns in most of the United States.[72] In a recent commentary in the journal *Pediatrics*, Dr. William Silverman suggested that because neonatal intensive care centers had become such a great source of revenue for hospitals, "opportunism" replaced compassion as the primary motivation for neonatologists in the care of patients.[73]

Finally, the United States compares poorly to other nations. Compared with the three other industrialized, English-speaking countries, the United States has more neonatal intensive care resources yet provides proportionately less support for preconception and prenatal care.[74] (See Figure 2.) Some evidence suggests that the provision of neonatal care is more rational in other countries without the sacrifice of good outcomes.[75]

Pediatrix Medical Group is an increasingly dominant for-profit corporate medical group providing hospital-based neonatal services. Starting as a practice with two Floridian pediatricians in 1979,[76] Pediatrix is now the nation's largest provider of maternal-fetal-newborn care and is traded on the New York Stock Exchange.[77] According to its annual report to the Securities and Exchange Commission,[78] the Pediatrix network has over 800 affiliated physicians, including over 600 neonatal physician specialists and other hospital based pediatric specialists. Pediatrix has contracts, which are generally exclusive, to provide clinical care in 32 states and Puerto Rico. Pediatrix physicians staff and manage clinical neonatology services at more than 240 hospitals. Pediatrix has also founded a similar corporate medical group for hospital-based obstetrics called Obstetrix Medical Group.[79]

Pediatrix employs most of its physicians. Indeed Pediatrix advertises regularly in major pediatrics journals pitching an opportunity to practice without business hassles. Pediatrix Medical Group requires employed physicians to enter contracts with the following provisions:[80] (1) a two-year covenants-not-to-compete in any hospital at which Pediatrix provides services or has an affiliated physician on its staff,[81] and (2) covenants to agree to resolve any disputes with Pediatrix through private arbitration from a specified arbitration services such as that of the American Health Lawyers Association.[82]

Of note, Pediatrix has also been the subject of several state and federal so-called fraud and abuse inves-

Figure 2

Comparative Neonatal Care Capacity and Outcomes, 1993–2000

	U.S.	Canada	U.K.	Australia
Neonatologists per 10,000 live births	6.1	3.3	2.7	3.7
Intensive Care Beds per 10,000 live births	3.3	2.6	0.67	2.6
Relative Risk of Neonatal Mortality for Infants Less Than 1000 g (U.S. as reference)	1	1.12	.99	0.84
Relative Risk of Neonatal Mortality for Infants between 1000 g and 2499 g (U.S. as reference)	1	1.26	.95	.97

Source: Thompson, Goodman & Little, footnote 74.

tigations regarding its billing practices and has paid settlements to the government to resolve these investigations.[83] It is troublesome that this for-profit medical group has come to the attention of fraud and abuse regulators in many of the states in which it does business. This phenomenon suggests Pediatrix aggressively pursues profits at the expense of a publically subsidized health insurance program for the poor.

IV. Is For-Profit Medicine Good for American Health Care?

In 1982, sociologist Paul Starr predicted the phenomenon in his seminal work, *The Social Transformation of American Medicine*.[84] He described increased economic power of physicians with the influx of funding for health care delivery through ever more private and public health insurance. He also predicted that either government or the private sector would ultimately rationalize the economics of medicine:

> The failure to rationalize medical services under public control meant that sooner or later they would be rationalized under private control. Instead of public regulation, there will be private regulation, and instead of public planning, there will be corporate planning. [85]

Since the 1980s, Professor Starr's predictions have indeed come to past. Rationalization of medical services in the United States has proceeded largely under private rather than public control. The federal government failed to enact comprehensive single-payer health insurance in the 1970s or managed competition in the 1990s that would have regulated providers of health care and sharply transformed the role of private health insurers and HMOs.[86]

In 1995, when managed care organizations were moving to control physician practices, an editorial in the *New England Journal of Medicine* — entitled "Extreme Risk — The New Corporate Proposition for Physicians" — decried the contractual terms that the physician authors had with one HMO,[87] such as maintaining the confidentiality of the agreement. The editorial raised concerns that managed care organizations were imposing limits on member physicians' practice in the interest of generating corporate profits that did not go back into patient care. Where is the hew and cry of physicians and their organizations today about for-profit medical groups employing physicians through comparable restrictive contracts? Arguably, the use of such provisions in physician employment contracts by for-profit medical specialty groups poses similar if not greater risks to the clinical freedom of their employed physicians.

