THE TEXAS COLLECTIVE BARGAINING STATUTE:
GIVING A TOOTHLESS STATUTE SOME BITE

V. Denise Rose

INTRODUCTION

An 18-year old girl visits her family doctor for her annual exam. She has seen this doctor for ten years and she is familiar with the doctor, so the procedure is not horribly uncomfortable. Her doctor chats with her, asks about her college plans, and answers her questions. Two years later, her doctor has left the girl’s parents’ health plan, and the girl now sees a new doctor for the same procedure. This doctor is in and out of the exam room in fifteen minutes. She has no time to answer the girl’s questions. The doctor does not ask how college is going for her. The girl feels like part of an assembly line. The following year, the girl’s parents change health plans for the sole purpose of returning to their old doctor. The family’s Health Maintenance Organization (HMO) will not allow visits to doctors who are not included on that particular health plan. The new health plan is a Preferred Provider Organization (PPO), and the parents must now pay much higher co-payments and deductibles.1

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But the girl and her family can see their old doctor again. Their
doctor tells them she had to leave the HMO because she could not
practice medicine effectively. The doctor asks the girl about college
and lets her observe at the office when the girl thinks she wants to
attend medical school. Today, the doctor asks the girl’s mother how
her daughter is doing in law school.

It was worth it to the girl’s family, but what of the families
who cannot afford to change health plans?2 These families are
forced to accept mediocre health care because their HMO will not
allow them to see the doctor of their choice.3 In turn, their current
doctor cannot refer them to a different physician and still must see
twenty-five more patients that day to meet his quota.4 What happens
when a doctor spends only fifteen minutes taking a patient’s
history and performing the necessary procedure because he has to
devote the majority of his time to paperwork?5 What about the doc-
tor who needs to send his patient to a specialist, but the HMO de-
nies his request because it will take away from that month’s
profits?6 What of the doctor who cannot voice his dissatisfaction
because he is considered an “independent contractor,” which allows
the HMO to fire him without cause?7

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2 See HealthChoice Website, supra note 2. Currently, for a family to switch health plans
under the Oklahoma State and Education Employees plan, it costs almost $100 more per
month. Id.

for therapy to treat her Lyme disease, and she could not afford to pay for the therapy
herself. Id. Four months elapsed before the therapy was approved and during this period
her condition worsened. Id. at *3. See also John P. Little, Note, Managed Care Contracts of
Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health, 49
RUTGERS L. REV. 1397, 1401-02 (1997) (noting the disputes that have occurred when Man-
gaged Care Organizations (MCOs) have delayed authorizing benefits for needed medical
treatments).

4 See Todd A. Lyon, Union Docs: The AMA, The HMOs, and Physicians’ Rights To Collectively

5 See David Noonan, An Ailing Profession, NEWSWEEK, Sept. 25, 2000, at 32-33 (noting the
time-consuming paperwork process required by most HMOs); see also Jeffrey Rugg, An
Old Solution To A New Problem: Physician Unions Take The Edge Off Managed Care, 34 COLUM.
J.L. & SOC. PROBS., 1, 2-3 (2000).

6 See Little, supra note 4, at 1400-01 (citing Thomas S. Bodenheimer & Kevin Grumbach,
UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH (1995)).

7 See Denise Smith Amos, Medical Balancing Act: Doctors Weigh Patient Needs Against Insurers’
Rules, ST. LOUIS POST DISPATCH, Apr. 1, 1996, at 10. The author notes that doctors who do
To say that the state of health care in America is currently in disarray would be an understatement. Both physicians and patients are unhappy. Politicians win elections on health care reform platforms, but then remain silent. Legislators propose plan after plan, but fail to pass legislation that effectively changes anything. The uncertainty and growing limitations in the medical field have resulted in consistently lower numbers of applicants to medical school. One of the reasons given by medical schools for the lowered number of applicants is “the impact of managed care.” Meanwhile, HMOs and Managed Care Organizations (MCOs) continue to profit by limiting what doctors can and cannot do, severely reduc-

not comply with profit-maximizing policies are often terminated by the HMO. Id. See also Little, supra note 4, at 1416 (discussing “termination without cause” clauses).

See Rugg, supra note 6, at 12. The author quotes a Discovery Channel/Newsweek poll that states “sixty-one percent of Americans are frustrated and angry with the state of health care” and that physicians too are “frustrated,” often leaving the profession altogether, or moving out of the country to practice. Id.

See id. (noting that seventy percent of Americans think the government should “do something” about the state of health care); see also Dionne Koller Fine, Exploitation Of The Elite: A Case For Physician Unionization, 45 St. Louis U. L.J. 207, 212 (2001) (citing a study in Modern Healthcare showing that morale amongst doctors was “low” and that they felt like they were “under siege”).

See Office of Congresswoman Kay Granger, 12th District of Texas, Issues, Healthcare and HMOs, at http://kaygranger.house.gov/issues.asp (last visited Jan. 9, 2003) [hereinafter Kay Granger]; http://clerkweb.house.gov/cgi-bin/vote.exe (last visited Jan. 9, 2003) [hereinafter Communications]. Congresswoman Kay Granger, Representative for the 12th District of Texas, states that one of her goals for health care reform is to “restore the doctor-patient relationship without dramatically increasing health care costs or increasing the number of uninsured.” Kay Granger. However, Congresswoman Granger did not vote on House Resolution 2723, the Bipartisan Consensus Managed Care Improvement Act, which eventually failed. Communications.


NCPA, supra note 13.
ing doctors’ abilities to treat patients in an effective manner, and jeopardizing the lives of patients.\textsuperscript{14}

In 2001, proposals appeared in various state legislatures and Congress after the failure of the Clinton Administration’s healthcare reform plan.\textsuperscript{15} The Texas Legislature introduced a bill allowing collective bargaining between physicians and HMOs and MCOs in an attempt to “level the playing field.”\textsuperscript{16} Collective bargaining technically does not unionize physicians, which is prohibited under the Sherman Antitrust Act, but allows physicians to band together to negotiate certain terms of managed care contracts with the respective HMO or MCO.\textsuperscript{17} For example, physicians may collectively bargain for alteration of restrictive contract terms that are “non-price issues,” such as requiring MCOs to specify administrative rules and procedures so they cannot be secretly changed. Although physicians may collectively bargain for the termination of contract procedures, they may not collectively bargain for increased fees or salaries.\textsuperscript{18}

Texas took a large step in 1999 as the first state to actually pass a collective bargaining statute, circumventing the antitrust laws that prevent this type of action.\textsuperscript{19} However, the complexity of the rules promulgated by the Office of the Attorney General, coupled with the tediousness and cost of the application to request to bargain with the health plan, led to a rarely utilized process.\textsuperscript{20} In addition,
the statute contained a sunset clause, making it moot on September 1, 2003.\textsuperscript{21} The statute made no impact and became invalid before it had a chance to show any results.\textsuperscript{22} While the statute may have been a good idea theoretically, it failed to give physicians equal bargaining power against MCOs and HMOs.\textsuperscript{23}

This comment discusses the problems with the collective bargaining statute, why it did not work in Texas, and why it would not work anywhere else unless its provisions are significantly altered. Part III-C will suggest changes that would improve a collective bargaining statute if a legislature were to enact similar legislation and alternatives to collective bargaining legislation.

