

2017

## Healthcare in America: A Contradiction in Terms?

Samantha Koppel

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### Recommended Citation

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# HEALTHCARE IN AMERICA: A CONTRADICTION IN TERMS?

*Samantha Koppel* \*

## TABLE OF CONTENTS

I. INTRODUCTION .....	46
II. ANTITRUST JURISPRUDENCE IN THE UNITED STATES .....	51
A. Accreditation Shield.....	52
B. State ( <i>Parker</i> ) Immunity .....	53
III. LIABILITY UNDER SECTION 2.....	55
A. Market Power .....	56
B. How the Free Market Would Address These Problems	59
C. Monopolization market Manipulation.....	59
i. <i>Effect on Supply: Resulting in Increased market</i> <i>Price for Medical Doctors</i> .....	60
ii. <i>Effect on Consumer: Increased Costs of</i> <i>Healthcare</i> .....	62
iii. <i>Lack of Pro-Competitive Justifications: Quality</i> <i>of Care</i> .....	63
IV. <i>DENTAL EXAMINERS: A NEW HOPE</i> .....	64
V. CONCLUSION .....	67
VI. APPENDIX: LICENSURE REQUIREMENTS BY STATE .....	67

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## I. INTRODUCTION

Americans trust doctors less than they ever have before.<sup>1</sup> This distrust has been attributed, in large part, to the time constraints that doctors face. The average appointment time lasts fifteen minutes.<sup>2</sup> Doctors and patients struggle to make meaningful and authentic connections in those allotted fifteen minutes. This time scarcity has reverberating effects. A 2001 study by researchers from the University of South Carolina found that their physicians typically interrupt patients within about twelve seconds of speaking.<sup>3</sup> At the same time, costs of medical care have risen. For example, colonoscopies, necessary screening tests that most Americans have to identify certain types of cancer<sup>4</sup>, cost somewhere between \$6,000 and \$19,000<sup>5</sup> in the United States; the same procedure in most other developed countries costs \$1,000.<sup>6</sup> Americans pay, on average, four times as much for a hip replacement than do patients in Switzerland or France, and more than three times as much for Caesarean sections.<sup>7</sup> Hospital stays of duration

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<sup>1</sup> Just 34% of 2012 Americans said they had “great confidence” in the “leaders of the medical profession,” down from 76% in 1966. See Anne Harding, *Americans' Trust in Doctors is Falling*, LIVESCIENCE (Oct. 22, 2014), <https://perma.cc/43EU-WKHV>. A survey of people in twenty-nine countries revealed that the United States ranks twenty-fourth in public trust of doctors. *Id.*; see also Donna R. Rhoades, et al., *Speaking & Interruptions During Primary Care Office Visits*, 33 FAM. MED. J. 528, 528 (2001)(highlighting the importance of communication in the practice of good medicine); see also Dignity Health, *Here's Why We Struggle to Make Connections With Our Physicians—and Why it Matters*, HUFFINGTON POST (Mar. 31, 2016), <https://perma.cc/854T-QCQ2>.

<sup>2</sup> Dignity Health, *supra* note 1.

<sup>3</sup> Ease of conversation is related to the development of meaningful and authentic connections, especially when a patient is communicating symptoms to her doctor, but even if small talk is being exchanged. See Donna R. Rhoades, et al., *supra* note 1, at 528-29.

<sup>4</sup> Using the colonoscopy as a comparative tool allows one to effectively control for conditions that may be particularly common among a specifically American demographic, namely obesity, and procedures that might thusly be more expensive because of their “higher” demand. It is clear, then, that American’s healthy lifestyle, or lack or thereof, cannot be the reason for the difference in cost.

<sup>5</sup> Elisabeth Rosenthal, *The 2.7 Trillion Dollar Medical Bill: Colonoscopies Explain Why U.S. Leads World in Health Expenditures*, N.Y. TIMES (June 1, 2013), <https://perma.cc/FQ9S-JJ22>.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

cost around three times more in the United States than in other developed countries.<sup>8</sup>

This elevated cost is borne by the *consumer* (or patient) of these medical *goods* (treatment), while a consumer's ability to anticipate the costs of those goods is non-existent.<sup>9</sup> The consequence of this structural alignment against the consumer is particularly devastating when the consumer's choice is limited to one of two options: (1) access the goods, or (2) die. Unsurprisingly, medical debt is the primary cause of bankruptcy in the United States.<sup>10</sup>

Before the Affordable Care Act (ACA),<sup>11</sup> much of the elevated and rising cost of access to medical care was attributed to two categories of people. The first category was Uninsured persons, who cannot be turned away by law and were more likely to be unable to pay. The second category was the obese, who were thought to access medical care more frequently and drive up demand. While these arguments fail for several reasons, it is important to address and then dismiss them as causal factors for the high cost of access to medical care.

