AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: A
(I-22)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislation and Advocacy and RFS Committee on Medical Education

Subject: Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations

Referred to: Reference Committee

INTRODUCTION

At its 2022 Annual Meeting, the AMA-RFS Assembly referred RFS Resolution 7, “Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other relevant Associations or Organizations”, which stated the following:

1) RESOLVED, That our AMA advocate for significant modification or the repeal of Section 207 of the Pension Funding Equity Act of 2004 such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further

2) RESOLVED, That our AMA work with relevant stakeholders to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.

Accordingly, your AMA-RFS Governing Council referred this report to your RFS Committee on Legislation and Advocacy (COLA) and RFS Committee on Medical Education (CME). Your COLA and CME have researched this topic and have documented our findings and recommendations below.

BACKGROUND

The Sherman Antitrust Act

Passed in 1890, The Sherman Antitrust Act was the first antitrust law to be signed by Congress, and outlaws "every contract, combination, or conspiracy in restraint of trade," and any "monopolization, attempted monopolization, or conspiracy or combination to monopolize." In essence, the piece of legislation broadly prohibits anti-competitive agreements, and was the first measure enacted by the Congress to prohibit trusts or monopolies of any type in order to promote economic fairness and competitiveness, signaling a key shift within American regulatory policy at a time of growing monopolies within the likes of Standard Oil and the American Railway Union.

The Sherman Antitrust Act consists of three major sections:

1. Anti-competitive practices that restrain trade between states are illegal, including agreements to fix prices, exclude certain competitors, limit production outputs, combinations to form cartels.

2. Monopolization or attempts to monopolize trade are prohibited, including mergers and acquisitions that concentrate too much power in the hands of one entity.
3. Extends above provisions to all US territories and the District of Columbia.

The Sherman Antitrust Act was later followed in 1914 by the Federal Trade Commission Act which established the FTC, and the Clayton Act which further defined specific practices that the Sherman Act did not ban, thus comprising the three, core federal antitrust laws aimed to preserve the process of free market competition. Though these antitrust laws generally prohibit unlawful mergers and monopolistic business practices, it is ultimately left to the courts to ultimately decide case by case basis of legality. As both a civil and criminal law, penalties for violating the Sherman Act are significant, with criminal penalties up to $100 million for a corporation and $1 million for an individual, along with up to 10 years in prison.

The Pension Funding Equity Act of 2004
The Pension Funding Equity Act of 2004 was signed into law by President George W. Bush on April 8, 2004. This act was passed by the 108th Congress with the explicit purpose of amending the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to temporarily replace the 30-year Treasury rate with a rate based on long-term corporate bonds. Prior to the development of this bill, Dr. Paul Jung had launched a lawsuit against the Association of American Medical Colleges (AAMC), alleging that the organization had violated Section 1 of the Sherman Antitrust Act and colluded to prevent American trainee doctors from negotiating for better working conditions.

The AAMC and the American Hospital Association (AHA) subsequently lobbied unknown members of Congress to include a last-minute rider in the Pension Funding Equity Act stating that “antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so.” This rider was included as section 207 of the Bill and sponsored by Senator Judd Greg of New Hampshire and Senator Edward Kennedy of Massachusetts. Upon its passing, the Pension Funding Equity Act retroactively prohibited using allegations related to the Match to support any antitrust claim as “antitrust lawsuits...have the potential to undermine this highly efficient, pro-competitive, and long standing process.” The inclusion of section 207 in the Pension Funding Equity Act has been criticized by legal scholars over the past two decades as exemplifying the power of special interests in Congress.

Jung vs. Association of American Medical Colleges (AAMC)
On May 7, 2002, Jung et al. filed a class action lawsuit in the U.S. District Court in Washington, D.C. The lawsuit alleged anticompetitive efforts by the involved parties of the MATCH. The plaintiff was a group of three physicians representing all persons who had been employed as a resident and fellow physician since 1998 in ACGME-accredited programs. These included hundreds of thousands of doctors. The defendants were two groups involved in the match. The first is the organizations involved in the administration of GME in the United States, including AAMC, NRMP, and ACGME. AMA was also listed as a defendant but was subsequently dropped. The second group of defendants were the groups that sponsor the medical residency programs including hospitals and health centers.