I. BACKGROUND

A. The Emergence of Managed Care and Health Maintenance Organizations

MCOs and HMOs gained popularity in the early 1970s as a response to increasing health care costs.\textsuperscript{24} The government also contributed to the growth of these organizations by passing the Health Maintenance Organization Act of 1973.\textsuperscript{25} An HMO or MCO is loosely defined as "a type of health care financing and delivery that seeks to contain costs through using administrative procedures and granting financial incentives to providers and patients."\textsuperscript{26} It can also be defined as:

[\textit{Any health coverage arrangement in which, for a pre-set fee (i.e. the premium), a company sells a defined package of benefits to a purchaser, with services furnished to enrolled members through a network of participating providers who operate under written contractual or employment agreements, and whose selection and au-}

\textsuperscript{21} TEN. INS. CODE ANN. art. 29.14 (Vernon 2000).
\textsuperscript{23} See id. The author states that physicians "never have gained the power to force an HMO to bargain with them. . . ." Id.
\textsuperscript{24} See Fine, supra note 10, at 210 (citing Dennis A. Robbins, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES 5 (1998)).
thority to furnish covered benefits is controlled by the managed care company. 27

MCOS and HMOs are profit-making organizations which means they favor doctors and physician groups who treat patients as cost-effectively as possible, even if cost-effectiveness comes at the expense of a patient’s health. 28 MCOS make the most money when patients are seen in the least amount of time, and referred to the fewest numbers of doctors or specialists outside the health plan. 29 The government acknowledges that its motivation for the support and change over to MCOS was “cost reduction, not quality improvement. . .”30

However, cost reduction was not always the ultimate goal. 31 In the era of fee-for-services, a patient simply paid a doctor directly for the particular procedure the doctor performed. 32 Fee-for-service allowed physicians to set their own fees, provided they were reasonable, and also gave them strong bargaining power. 33 The introduction of HMOs and MCOS came at a time when costs for medical services increased significantly over a short period of time, amplifying their appeal to large corporations and private individu-

27 Fine, supra note 10, at 210 (quoting Rand E. Rosenblatt et al., LAW AND THE AMERICAN HEALTH CARE SYSTEM 551-52 (1997)).

28 See Little, supra note 4, at 1400-01 (citing Council on Ethical and Judicial Affairs, Ethical Issues in Managed Care, 273 JAMA 330, 333 (1995)). In Gross v. Prudential Health Care Plan, No. CI-9474267 (Okla. Cty. Ct. Oct. 1, 1996), a “patient’s husband alleged that the financial incentives contained in his physician’s MCO contract led the physician to not refer him to a neurosurgeon or order an MRI. Id. The patient had complained of back pain and later developed a spinal infection leaving his spine permanently damaged.” Id. at n.80. Consequently, the physician’s lack of action left his spine permanently damaged. Id.

29 See id. (citing Neil B. Caesar, Don’t Get Burned by the Boilerplate In Your Managed Care Contract, MANAGED CARE 53, 53 (1994)).

30 See Fine, supra note 10, at 210 (quoting Dennis A. Robbins, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES 5 (1998)).

31 Id.

32 Lynne Bernabei & Alan R. Kabat, Health Care Law and Litigation: The Status of Private Practice Physicians Under Employment Discrimination and Labor Laws, SG013 ALI-ABA 149, 153-54 (2001); see also Baldrige, supra note 27, at 68 (citing George W. Whetsell, The History and Evolution of Hospital Payment Systems: How Did We Get Here?, NURSING ADMIN. Q. 1, 1 (1999)). Traditionally, the individual paid premiums to an insurer, either independently or through his employer. Baldrige, at 68. He was then able to see the physician of his choice, after which the physician would present the bill for the services to the individual’s insurance company, which then remitted payment. Id.

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Both public and private payors believed that rising health care costs "threatened the future of health insurance." More expensive health care, although virtually unnoticed by most Americans due to their insurance coverage, is paid for through increases in taxes, insurance premiums, and costs of goods and services, thus insulating most Americans from the high costs associated with these treatments because of insurance coverage.

Although millions of people voluntarily signed up for an HMO or MCO, MCOs and HMOs became especially important to employers who provided their employees' health care, and to the government, who purchased health care for citizens receiving Medicaid and Medicare benefits. These two influential entities became concerned about the skyrocketing cost of health care and subscribed to the theory that saving money should be the ultimate goal. Thus, these entities searched for ways to purchase cheaper plans for employees. In the case of the government, these types of plans could be bought for those citizens eligible for Medicaid or Medicare. Although these plans would not cover all treatments, they would cover most, saving large sums of money for the employer, as opposed to the more expensive method of paying for fee-for-services. Quality improvement was not "the predominant motivation for the switch to managed care."

B. The Effect of MCOs and HMOs on Physicians

As the government and large corporations leaned more on MCOs and HMOs to provide health insurance for their constituents, doctors unwillingly became "cogs in the corporate health care ma-

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34 See Fine, supra note 10, at 210.
35 Id. (quoting Rand E. Rosenblatt et al., LAW AND THE AMERICAN HEALTH CARE SYSTEM 546 (1997)).
37 See Fine, supra note 10, at 210 (citing Dennis A. Robbins, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES 5 (1998)); see also Rugg, supra note 6, at 7.
38 See Fine, supra note 10, at 210.
39 See id.
40 Id.
41 See id.
42 Id. (citing Dennis A. Robbins, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES (1998)).
chinery.' 43 Their decision-making power pertaining to patient care waned, increasingly shifting to insurers or employers. 44 Physicians once "owned" their practices, but are now considered "employees." 45 More and more, MCOs and HMOs interfere with doctors' autonomy, often rendering the doctors bitter and helpless. 46

An administrative worker with little or no medical background now determines what treatment a patient will or will not receive. 47 For example, in 1992, Christy DeMeurers' physician referred her for bone marrow transplant therapy, but her MCO, Health Net, refused to pay for the therapy and instead sent her to a center that did not offer the therapy. 48 After months of delay and an eventual lawsuit, Health Net finally agreed to pay for the therapy, but Mrs. DeMeurers' condition had become untreatable and she died. 49 Health plans deny decisions submitted by doctors concerning patient treatment. 50 Indeed, one physician recently stated that "health care decisions [were] being dictated by a 'cookbook class' of accountants." 51

By dictating the number of patients a physician sees each day, HMOs and MCOs reduce the amount of time a physician can spend with the patient, leaving the physician an inadequate period to as-

43 Lutsky, supra note 34, at 33; see also Ofstein, supra note 34, at 447; see also Ellen L. Luepke, White Coat, Blue Collar: Physician Unionization And Managed Care, 8 ANNALS HEALTH L. 275, 276 (1999) (calling managed care's introduction of "cost-saving techniques" the "corporatization of medicine").