The first category of persons were those who are uninsured and underinsured; and persons who, partially due to the high cost of medical care and insurance, chose to forego preventative care and instead opted for emergency care. These people represented a significant unreimbursed expense for hospitals, which needed to recoup these losses. They accomplished this by raising their bills for both the insured and uninsured. They did so to significant heights largely expecting that insurance companies would negotiate at least some of that increase back down to market value. Given the weaker bargaining position that uninsured persons possessed, these people ended up the casualties of that broken system. It was precisely this problem that the provision requiring individuals to purchase health insurance in the ACA was meant to address. By 2015, more than twelve million new people had obtained insurance through the ACA.<sup>12</sup> The uninsured rate in America sunk from

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<sup>8</sup> *Id.*

<sup>9</sup> Costs of medical care are opaque. The cost of the same procedure can vary drastically depending on the patient, the type of insurance carrier, and the treatment facility. Importantly, costs also vary *even amongst those with the same insurance* based on the amount an insurer actually ends up reimbursing the patient. *See id.*

<sup>10</sup> Dan Managan, *Medical Bills are the Biggest Cause of US Bankruptcies: Study*, CNBC (Jan. 25, 2013 2:29 PM), <https://perma.cc/2ZH3-JGBQ>.

<sup>11</sup> Colloquially known as *Obamacare*.

<sup>12</sup> Stephanie Marken, *U.S. Insured Rate at 11.6% in Third Quarter*, GALLUP (Oct. 8, 2015), <https://perma.cc/K69G-V6L6>.

17.1% in 2013 to 10.9% in the final quarter of 2016.<sup>13</sup>

The second category was obese persons, who were thought to access care at a higher rate than non-obese persons, thus driving up demand. Because they require more medical care in an insurance-based system, they were thought to drive up the price of insurance premiums paid by healthier and wealthier individuals, especially in a federally subsidized system. This argument fails to explain elevated price levels in the system as it existed prior to the ACA because obese persons could be price-discriminated against or left out of the insurance-based system as a whole due to pre-existing conditions. Because insurance companies were able to discriminate against obese people on those grounds at that time, the obese persons as individuals, likely had to face those higher costs themselves; i.e., the cost therefore wasn't necessarily passed on to others attempting to access healthcare. Additionally, it is of particular importance to note that Britons live longer and healthier lives than Americans despite living similar lifestyles.<sup>14</sup> To be clear, Americans and Britons make similar lifestyle choices (e.g., exercise at similar frequencies, eat similar portion sizes) and have similar rates of obesity, yet Britons live longer and have fewer obesity-related health issues.<sup>15</sup> This evidence suggests that obesity is less likely to be a factor in our elevated costs of healthcare because even despite the significantly decreased uninsured population, Americans still pay significantly more for access to healthcare than any other country, including peer nations such as Great Britain.<sup>16</sup>

America spends 17.4% of its Gross Domestic Product (GDP) on healthcare,<sup>17</sup> significantly more than any other country, including both

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<sup>13</sup> Stephanie Marken, *U.S. Insured Rate at New Low of 10.9% in Third Quarter*, GALLUP (Oct. 7, 2016), <https://perma.cc/S37X-MVQG>.

<sup>14</sup> Eileen M. Crimmins, et. al, *Explaining Divergent Levels in High-Income Countries*, NATIONAL RESEARCH COUNCIL OF THE NAT'L ACADEMIES 1, 11 (2011), <https://perma.cc/JVQ2-HDUG>.

<sup>15</sup> Compare *id.* (discussing the U.S. longevity with other high-income countries), with Ami Sedghi, *How Obese is the U.K.? And How Does it Compare to Other Countries?*, THE GUARDIAN, May 28, 2014, <https://perma.cc/UU24-AS5K>.

<sup>16</sup> As of 2015, U.S. annual health spending per capita is \$8362.00, while Britons spend \$3480.00 per capita, annually; for every dollar Americans spend on healthcare, Britons spend 41 cents. See World Health Organization, *Global Health Observatory Data* (2015); <https://perma.cc/F4JQ-5UXE>.