Pediatrix has also been the subject of several state and federal so-called fraud and abuse investigations regarding its billing practices and has paid settlements to the government to resolve these investigations. It is troublesome that this for-profit medical group has come to the attention of fraud and abuse regulators in many of the states in which it does business. This phenomenon suggests Pediatrix aggressively pursues profits at the expense of a publically subsidized health insurance program for the poor.

A. A Bad Business Model

The business model for the employment of physicians used by for-profit medical specialty groups is not good for the health care sector. Historically and ethically, physicians should serve as advocates of their patients.[88] Restrictive employment contracts sharply limit the ability of employed physicians to take positions or actions that are contrary to the policies and interests of their for-profit employers. Employed physicians cannot easily break their employment arrangement without leaving the geographic area to find new work. If they have a dispute with their employer, the dispute goes to private arbitration. Because of the flexibility of arbitrators in applying law and procedure, physicians lose the guarantees of state and federal law. With these constraints, the employed physician has little liberty to advocate for patients if such advocacy is adverse to the interests of the for-profit medical group employer.

Another undesirable ramification of this business model and its operation in the current antitrust environment is the abuse of peer review. For-profit medical groups working with the hospitals can use and have used peer review to go after physicians who leave the practice or otherwise fall into disfavor.[89] They can do so with impunity since the Health Care Quality Improve-

ment Act of 1986 and state law accord antitrust and state tort law immunity to physicians engaged in peer review for any peer review activities.

Further, the combined effect of non-compete covenants in physician employment contracts and the widespread use of exclusive contracting between corporate medical groups and hospital systems damages competition in the market for medical specialty services. Bound physicians are precluded from offering services in the same or neighboring hospitals for a significant period of time even though their services might be of higher quality or lower prices.

With hospital systems locked up with exclusive contracts and their own physicians under tight control, a for-profit medical group that controls the practice of a specialty in a wide geographic area can move more easily to control the delivery of particular medical services in that area. They are in a better position to raise prices and eliminate unprofitable service delivery venues once they have consolidated their market. In this eventuality, consumers are left with fewer choices and higher prices.

However, the markets for medical specialty services, generally and specifically neonatal intensive care services, are not conventional free markets: they are highly subsidized by government programs and tax expenditures.

Public health insurance programs financed the great proportion of medical care in the United States.[92] A third of the insured are insured through public health insurance programs.[93] Pricing of services is based on the assumption that most patients, particularly recipients of expensive, technology intensive care, will have health insurance. Also, well over three-quarters of American hospitals in the United States operate as either not-for-profit or public corporations and are thereby exempt from government taxation.[94]

Furthermore, there is great public investment in the training of physicians. This investment includes costly education and training — $140,000 for public schools and $225,000 for private schools[95] — and this does not even include post-graduate training for specialties. It seems contrary to sound policy to permit for-profit medical groups to restrict the mobility of physicians in the market for physician specialty services in order to protect the competitive position of the for-profit medical group.

Current law allows for-profit medical groups to consolidate market share through the business model of employed physicians, which enables the for-profit medical groups to control their physicians and eliminate their competition. Ineffective antitrust protections facilitate the ability of for-profit medical groups to generate and consolidate their market share, eliminate competition, and obtain greater profits from public subsidies without effective regulatory or judicial oversight.

B. The Fact of Market Failure and Publically Subsidized Health Care

The current reality is that physician services are delivered and paid for in the context of colossal market failure. Over 16 percent of the U.S. population has no health insurance and even more have inadequate health insurance.[90] And costs of health care services are rising, thus threatening the ability of individuals and the sponsors of their health insurance — be they private employers or public programs — to continue providing affordable health care coverage.[91]

Under conventional economic theory, non-compete clauses, arbitration agreements, exclusivity contracts, and certain legal immunities are trade restraints that limit free competition in the market place. Nevertheless, they might be appropriate if physician specialty services or insurance coverage for these services were readily available to consumers at an affordable price.

Under prevailing economic principles, public subsidies and not-for-profit business organizations are techniques to adjust for market failures to ensure that goods and services of perceived essential value are available to the public at a reasonable price or even for free. Such extraordinary steps are justified because the goods and/or services provided in the failed market are of perceived essential value and must be available to all. Commerce in physician services does not operate as a free market in which for-profit firms compete for quality and prices in a competitive market and are able to provide high quality, affordable products without public subsidies. In highly subsidized markets in essential goods, it is unseemly that business should be able to raise extraordinary profits and gain broad mar-

ket power through commercial contractual restraints and lax antitrust orthodoxy. But that is exactly what is happening today with for-profit medical groups.