44 See Ofstein, supra note 34, at 447-48; see also Fine, supra note 10, at 211-12.

45 Rugg, supra note 6, at 8-9 (citing Mike Mitka, Doctors Opt for Employment, Larger Groups: Managed Care Driving Trends to Consolidation, AM. MED. NEWS, Jan. 20, 1997, at 1). The author noted that the growth of managed care has made it inefficient for doctors to stay in single or small group practices. Id.

46 See Luepke, supra note 44, at 277 (noting a "rising degree of unrest" among physicians); see also Fine, supra note 10, at 211-213 (stating that generally, physicians feel they have lost control of their practices).

47 See Luepke, supra note 44, at 277 (pointing out that "utilization management and review may be conducted by a non-physician").

48 Little, supra note 4, at 1397-98 (referring to Contract Issues and Quality Standards for Managed Care: Hearing Before the Subcomm. On Health and Env't of the House Comm. on Commerce, 104th Cong. 146 (1996) (statement of Alan Charles DeMeurers)).

49 Id. at 1398.

50 Id. at 1399 (citing Ken Terry, When Health Plans Don't Want You Anymore, MED. ECON., May 23, 1994, at 138, 145). Little refers to two incidents in 1991 involving Dr. Marciana Wilkerson. Id. She requested that CapitalCare authorize the admission of a pregnant woman with gestational diabetes to the hospital for overnight observation, only to have CapitalCare refuse to do so both times. Id.

51 Luepke, supra note 44, at 277 (quoting Sanford Marcus, M.D., former president of the Union of American Physicians and Dentists).
cess the patient’s history or symptoms. These limitations lower the physician’s income and prevent him or her from treating patients in the way he or she sees fit. Physicians view MCOs and HMOs as “oppressive” and believe they interfere with the physician-patient relationship. Consequently, many doctors are leaving the medical field altogether, or, if they continue to practice, become frustrated and angry as their job satisfaction fades.

C. Why Independent Physicians Are Prevented From Joining Or Forming Unions

The Clayton Act and the Sherman Antitrust Act enacted labor and antitrust laws, which sometimes clash. The purpose of the Clayton Act was to “[prevent] the development of unfair market conditions that serve to foster monopolies or deter competition.” It includes “an Act to protect trade and commerce from unlawful restraints and monopolies . . . an Act to reduce taxation, to provide revenue for the Government, and for other purposes . . . and an amendment to the previous act.” “Commerce” referred to in the Clayton Act includes commerce “among the several States” and “with foreign nations.” It also includes “corporations and associa-

52 See Lyon, supra note 5, at 138.
55 Luepke, supra note 44, at 277; see also Fine, supra note 10, at 211.
56 Jay Greene, Physicians Enticed Into Early Retirement, AM. MED. NEWS, July 24, 2000, at 1. Greene stated that an “increasing number of physicians are retiring, reducing their work load, changing their practice or moving into nonclinical jobs.” Id.
60 See Luepke, supra note 44, at 282.
63 Id.
tions existing under or authorized by the laws of either the United States, the Territories, the laws of any state, or the laws of any foreign country” within its definition of “person or persons.”

The Sherman Antitrust Act (Sherman Act) states that “[e]very contract, combination in the form of trust or otherwise, conspiracy, in restraint of trade or commerce among the several states or with foreign nations, is . . . illegal.” Illegal restraint of trade by either a corporation or a person is declared a felony, punishable by a fine or imprisonment or both, at the discretion of the court. The Sherman Act prevents market participants from making agreements that “illegally restrain trade.”

The Clayton Act balances the Sherman Act by exempting labor unions from the antitrust laws by allowing unions to collectively bargain on behalf of their members. In addition, the National Labor Relations Act (NLRA), also known as the Wagner Act, further classified the labor exemptions set out in the Clayton Act, and formed the National Labor Relations Board (NLRB), which handles federal labor issues.

Most doctors are categorized as independent contractors, and not “employees” of a health plan or hospital. Under the Clayton Act and the NLRA, someone who is not an “employee” is not eligible to collectively bargain. Only doctors who are employed by the government, hospitals, or MCOs and HMOs fall into the category of “employees” covered by the Clayton Act, which consists of a mere fifteen percent of practicing physicians. The remaining eighty-five percent, particularly physicians in private practice groups or solo practitioners, fall into the “independent contractor” categorization.

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64 Id.
67 Luepke, supra note 44, at 282; see also Fine, supra note 10, at 214.
68 15 U.S.C. § 17 (2001); see also Luepke, supra note 44, at 282. The Clayton Act can coexist with the Sherman Act because it removes “human labor” from the “commodity or article of commerce” category, therefore removing it from the realm of Sherman Act regulation. Id.
69 National Labor Relations Act 29 U.S.C. § 151 (1935); see also Luepke, supra note 44, at 282.
71 See Luepke, supra note 44, at 282-83.
72 Fine, supra note 10, at 214 (citing Julie Rovner, USA Takes First Steps to a Doctors’ Union, 354 LANCET 54 (1999)).
73 See id.
This classification prevents these physicians from bargaining collectively because under the Sherman Act, these practices are considered price fixing.\textsuperscript{74} The Sherman Act deems price fixing "per se unlawful" and subject to criminal prosecution.\textsuperscript{78} Under another definition, physicians can be considered "managers" and "supervisors" by the NLRA because of their "supervisory authority" that they exercise over "the delivery of patient care."\textsuperscript{76} Under the NLRA, a "supervisor" is defined as:

Any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.\textsuperscript{77}

This classification also prevents participation in collective bargaining under the NLRA.\textsuperscript{78}

Texas limits doctors even further due to strict adherence to the Corporate Practice of Medicine doctrine. This doctrine states that lay organizations “cannot employ physicians” and “cannot share in physician fees.”\textsuperscript{79} Many states have made statutory exceptions to the doctrine for hospitals and HMOs, among others, but Texas has only recently made one exception allowing private medical schools to employ physicians.\textsuperscript{80} Thus, only an extremely small group of physicians in Texas could collectively bargain under the Clayton Act.\textsuperscript{81}

\textsuperscript{74} Luepke, supra note 44, at 290 (citing 15 U.S.C. § 1).

\textsuperscript{75} Id.

\textsuperscript{76} Id.


\textsuperscript{78} Id. (citing 29 U.S.C. § 152(11) (2000)).

\textsuperscript{79} See id.

\textsuperscript{80} Elaine A. Lisko, \textit{Texas Legislature Passes Medical School Exception to the Corporate Practice of Medicine Doctrine}, at http://www.law.uh.edu/healthlawperspectives/Medical Professionals/990520Texas.html (last visited Aug. 5, 2003).

\textsuperscript{81} Id.
D. The Emergence of Collective Bargaining as a Solution and Senate Bill 1468 (SB 1468)

Since most provisions of labor and antitrust law prevent independent physicians from forming or joining unions, any “bargaining” must take place through an intermediary. Texas’ law does not violate the Sherman Act because it was written to place these activities under the state action doctrine. The state action doctrine “gives private actions antitrust immunity if the challenged action is the result of a clearly articulated and affirmatively expressed state policy to exclude the activity from application of the antitrust laws,” and the action is “actively supervised by the state itself.”