The plaintiffs had three interdependent components in their anticompetitive claims. These claims were based on section 1 of the Sherman Antitrust Act: “Every contract...or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.” Of note, some systems are immune to the Sherman antitrust act, like Major League Baseball. The anticompetitive claim had three interdependent components. The first was that prospective resident physicians are forced to enter residency through the NRMP, a system that eliminates a free and competitive market. Instead, the NRMP has a centralized allocation system for residency that does not allow negotiations. The second anticompetitive claim was
that parts of the ACGME accreditation standards restrict residency employment. The third anticompetitive claim was the sharing of resident’s terms and benefits of employment through AAMC annual survey of members and a database maintained by AMA.

The perception of Jung vs AAMC was mixed for medical students, residents, and fellows. The American Medical Student Association chose not to be part of the defendant’s case in June 2002. AMSA was involved in the NRMP change to applicant-oriented algorithm. The AMA-RFS also noted concerns about the lawsuit, and the ramifications of an alternative to the MATCH. Of note, ACGME instituted an 80 hour work limit in 2003, with preliminary approval in summer of 2002. The class action lawsuit ultimately ended up being dismissed due to legislation in 2004. A provision was added to the “Pension Funding Equity Act of 2004.” Section 207 noted that the match system is not subject to antitrust laws. The second provision is that evidence of anticompetitive behavior is not admissible in Federal court.

**National Collegiate Athletic Association v. Alston et. al.**

In historical perspective, The National Collegiate Athletic Association (NCAA), having monopsony powers, has been generating roughly one billion dollars in revenue through college football each year. Consequently, huge sums of money were paid to football coaches, Director sports and other managerial staff while student athletes were restraints from taking any monetary compensation/salary on the claim of being “amateur product” and this distinction of their product was presumed to be main responsible factor for huge consumer market demand in comparison with demand for professional football. However, football players, mostly coming from underprivileged backgrounds, were eligible to receive the cost of attendance at universities/colleges as compensation, which included “tuition and fees, room and boards, books and other expenses related to attendances.”

This case falls under the purview of Antitrust Laws. The core of USA Antitrust law was created by three pieces of legislation: The Sherman Antitrust Act 1840, the Federal Trade Commission Act, and the Clayton Act. Antitrust laws are also referred to as anti-competition laws, developed to protect consumers from predatory practices and ensure that fair competition exists in an open economy. In NCAA v. Alston, The Supreme Court upheld a district court ruling that NCAA rules limiting education related compensation violated Section 1 of the Sherman Act. Shortly after the court’s decision, NCCA voted of its own accord to allow students athletes to receive compensation in exchange for use of their name, image, and likeness while keeping restriction on compensation unrelated to education which prima facie can be taken as token of acknowledgment of district court decision.

Despite of the fact that the student athlete did not challenge the remaining NCAA rules in the Supreme Court, the Alston decision, along with background principles of antitrust law that the court did not consider, laid down ample scope for a successful future challenge to the NCCA restrictions on compensation in revenue sports; they cannot collectively fix the price of educational benefits offered to those student-athletes

**DISCUSSION**

**Evidence That Graduate Medical Education Violates Antitrust Laws**

The idea that the matching process limits price competition due to the system setting the same salary for all trainees at any given hospital was investigated with alternative solutions presented in the paper “Matching and Price Competition” by Jeremy Bulow and Jonathan Levin which was referenced in the lawsuit. The paper evaluated the match system, how it can compress wages and an alternative solution. In the paper it is surmised that without personalized prices, competition within the market is lessened thus compressing wages. In the current NRMP match
process, all applicants for the same training year are paid the same amount as determined by
the hospital system at which they match to.