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The case of for-profit neonatal intensive care aptly demonstrates the problems with today's flawed market for medical specialty services. One problem is the burden of neonatal intensive care that often falls on the poorest members of society and the public programs that support them. Public funds through the Medicaid and State Children's Health Insurance Programs program for the poor (financed with federal and state tax revenues) and private health insurance (financed largely with federal tax expenditures)[96] heavily subsidize the market for neonatal care. The difficult ethical dilemmas associated with determining the extent of medical care for preterm infants also reveal the problematic nature of for-profit medical care. One issue is whether decisions about medical treatment of individual infants as well as the allocation of neonatal services are influenced by the for-profit mission of generating profits for shareholders. A second issue is whether it is appropriate to generate "profits" for shareholders rather than pump excess revenues back into the delivery of neonatal care. Finally, do these contractual restrictions on physicians limit their ability to advocate for clinical decisions that might not be consistent with the corporate policy of the for-profit medical specialty group?

C. Proposed Reforms

The major purpose of this article is to identify and describe the flawed nature of the market for physician specialty services and the deleterious impact of the business model of for-profit medical specialty groups. It is beyond the scope of this article to specify reforms to address these deficiencies in great detail. Nevertheless, some reforms of current law seem worth exploring to address the dysfunctional business model of many for-profit medical groups.

First, states should consider legislation to eliminate or limit physician-non-compete clauses in physician employment contracts. These covenants only serve the commercial interests of powerful hospitals and medical practice groups corporations in their efforts to eliminate competitors and consolidate market share. They are harmful to patients and consumers, particularly if they encourage monopolistic practices of for-profit medical groups.

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Second, states and even the federal government should prohibit mandatory arbitration agreements in physician employment contracts. Arguably this is a broader problem of all employment relationships. However, the special nature of medicine may favor a targeted approach directed at physicians and for-profit medical groups. More importantly, they are potentially coercive in that they enhance the corporate power over the physician and potentially restrict the physician's ability to advocate for patients. They may also compromise access to needed care for consumers.

Third, federal lawmakers should revisit antitrust orthodoxy that tolerates anti-competitive activity through exclusive contracts. Although the *Hyde* decision suggests that there are limits to exclusive contract arrangements between a physician corporate practice and a hospital, those limits were not met in *Hyde* as the case involved one anesthesiology group with an exclusive contract with one hospital without the requisite impact on the market. But the *Hyde* case did not involve an exclusive contracting arrangement between a large hospital chain operating in a large geographic area and a large medical specialty corporation with contracts with nearly all hospitals in an even larger geographic area. Federal policymakers in either Congress or the Executive Branch might delineate circum-

stances when exclusive contracts affect the market for physician specialty services in anticompetitive ways.

Finally, Congress should repeal or fundamentally reform the peer review immunity provisions of the Health Care Quality Improvement Act as they provide shelter for competitors and for-profit medical groups to consolidate market share and, indeed, monopolize markets for physician specialty services. Considerable evidence suggests that this immunity has protected highly anti-competitive and tortuous conduct that has damaged the careers and lives of many physicians. There is insufficient justification for shielding hospitals and physicians from legal accountability for their peer review decisions. No other private commercial activity enjoys this kind of immunity.

V. Conclusion

Although the for-profit mode of business often achieves real efficiencies in controlling costs and ensuring affordable access to products and services, it does so most effectively when the regulatory environment limits anticompetitive and monopolistic conduct in a conventional-free market. Until for-profit health care providers as well as private health insurers can figure out how to design a market for health care services that assures access to affordable health care services either for direct purchase or through affordable insurance, it is inappropriate for for-profit medical groups to operate under legal regimes that permit them to consolidate their markets, eliminate competition, and generate greater profits from their services. No other market in the U.S. economy — except defense and possibly education — is so highly dependent on public funds for the economic returns to its producers. Financing and delivering medical specialty services through for-profit structures, which capture excess revenues as profit for shareholders rather than funds to reinvest in expanding access and reducing costs of public programs, is problematic. The expectation of profit is only appropriate when the economic actors in a market are able to provide goods and services at affordable prices for all who seek to purchase goods and services and without public subsidies.

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