When Congress enacted the NLRA, collective bargaining technically violated the Sherman Act. However, it was believed that a certain inequality existed between employees and their employers in their bargaining power. The purpose of the NLRA was to “promote industrial peace and stability . . . .” Blue collar workers first
utilized collective bargaining to "level the playing field" between them and their employers.\textsuperscript{89}

In 1999, the American Medical Association (AMA) voted to implement a national labor association to represent employed physicians and residents, since these groups fell outside NLRA restrictions and could lawfully form unions.\textsuperscript{90} They also voted to continue supporting antitrust relief for self-employed physicians and residents, and to implement a labor organization once the roadblocks were removed.\textsuperscript{91} That same year, U.S. Representative Tom Campbell proposed the Quality Health Care Act (Health Care Act).\textsuperscript{92} After passing the U.S. House, the Health Care Act garnered little support in the U.S. Senate due to Senate majority leader Trent Lott's opposition and the bill's lack of sponsorship.\textsuperscript{93}

However, in 1999, the Texas legislature passed its own version of the Health Care Act via Senate Bill 1468 (SB 1468), a "Joint Negotiations" statute.\textsuperscript{94} The statute did not unionize physicians, but gave them greater power in negotiating certain "fee" and "non-fee related terms and conditions" with health benefit plans.\textsuperscript{95} Once Governor George W. Bush signed the statute into law, he instantly hailed it as a "check and balance to make sure that HMOs are not able to unfairly use their market power to dictate the quality of patient care."\textsuperscript{96} Initial estimates by the Office of the Attorney General (OAG) placed the expected number of negotiation requests at 112 per year.\textsuperscript{97} Some believed it would tremendously impact other state legislatures in

\textsuperscript{89} Id. (referring to Am. Ship Bldg. Co. v. NLRB, 380 U.S. 300 (1965)).

\textsuperscript{90} Lyon, supra note 5, at 138 (citing AMA House of Delegates, Report of Reference Committee I, at 2-3 (Annual Meeting, 1999)).

\textsuperscript{91} Id.


\textsuperscript{93} Id. (citing Robert Pear, After Doctors' Antitrust Triumph, Lott Puts Up Roadblock in Senate, N.Y. TIMES, July 1, 2000, at A1).

\textsuperscript{94} An Act Relating to the Regulation of Physician Joint Negotiation, TEX. INS. CODE ANN. tit. 1, §§ 29.01-29.14 (Vernon Supp. 2003); see also Rugg, supra note 6, at 34-35.

\textsuperscript{95} Quinn, supra note 17, at 149.


their attempts to enact similar legislation. To the contrary, it has been anything but a check and balance, and three years after the passage of the statute, the relationship between physicians and MCOs has not changed.

SB 1468 required physician groups who wished to negotiate with their health plan to choose a member of the group as their representative. This representative was the only person authorized to bargain with the MCOs. The representative had to submit an application to the OAG and then wait for approval. Only after the application was approved could the representative begin negotiations with the health plan. The physician representative had to resubmit the terms and conditions of the proposed contract and action plan to the OAG for approval. If the negotiations fell through, the representative was required to notify the OAG within fourteen days of the failed negotiations. In addition to the approval process, the OAG instituted its own set of rules that governed the application and negotiation process, including a provision that allowed public disclosure of the parties and the subject of their negotiations.

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88 See generally Powers, supra note 62, at 241. Powers stated that it was “likely” that the Texas statute would have “considerable impact” on other states. Id.

89 See generally Carroll, supra note 23, at 10 (quoting the director of managed care at Henderson Memorial Hospital as saying, “All I can tell you is that it didn’t work.”).

100 Tex. Ins. Code Ann. art. 29.07(3) (Vernon 2000); see also Quinn, supra note 17, at 146.


103 Tex. Ins. Code Ann. art. 29.09(a) (Vernon 2000). However, the first group of physicians to have their application approved applied to the OAG on February 8, 2001. Borges. Their application was not approved until the end of August. Borges.

104 Art. 29.08(2).

105 Art. 29.08(3).

106 T EX. ADMIN. CODE § 58.5 (Vernon 2000).
II. **Analysis**

A. **Why Collective Bargaining is Effective in the Public Sector and Why, Theoretically, It Should Also Be Effective for Physicians**

Imagine a construction worker, who has received training to build complex structures. Though he may lack a “higher education,” he does a job that would likely be difficult for the average American to complete without construction training. Although he has a supervisor, he knows the parts of the structure that go into each particular section of the building, and which tools put them into place. He works a set number of hours to complete a specific job. He is directly paid by the particular project to which he is assigned and earns a modest living. For the most part, he is satisfied with his job and ultimately, he erects a new building, which gives him a sense of accomplishment.

Now imagine that the construction company who employs him learns of a way they can save money and increase their profits. They enter into an agreement with a larger construction company, one that controls thousands of workers like him. The “mega-company” has a specific process each worker must follow in order to maximize profits. Now, our construction worker has to perform twice the amount of work in the same amount of time. He has to ask for permission to use tools he already knows how to use. If he bypasses the new company’s “regulations,” he risks losing his job and his only source of income because his new contract (one he was not allowed to negotiate) contains a provision that allows the company to terminate him at-will. His salary declines, yet his hours on the job increase. Could we continue to expect high-quality work from the construction worker? Would we be appalled at the intolerable working conditions to which he is submitted by the mega-company? We would find ways to return him to his earlier working conditions, so that he might build sound buildings again. Yet, this situation mirrors that which doctors have faced since MCOs and HMOs came onto the scene in the early 1970s.

The typical union participant mirrors the construction worker: a blue-collar employee working long hours for generally lower pay, supervised by a large company or Chief Executive Officer (CEO),

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107 This hypothetical was manufactured by the author.

and usually lacking a college education. Viewed as someone with little power, he can join a union to acquire a voice in the event the bigger, more powerful company or CEO takes advantage of him by unjustly lowering his pay or creating intolerable working conditions. The government has recognized that human labor is not a commodity and made an exemption from antitrust laws for these types of workers who could potentially face exploitation. Through unions, these workers can voice their dissatisfaction and, at the same time, keep the large company from controlling the balance of power in their relationship.

Because of doctors’ status in the community, combined with their high level of education and pay, doctors are not afforded the sympathy extended to blue collar employees like construction workers. Physicians occupy a “position of power, even reverence, in American society.” Yet, an argument can be made for doctors analogous to the argument for the hypothetical construction worker: if the point of collective bargaining is to give a voice to those experiencing intolerable working conditions, then doctors should be given this voice, too.

For physicians, one goal of collective bargaining includes gaining more leverage against MCOs and HMOs in contract negotiation, ultimately resulting in better quality of care for patients. Collective bargaining should supposedly “[shift] control of medical deci-

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109 See, e.g., A.L. Blades & Sons v. Yerusalim, 121 F.3d 865 (3d Cir. 1997). The plaintiffs in this case were highway construction contract workers. Id. at 867.