On one hand, hospital systems are inherently less aggressive when setting these price points
when making offers to trainees because they have limited say in who they ultimately get as a
trainee. Therefore, they cannot commit to different incomes for different trainees during the
match process. However, this alone does not produce the reduced salaries that are offered to
trainees, instead it is this concept in combination with the asymmetries that exist between
hospital systems that decreases competition and alters the wage set-points for trainees. This
inevitably leads to a situation in which fair competition is brought into question. Hospitals don’t
have to adjust their salary thresholds to maintain competition, because the salary does not
necessarily impact whether or not they match trainees.

In contrast, the model described in the paper, allows trainees to rank hospitals by their offers
that are made to the trainees. It is implied that the offer includes salary as well as hours and
training. It assumes that the firm that makes the “highest” offer, is matched with the most “able”
or most sought-after trainee allowing for increased competition in the marketplace. All trainees
in this model are ranked by the hospital systems as well.

Relevancy to Residency Match

Following Jung vs AAMC and the Pension Funding Equity Act of 2004, there has been little
change to the matching process. Within this law, GME was protected from any antitrust suits
and was not ever verbally debated on the House or Senate Floor. There were multiple criticisms
of the addition of this “pork-barrel” legislation with comments from Senators concerned about
granting immunities to antitrust law. Unfortunately, intense lobbying efforts were ramped up by
the AAMC following the Jung vs AAMC case and has ultimately led residents to their current
state. Now that the current matching process has been supported by federal law, there are few
ways to challenge the process. This has led to residents using other means to obtain fair wages,
safe working environments, and other benefits that are unable to be negotiated within the
current system.

Current AMA Stance on Antitrust

Our AMA holds multiple policies (H-383.992, H-383.990, D-383.983, and D-383.990) regarding
antitrust in medicine primarily with the goal of preserving clinical autonomy, the patient-
physician relationship, and ensuring fairness toward physicians and physician-owned entities in
the application of antitrust laws. Policy D-383.983 in particular, points toward rules including
those within the Statements of Antitrust Enforcement Policy in Health Care by the U.S.
Department of Justice and the Federal Trade Commission that govern enforcement of physician
antitrust, as well as guidance that defines acceptable physician involvement and ownership of
health care entities and networks. Given the evolving and rapidly concentrating health care
environment, our AMA advocates for policy revisions that no longer disadvantage physicians in
contract negotiations with health care entities such as health insurance companies.

AMA policy also calls for equitable distribution of graduate medical education (GME) funds from
the federal government and including those distributed by the Centers for Medicare and
Medicaid services. Policy D-305.973 also advocates the federal government adopt an all-payer
trust fund that mandates involvement from health insurers—one of the largest stakeholders of
the health care industry—in funding graduate medical education.

Despite the significant interest in antitrust policy related to physician practice and
reimbursement, and some policy regarding funding of GME, antitrust regarding resident
physicians and associated matching or placement policies are relatively sparse. AMA policy D-
310.977, which has been appended multiple times including most recently at the 2022 Annual Meeting, calls on stakeholders including the National Resident Matching Program (NRMP), Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to enact reform of the matching process. Our AMA advocates for principles such as transparency in the Match and with match outcomes, as well as fairness with terms of employment during GME. Specific to antitrust, our AMA does not support the “all-in” policy required to participate in the NRMP Main Residency Match. This “all-in” policy stipulates that programs cannot offer residency positions for specific specialties outside the Match process, thereby concentrating job placement privileges singularly with the NRMP.