110 See, e.g., Am. Steel Foundries v. Tri-City Cent. Trades Council, 257 U.S. 184 (1921). Steel workers went on strike after the reopening of the steel plant, when their wages were reduced from ten cents an hour to two cents an hour by the company. Id. at 196.

111 See generally 15 U.S.C. § 17 (2001); Luepke, supra note 44, at 282 (summarizing generally the checks and balances of the Sherman and Clayton Acts); Fine, supra note 10, at 221 (defining how exploitation could occur between two parties engaging in a transaction).

112 See Fine, supra note 10, at 221 (citing Alan Wertheimer, Remarks on Coercion and Exploitation, 74 Denv. U. L. Rev. 889, 904 (1997)).

113 See id. (stating that doctors are generally thought of as “societal elites”).

114 Luepke, supra note 44, at 278.

115 See generally Fine, supra note 10, at 221 (citing Alan Wertheimer, Remarks on Coercion and Exploitation, 74 Denv. U. L. Rev. 889, 904 (1997)).

tion-making back into the hands of physicians.”117 Opponents of physician collective bargaining view the process only as a way for doctors to negotiate better pay for themselves, with quality of care getting lost in the shuffle.118 Indeed, even the United States Supreme Court acknowledged that “[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests. . . .”119 However, the majority of people, whether part of the medical community or not, believe the decrease in doctors’ autonomy and job satisfaction is the chief culprit for the decline in the quality of health care service.120

Every day, doctors experience the unpleasant working conditions collective bargaining was designed to prevent.121 Poor working conditions for physicians breed unhappy, tired, and underpaid doctors, which means a decline in services for patients.122 Doctors earn less money than they ever did prior to the rise of MCOs and HMOs.123 They also see more patients in less time in order to comply with MCO and HMO profit-making schemes.124 Doctors attend

117 See Bernat & Flaherty, supra note 77, at 17.
118 Fine, supra note 10, at 218 (citing The Quality of Health Care Act of 1998, Hearings on H.R. 4277 Before the Comm. on the Judiciary House of Representatives, 105th Cong. 73-79 (1998) (statement of Steven J. Demontmollin, Vice-President and General Counsel, AvMed Health Plan, on behalf of the AAHP)); see also Powers, supra note 62, at 226. Powers notes the arguments of physician unionization opponents that collective bargaining would only “serve to stifle competition within the health care arena, fattening the pockets of already overpaid physicians and yet not significantly improving the quality of care provided to patients.” Id.
120 See Powers, supra note 62, at 223.
121 See Fine, supra note 10, at 221 (stating that MCOs do in fact “take unfair advantage of physicians” and use it to their benefit).
122 See Rugg, supra note 6, at 3-4. The author uses a hypothetical “day-in-the-life” of a doctor, who meets with other physicians after her fourteen-hour shift for a union information meeting. Id. at 3. Among the problems listed by the doctors in their meeting are “quality of care,” “lack of voice,” and lowered salary. Id.
123 Fine, supra note 10, at 222 (referring to a 1994 study that showed an eleven percent drop in earnings among “markets that had high levels of managed care penetration”); see also Daniel R. Roach & Cori MacDonnell, The Compliance Conundrum, 32 J. HEALTH & HOSP. L. 565, 568 (1999) (noting that in California, one hundred fifteen physician groups had declared bankruptcy or gone out of business since 1996, and that approximately eighty-five percent were in “serious financial trouble.”).
124 See Noonan, supra note 6, at 32-33 (discussing the effects that paperwork and other insurer requirements have on treating patients); see also Rugg, supra note 6, at 2 (noting a hypothetical doctor’s frustration at using a “scripted examination questionnaire”).
school for eight years or more, depending on their specialty. They emerge from medical school thousands of dollars in debt. They take medical licensing exams at the end of their second and fourth years of medical school, and are periodically required to take re-qualification exams for their field. Yet someone in front of a computer with no medical experience tells them which procedures they can perform and when they can perform them. This same person denies referrals to anyone other than doctors “in the network.” This person’s supervisor can control the doctor’s salary, based on the number of patients the doctor treats. The supervisor also controls bonuses based on the least amount of referrals. It is difficult to argue that an individual doctor can equally bargain with the MCO.

If physicians could collectively bargain in the same manner as the construction worker, they could demand better hours, more decision-making power, and more palatable contract terms that would, in turn, enable them to provide better quality of care to their patients.

125 See Rugg, supra note 6, at 2. The author’s hypothetical doctor had “four years of medical school, three years of residency, three years as a fellow, and ten years of practice.” Id. See also Chris Phan, Physician Unionization: The Impact on the Medical Profession, 20 J. LEGAL MED. 115, 116 (citing Grace Budrys, When Doctors Join Unions 9 (1997)).


127 See American Medical Association, Becoming An MD, at http://www.ama-assn.org/ama/pub/printcat/2320.html (last visited Jan. 16, 2003). Medical students can only obtain a permanent license after completing a series of exams and, once they become licensed, are required to acquire a certain number of continuing education credits every year. Id.

128 See Noonan, supra note 6, at 32, 33; see also Rugg, supra note 6, at 2; Lyon, supra note 5, at 138.

129 See Little, supra note 4, at 1412 (citing James P. Freiburg, The ABCs of MCOs: An Overview of Managed Care Organizations, 28 ITL. B.J. 584, 584-88 (1993)).

130 See Lyon, supra note 5, at 138. Lyon notes that “physicians have seen managed care entities dictate which patients to see...while reducing physicians’ fees for services.” Id.

131 See Rugg, supra note 6, at 1 (referring to the hypothetical physician’s loss of her “productivity bonuses” for the day); see also Fine, supra note 10, at 211 (citing David A. Hyman, Regulating Managed Care: What’s Wrong with a Patient Bill of Rights, 73 S. CAL. L. REV. 221, 229 (2000)).

132 See AMA Statement, supra note 117; see also Fine, supra note 10, at 209.
B. The Aftermath of SB 1468 and Why It Did Not Work

Since its passage in 1999 and the final application process completion by the OAG in 2000, physician groups made only two applications to collectively negotiate with their respective health plans. The OAG denied one application because it lacked sufficient information and approved the other application in late August 2001. The approved application came from a group of eleven Henderson Memorial Hospital physicians who wanted to negotiate with Blue Cross/Blue Shield of Texas. Their plan called for “improved access to local physicians; continuity of care to local residents; prompt treatment; ... improved administrative procedures. ... and better communication to patients about their benefits.” However, Blue Cross/Blue Shield refused to negotiate with the group, regardless of the OAG’s approval of the application.

If, by passing the statute, the Texas legislature intended to give doctors more weight on a scale increasingly tipped in favor of HMOs and MCOs, they did not achieve this goal. First, the statute required an “expensive and time-consuming application” process. The OAG served as a middleman, preventing doctors from going directly to the source of the problem, the health plan. In addition, the rules stipulated that the physician group’s representative pay the Texas Department of Insurance a $500 fee to act as the representative, then an “OAG fee” of $2000 for a non-fee related negotiation application, and $4000 for a fee-related negotiation appli-

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133 Hellinger & Young, supra note 12, at 86.
134 Id.
136 Health Monitor, supra note 136.
137 OAG Press Release, supra note 136.
138 Health Monitor, supra note 136 (quipping that Blue Cross/Blue Shield’s reaction was “thanks, but no thanks. . .”).
139 See Carroll, supra note 23, at 10 (noting the inability of the Henderson physicians to bargain with Blue Cross/Blue Shield).
140 Quinn, supra note 17, at 142.
141 See id. at 146.
cation. If the OAG approved the contract, the physician group paid the OAG for the contract that emerged from the negotiations—$500 for a non-fee related contract and/or $1000 for a fee-related contract (including renewals and alterations, which could have resulted in multiple contracts). Similar to an MCO’s use of a third party in the decision-making process, why should the OAG determine the validity of collective bargaining requests?

Additionally, physicians risk deselection, or termination, by their MCO. As previously mentioned, contract law allows independent contractors to be terminated at-will and without cause, and most MCO contracts contain a “termination without cause” clause. This means that a physician could technically be fired in bad faith and the MCO would never be held accountable for this decision, nor would the doctor be able to bring a legitimate claim in court for wrongful termination. The Texas statute required the names and addresses of all the physicians in the represented group to be reported to the OAG, which is subject to public disclosure under the Texas Open Records Act. If terminated from the health plan, the doctor would lose access to his patients, as the patients would then be considered patients of the MCO. This requirement also places at a disadvantage physicians in group practices because other existing groups are willing to be picked up by MCOs in the event that the MCO releases an entire group. Physicians must

144 See Rugg, supra note 6, at 2 (citing Nancy McVicar, Medicine By The Numbers: Managed Care Companies Use Several Guidelines To Decide What Treatment Is Best For A Patient, SUN-SENTINEL, Feb. 27, 2000, at 13G).
145 Little, supra note 4, at 1416 (citing Denise Smith Amos, Medical Balancing Act: Doctors Weigh Patient Needs Against Insurers’ Rules, St. LOUIS DISPATCH, Apr. 1, 1996, at 10); see also Deis, supra note 83, at 955-56.
146 Little, supra note 4, at 1416-17 (citing Amos, at 10); see also Deis, supra note 83, at 955-56.
147 See Little, supra note 4, at 1398 (citing Napoletano v. CIGNA Healthcare of Conn., Inc., 680 A.2d 127, 131 (Conn. 1996) (referring to the “termination without cause” provision in CIGNA’s standard-form physician contracts)).
149 See Deis, supra note 83, at 956; see also Little, supra note 4, at 1402. Little notes that “terminations interrupt the continuity of patient care and destroy long-standing relationships between physicians and their patients.” Id.
150 Interview with Ron Turner, Professor, University of Houston Law Center, in Houston, Tex. (Nov. 26, 2002) [hereinafter Turner Interview].
choose between voicing their unhappiness with the plan and facing
deselection, or staying quiet and keeping their job, a lose-lose
situation.151

As if applying to bargain under the OAG’s exhaustive process,
paying excessive amounts of money to the OAG, and risking their
jobs and livelihood were not enough, in the end, the HMO or MCO
could still simply refuse to bargain with the physician group.152 It is
no wonder that so few physician groups utilized the process.153 The
risks associated with the statute far outweighed the benefits, leaving
doctors with the sense that the process was fruitless.154

C. Are There Other Effective Alternate Solutions?

Effective alternate solutions to impotent statutes such as this
one exist; the question remains as to whether or not they can be
implemented.155 Alternative measures may be viewed as politically
unacceptable.156

The basic problem with the Texas statute was that it discour-
aged physicians from bargaining.157 It was a “toothless” law, merely
a suggestion, albeit one that may have seemed politically correct at
the time of its passage.158 The Texas legislature failed to consider
several different avenues before the statute expired last Septem-

151 See Little, supra note 4, at 1398-99 (citing Ambroze v. Aetna Health Plans of N.Y., Inc. No.
95 CIV. 6631, 1996 WL 282089, at *3 (S.D.N.Y. May 28, 1996)). A group of anesthesiologists
tried to negotiate terms of a contract with an Aetna managed care plan, but the health plan
“refused to negotiate physician agreements.” Id. at 1398. Aetna then threatened the anes-
thesiologists with termination if the agreement was not signed in its original form. Id. at
1398-99.

152 See Carroll, supra note 23, at 10. Blue Cross/Blue Shield stated that they would be “willing
to continue... discussions, but not as part of a collective bargaining process.” Id. The
statute had no provision requiring it to take part. Id.

153 See discussion infra Part II-D. The two applications filed with the OAG in two years are
significantly less than the expected 224. Id.

154 Quinn, supra note 17, at 142.

155 See discussion infra Part III-C 1-4.

156 See generally Powers, supra note 62, at 241. Powers states that “one of the most attractive
aspects of [the] statute” was that it contained “safeguards” that keep physicians from
“abusing their newly granted power.” Id. See also Phan, supra note 126, at 138 (noting
even doctors’ negative view of physician unions).

157 Turner Interview, supra note 151.

158 See Carroll, supra note 23, at 10 (quoting Linda Davis, director of managed care for Hen-
derson Memorial Hospital).
ber, ranging from changing parts of the existing statute, including the sunset clause, to doing away with the statute altogether and trying an entirely different method.

1. **Change Three Major Provisions of the Statute**

   a. **Require MCOs and HMOs to Bargain with the Physician Groups**

   In ordinary collective bargaining situations, such as one that might involve the hypothetical construction worker, federal labor law requires bargaining between the employer and employee. Although the corporate entity has a legal duty to bargain, it does not have to agree to the requests of the employees. In fact, refusing to meet with the groups at reasonable times and refusing to discuss "mandatory subjects of bargaining" is considered unfair labor practice. Because an employee-employer relationship exists between physicians and the respective health plan with which they are under contract, similar to the one that exists between the construction worker and the company that employs him, HMOs and MCOs should be bound by this same duty. Yet the Texas statute did not give physicians the same rights construction workers are afforded under different laws. Physicians were given only the right to "try" to bargain. If this were changed so that bargaining was compelled between MCOs and the physician groups, they might not

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159 TEX. INS. CODE ANN. art. 29.14 (Vernon 2000). The statute's sunset clause took effect on September 1, 2003. Id.

160 Rugg, supra note 6, at 5 (citing 29 U.S.C. § 157 (1999) (noting that employers are required by law to negotiate with workers regarding "wages, hours, and other terms and conditions of employment").

161 Id.


163 See Fine, supra note 10, at 214. Fine notes that "physicians who are employed by the federal government, hospitals, or Health Maintenance Organizations . . . are covered by the Clayton Act," which should permit collective bargaining. Id. Conversely, they "are frequently considered to be independent contractors or supervisory employees," which prevents them from collectively bargaining. Id. See also Little, supra note 4, at 1406 (noting that in 1995, eighty-five percent of physicians in the U.S. were enrolled in at least one managed care plan).