CONCLUSION

Next Steps to Address Antitrust Status of Graduate Medical Education Programs

The MATCH poses significant anticompetition concerns. While Jung vs. Association of American Medical Colleges (AAMC) was dismissed after the passing of the Pension Funding Equity Act of 2004, National Collegiate Athletic Association v. Alston et. al. suggests a different analysis for the MATCH system. Section 1 of the Sherman Act has two substantive elements needed to determine a violation. First, there must be a legally binding agreement between two parties that are capable of making an agreement. Second, the agreement’s effect is an unreasonable restriction of competition. The restraint is considered unreasonable by either a per se analysis or by the rule of reason. Per se unreasonable restraints include price fixing, market division, exclusive dealing, group boycotts, and tying arrangements. If an agreement does not fall into one of the per se categories, courts can still find an agreement to be unreasonable through the rule of reason. The rule of reason states that an agreement is an unreasonable restraint if the anticompetitive effects of the agreement outweigh the procompetitive effects. Generally, the defendant must have “market power” to raise prices in order to have the possibility of harming competition.

Next steps to address the antitrust status of GME would include: determining the impact of the Pension Funding Equality Act of 2004 on GME antitrust claims, determining if the anticompetitive effects of the MATCH outweigh the procompetitive effects under the rule of reason, and determining whether alternatives are substantially less restrictive on competition that the current MATCH system. The Pension Funding Equity Act stated that “antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so.” While the Pension Funding Equity Act states that having a residency matching system is not inherently a violation of Section 1 of the Sherman Act, there may be a viable argument that the specific way the MATCH operates is a violation. Similar to NCAA v. Alston, where the NCAA still has the right to restrict some of the competitive effects of college athletics, GME could be allowed to restrict competition to some extent while the current system could be considered a violation.

Regarding the Pension Funding Equity Act, the AMA could advocate for specific modification of the act to state specifically that the Act does not prohibit all antitrust arguments regarding the MATCH or could advocate for a complete repeal of the section. When balancing the procompetitive and anti-competitive effects of the MATCH, the analysis will likely hinge on the availability of alternatives that are less restrictive on competition. In NCAA v. Alston, the court ruling hinged on whether “substantially less restrictive alternative rules” existed that would achieve the same pro-competitive effect. This standard is difficult to pass regarding the MATCH unless alternate strategies are studied. The procompetitive effect of streamlining residency job applications and increasing percentage of position filled needs to be outweighed by the
anticompetitive effect of the lack of negotiation power of residents.

In *NCAA v. Alston*, the court held that the NCAA had violated the Sherman Act since the alternative requested did not impact the procompetitive effects of the NCAA rules. Alternatives to the MATCH process need to be studied in order to determine the impact on the current procompetitive effects of the MATCH.

RECOMMENDATION

Based on the report and recommendations prepared by the AMA-RFS Committees on Legislation and Advocacy and Medical Education, your RFS Governing Council recommends the following:

1) That the following resolved clauses be adopted in lieu of the original resolution:
   a) RESOLVED, That our AMA-RFS support efforts which seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in Section 207 of the Pension Funding Equity Act of 2004, such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further
   b) RESOLVED, That our AMA study, with relevant stakeholders, alternatives to the current residency and fellowship MATCH process which would be less restrictive on free market competition for applicants, to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.

Fiscal Note: Minimal

References:

5. Jung v. Association of American Medical Colleges: A Special Interest Victory, Miranda W. Turner, University of Houston Law Center, November 2, 2004

Relevant AMA Policy:

**Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973**

Our AMA will work with:
(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
(a) ensure adequate Medicaid and Medicare funding for graduate medical education;
(b) ensure adequate Disproportionate Share Hospital funding;
make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
(d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
(e) stabilize funding for pediatric residency training in children's hospitals;
(f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/sub specialties in shortage/defined need;
(g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
(h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13

National Resident Matching Program Reform D-310.977

Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.


Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

Citation: BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11; Reaffirmed: Res. 206, A-19

AMA's Aggressive Pursuit of Antitrust Reform D-383.990

Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans.

Citation: Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 09, A-18; Reaffirmed: Res. 206, A-19
Antitrust Relief H-383.992
Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.
Citation: Sub. Res. 905, I-07; Reaffirmation A-08; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: Res. 206, A-19