164 See generally Quinn, supra note 17, at 146. Physicians had to ask the Attorney General permission to bargain under the Texas statute. Id.

165 See id. (noting that "health benefit plans are not required to negotiate" with physician groups); see also TEX. INS. CODE ANN. art. 29.07(5) (Vernon 2000).
necessarily agree, but, at least the physicians would be permitted to bring their propositions to the table. Since the statute regulated the collective bargaining process and prohibits physician strikes, worries of physicians boycotting would be unfounded. The change would only force HMOs and MCOs to come to the bargaining table and hear doctors' proposals. They would not be forced to accept the proposals, although simply hearing them might make acceptance of the proposals more likely.

b. Reenact the Statute, Minus the Sunset Clause

Another problem was the brevity of the statute’s effective period. Although passed by the Texas House of Representatives and Senate in November of 1999 and signed into law by then-Governor George W. Bush in June of 1999, the final rules were not completed by Attorney General John Cornyn until May of 2000. This immediately decreased the statute’s effective period by six months. Representative John Smithee, co-sponsor of SB 1468 in the House, authored House Bill 1399 (HB 1399) and filed it on February 27, 2003. HB 1399 would have changed the sunset clause to

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166 See generally Carroll, supra note 23, at 10 (noting that the Henderson physician group and Blue Cross/Blue Shield “never even got to shake hands”); but see Turner Interview, supra note 151 (pointing out studies showing that in situations where parties are allowed to come to the table to bargain with each other, ninety-five percent of the time they reach an agreement, and the five percent of time in which they do not is often due to bad faith or trickery).

167 Powers, supra note 62, at 242 (noting that the “greatest fear” of those who oppose physician collective bargaining is a strike that would leave “hospitals . . . devoid of physicians when they or their loved ones are in need of medical treatment.”).

168 See Carroll, supra note 23, at 12 (noting that “U.S. Representatives in Texas and Washington are looking at a new bill that would force MCOs to bargain” or be fined if they did not act in good faith).

169 See Turner Interview, supra note 151. Professor Turner stated that statistical findings show that if two parties simply “come to the table” to negotiate, even if no acceptance of the proposal put forth by the one party is required by the other party, the party receiving the proposal is more likely to accept it regardless of whether acceptance is required. Id.


171 Rules Press Release, supra note 98.

172 Id. See also TEX. INS. CODE ANN. art. 29.14 (Vernon Supp. 2003); see also Rules Press Release, supra note 98.

September 1, 2007. The Insurance Committee heard testimony on March 17, but the bill was left pending in the committee that day.

c. **Make the 30-Day Application Review Standard**

In addition, the statutory provision which set a thirty-day limit for application review apparently was not strictly followed. If other doctors were waiting in the wings to see if any accomplishments happened before they stepped out on a limb to file their own application, they lost almost two years in the interim. Perhaps doctors gave up hope in the last few months of the statute's effective period, knowing it might take up to six months just to negotiate approval of their application, not to mention the time required to complete the bargaining process itself. If the statute had been left in place longer and its provisions adhered to more rigorously, it would have had a chance to make some progress, as doctors would not have been deterred by such a time crunch.

### 2. **Eliminate the Expensive, Tedium Application Process**

Only those physicians not employed by the government or a hospital are prevented from joining unions. Therefore, independent practitioners must conduct their collective bargaining through an intermediary to avoid anti-trust law violations. The Texas Legislature appointed the OAG as the intermediary. The general practi-

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175 HB 1399, supra note 174.
176 See Tex. Ins. Code Ann. art. 29.09(a) (Vernon Supp. 2003); see also Borges, supra note 103: (stating that the Henderson physician group submitted its application on February 8, 2001, but it was not approved by Attorney General Cornyn's office until August 30, 2001).
177 See Borges, supra note 103.
178 OAG Press Release, supra note 136; see also Health Monitor, supra note 136 (noting the significant time and expense involved in the application process, as well as the risk that insurance companies will not agree to bargain even after an application is approved).
179 See generally Carroll, supra note 23, at 12 (noting that physicians are no closer to "meaningful negotiations" than they were before the statute was passed).
180 See Messenger Models, supra note 83, at 376-77 (noting that because physicians in independent practice are not considered "employees" for the purposes of avoiding anti-trust law violations, many organized physician groups utilize a "messenger" to negotiate with health plans in order to avoid violating anti-trust laws); see also Deis, supra note 83, at 956-57 (1999) (noting that one approach utilized by independent contractors seeking to bargain in compliance with anti-trust laws is use of an intermediary to communicate with health plans).
tice of physician groups who have engaged in collective bargaining is to utilize a labor union representative, or messenger, to relay contractual terms agreed upon by the group to the MCOs or HMOs.\textsuperscript{182} While the physician group would still be paying the messenger for his or her service, it might be more economically feasible than paying the OAG for each application and altered contract.\textsuperscript{183} In addition, approval from the OAG would no longer be necessary, shortening the start-to-finish time of the negotiation process.\textsuperscript{184} Antitrust law does not require that groups obtain the "approval" of some third-party, only that they go through an intermediary.\textsuperscript{185}

3. Allow Arbitration Instead of Collective Bargaining

Another solution that might be effective would be to allow the physician group to arbitrate proposed negotiations.\textsuperscript{186} The arbitrator could select either the physician group’s new proposal as the solution or leave in place the MCO’s old regulation or fee.\textsuperscript{187} The arbitration could be binding on the parties, meaning the arbitrator's decision would be final, or non-binding, meaning the losing party could appeal, although non-binding arbitration is not common.\textsuperscript{188} Arbitration works in the public sector,\textsuperscript{189} and is allowed, although much contested, in the private sector.\textsuperscript{190} Arbitration works in the

\textsuperscript{182} See Messenger Models, supra note 83, at 376-77; see also Deis, supra note 83, at 957.

\textsuperscript{183} See generally Quinn, supra note 17, at 147 (citing 24 Tex. Reg. 10266 (1999) (to be codified at Tex. Ins. Code Ann. § 58.4(a)-(c), 58-11 (b), which sets a fee schedule for the bargaining process)).

\textsuperscript{184} See Borges, supra note 103 (noting the Henderson physician group’s application had yet to be accepted months after it was submitted to the OAG); see also OAG Press Release, supra note 136 (statement granting the Henderson application six months after it was submitted). The process ideally would be shortened from the six months that the Henderson physicians endured. Borges, supra note 103.

\textsuperscript{185} See Messenger Models, supra note 83, at 376-77; see also Deis, supra note 83, at 957.

\textsuperscript{186} Turner Interview, supra note 151.

\textsuperscript{187} Id.

\textsuperscript{188} See generally Porter & Clements, L.L.P. v. Stone, 935 S.W.2d 217, 220-21 (Tex. App.—Houston [1st Dist.] 1996). Parties usually sign agreements and agree to be bound by the arbitration. Id.

\textsuperscript{189} See generally Stone & Webster Engineering Corp. v. Local Union No. 38, 461 F. Supp. 882, 891 (N.D.N.Y. 1978) (involving a suit based on an arbitration agreement violation, in which the court noted that "'national labor policy' favors arbitration").

public sector mainly because, like collective bargaining by unions, public employees have the option to strike if they are not given an opportunity to present their ideas to an arbitrator.\textsuperscript{191} Because doctors are considered independent contractors,\textsuperscript{192} striking is not a viable option for them, even if their demands are not met.\textsuperscript{193} However, due to the finality of arbitration, it seems unlikely that doctors would make unreasonable demands that the MCO or HMO would be absolutely unwilling to consider.\textsuperscript{194} If their requests were not too outrageous, it appears, perhaps optimistically, that the parties could come to a consensus.\textsuperscript{195}

4. Enact House Resolution 3897

In response to the failure of the Quality Health Care Coalition Act (HR 1304), Michigan Representative John Conyers, a Democrat, and Georgia Representative Bob Barr, a Republican, are “tweaking” a new bill.\textsuperscript{196}

If this bill passes, Congress would create an advisory committee of health care professionals who would pick six areas throughout the country where doctors and MCOs would begin joint negotiations.\textsuperscript{197} The significance of this legislation is that, even if it does not pass in Congress, state legislatures may attempt to pass it, similar to Texas’ passage of SB 1468 after HR 1304 failed.\textsuperscript{198} The new statute would provide another alternative for states in their en-

\textsuperscript{191} See Stone & Webster, 461 F. Supp. at 889. The workers only threatened to strike once they felt that their employer violated the arbitration agreement. \textit{Id.}


\textsuperscript{193} See \textit{id.} at 32-33.

\textsuperscript{194} Turner Interview, supra note 151.

\textsuperscript{195} \textit{Id.}

\textsuperscript{196} Carroll, supra note 23, at 10. Conyers and Barr, authors of the bill, state that it is a “baby step” towards what the Quality Health Care Coalition Act was trying to accomplish and believe its “go-slow provisions” will help its chances in the Senate. \textit{Id.}

\textsuperscript{197} \textit{Id.}

\textsuperscript{198} See \textit{id.} at 12.
deavors to improve the state of health care for doctors and patients.199

III. Conclusion

Texas’ physician collective bargaining statute expired on September 1, 2003.200 The legislature unsuccessfully attempted to take some action to reauthorize the statute through 2007.201 MCOs and HMOs must have celebrated victory, since the OAG approved only one of two joint negotiation applications.202 In addition, the MCO did not even have to negotiate with the approved physician group.203 HMOs and MCOs waited out the statute successfully, although if they had looked closer, they would have realized that the statute was harmless in the first place.204

If the statute is to be re-enacted in a different bill, significant changes need to be made in several of its provisions in order to give doctors the power the statute allegedly intended.205 If given some teeth, a collective bargaining statute could potentially achieve tremendous good, significantly changing health care as we know it, and making Texas an innovator for other state legislatures to follow.206

Improved working conditions for physicians would have a trickle-down effect on the health care industry.207 Doctors would be

199 See id. at 10.


201 See HB 1399, supra note 174.

202 See Hellinger & Young, supra note 12, at 86 (citing that only two applications were filed); see also OAG Press Release, supra note 136, at 85 (noting Attorney General Cornyn’s approval of the “first-ever” application).

203 See Carroll, supra note 23, at 10; see also Health Monitor, supra note 136.

204 See Carroll, supra note 23, at 10.

205 See Powers, supra note 62, at 240 (citing 1999 Legislative Compendium: Market Fairness/Managed Care Reform, at http://www.texmed.org). Then-Texas Governor George W. Bush stated that the bill would serve to “level the playing field” between independent physicians and MCOs “when it comes to determining the quality of care for patients.” Id.

206 See Carroll, supra note 23, at 10 (quoting Linda Davis, director of managed care for Henderson Memorial Hospital); see also Hellinger & Young, supra note 12, at 83. Hellinger and Young note that after Texas passed SB 1468, eighteen state legislatures introduced similar legislation, although it passed only in the District of Columbia. Id. at 83.

207 Cf. Fine, supra note 10, at 213 (citing Daniel S. Greenberg, USA’s Changing Environment of Medical School Enrollments, 352 LANCET 1531, 1531 (1998)). Fine notes that the negative effects of managed care are having a trickle-down effect on medical schools. Id.
adequately compensated for their work,208 based on their extensive education.209 They could treat patients as they were taught in medical school, restricted only by medical ethics, which have always governed them.210 There would be no quota for a minimum number of patients treated each day, and referrals could be made without question.211 In turn, doctors could get back to the business of healing patients, not just treating symptoms. Patients’ needs could be adequately met, either through appropriate medical treatments, or simply talking to their physician about their concerns without feeling as if the physician had no time for them.

If physicians could be granted power to balance the inequity between themselves and MCOs, they could possibly remedy the problems plaguing the medical field.212 Texas took a step in the right direction as the first state to pass legislation allowing collective bargaining.213 However, the statute fell short of its intention by making it too difficult for physicians to bargain with MCOs and HMOs.214

If progress is to occur in this area, the statute needs provisions compelling MCOs and HMOs to bargain.215 In addition, the statute needs strict enforcement,216 and a longer opportunity to work.217 However, if the state legislature cannot agree on which provisions to change, other alternatives, such as utilizing labor representatives instead of the OAG’s application process, and arbitration, might be just as effective.218 Finally, a new and slightly different bill on the

208 See id. at 212-13.
209 See Phan, supra note 126, at 116 (citing GRACE BUDDYS, WHEN DOCTORS JOIN UNIONS 9 (1997)).
210 See Luepke, supra note 44, at 278 (citing GRACE BUDDYS, WHEN DOCTORS JOIN UNIONS 32-38 (1997) (noting that physicians are “highly educated, generally conservative and bound by a sense of professionalism and a strict ethical code”).
211 See Lyon, supra note 5, at 138.
212 See Powers, supra note 62, at 246. Powers states that HMOs and MCOs that dominate the current market “bully” physicians. Id.
213 See Hellinger & Young, supra note 12, at 83.
214 See Quinn, supra note 17, at 146-49. Quinn goes through the entire OAG application process. Id.
215 See discussion infra Part III.C.1.a.
216 See discussion infra Part III.C.1.c.
217 See discussion infra Part III.C.1.b.
218 See discussion infra Part III.C.2-3.
horizon in the House of Representatives could bring needed changes to the health care industry if passed as written.219

Ideally, mediocre health care in the United States would not exist. Doctors would no longer practice frugal medicine, nor fear the wrath of a "cookbook accountant."220 A visit to the doctor would not involve feeling like part of an assembly line, and appointments could be as long as necessary. The girl might have felt her medical needs were met, and maybe she would have gone on to medical school, inspired by the profession, instead of feeling relieved she did not. Although these improvements to the practice of medicine may not occur overnight, improvements to the way medicine is practiced can be made through state or federal legislation, coupled with the cooperation of physicians and insurance companies.

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220 Lucpke, supra note 44, at 277 (quoting Sanford Marcus, M.D., former president of the Union of American Physicians and Dentists).