<sup>17</sup> See Aaron Carroll, *What Makes the US Health Care System so Expensive?*, THE INCIDENTAL ECONOMIST (Sept. 10, 2010, 4:00 AM), <https://perma.cc/KDB7-CL6G/>; see also David A. Squires, *Issues in International Health Policy: Explaining High Health Care Spending in the*

industrialized and developed nations. Ability to pay is often one of the most important factors in explaining the rate of increase in health spending among industrialized countries, indeed, it explains 90% of healthcare cost;<sup>18</sup> however, even controlling for our ability to pay, Americans are still paying substantially more than we should for our healthcare.<sup>19</sup> One supposed explanation for the higher relative cost is that Americans receive higher quality care.<sup>20</sup> Unfortunately, it is debatable at best that the quality of our healthcare and our healthcare outcomes are any better than those of other industrialized nations.<sup>21</sup> What makes this pill more difficult to swallow is that Americans are nowhere near a path to healthcare spending stability.<sup>22</sup> The ACA was pitched, at least in part, as a cost-saving piece of legislation that would reduce healthcare costs as the pool of insured persons increased and the number of “free-riding” uninsured persons decreased. Unfortunately, that cost savings has not materialized; the exchanges set up by the ACA have merely slowed the rate of increase.<sup>23</sup> While the law has been good for some,<sup>24</sup> the optimistic view is that even while we are not on a path to lowering our cost of access to healthcare, we are also not steadily raising it. A more realistic view is that we are slightly worse off than before because we have eliminated as a causal factor what was believed to be the root of our problem. Because of the ACA, it is clear to scholars that the uninsured are not the driving force behind the higher healthcare costs. Because we can control for lifestyle choices that tend toward obesity, and even control for obesity itself by comparing ourselves to Britons, we have a basis for concluding that obesity is also not the driving force behind our higher healthcare costs. The nail in the coffin is that, in some cases, these costs are continuing to climb.

Healthcare costs are driven not only by the availability of affordable insurance, but also by the availability of healthcare providers.

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*United States: An International Comparison of Supply, Utilization, Prices, and Quality*, THE COMMONWEALTH FUND 1, 2 (2012), <https://perma.cc/QY86-NEB8>.

<sup>18</sup> See Carroll, *supra* note 17.

<sup>19</sup> *Id.*

<sup>20</sup> David A. Squires, *supra* note 17, at 9.

<sup>21</sup> *Id.* This will be discussed in more detail in Part III.

<sup>22</sup> CONG. OF THE UNITED STATES CONG. BUDGET OFFICE, THE 2014 LONG-TERM BUDGET OUTLOOK 1, 40 (2014), <https://perma.cc/R99R-69U3>.

<sup>23</sup> Cynthia Cox et al., *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces*, THE HENRY J. KAISER FAMILY FOUND. (2015), <https://perma.cc/83JG-SPCA>.

<sup>24</sup> See generally Margot Sanger-Katz et al., *Is the Affordable Care Act Working?*, N.Y. TIMES (Oct. 26, 2014), <https://perma.cc/T4SU-6Y4R>.

There is a documented shortage of healthcare providers in the U.S. Between 1985 and 2015, the number of medical schools and the number of graduating doctors entering the healthcare field increased only marginally and has failed to increase at a rate commensurable with population growth. Between 1985 and 2005, the United States population increased by 23%.<sup>25</sup> Between 2005 and 2015, the United States population increased at a rate of 8.6%. U.S. population growth added millions of Americans to the nation's demand for health care services and there has been no proportionate increase in supply. This increase in demand is reflected elsewhere; the interest in the medical profession has increased proportionally to demand for services. Applications to medical schools increased by 19% between 1985 and 2005 and again by 35.6% from 2005 to 2016.<sup>26</sup> Data about matriculation is unavailable for school years occurring before 2005, but since then, the number of matriculating medical students has only increased by 21.1%.<sup>27</sup>

It is fair to characterize this behavior as a market abnormality. Usually when demand increases so does supply. When markets defy expectations, often one of two things is happening, either: (1) the underlying assumptions upon which we are basing our predictions are incorrect or (2) there is some malfeasance occurring. This paper investigates both by examining whether the American Medical Association and medical schools are engaging in anti-competitive, perhaps even anti-social, conduct that has resulted in perennially high and increasing healthcare costs without a proportionate increase in healthcare quality and healthcare outcomes. This paper primarily examines the latter: the role that anti-competitive behavior by these groups, namely the use of monopolization prohibited by Section 2 of the Sherman Act, plays in determining American healthcare costs. Thus, Part II of this paper analyzes American Antitrust Jurisprudence, while Part III will thereafter discuss the application of such law to the American Medical Association (AMA), in light of the facts that are publicly

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<sup>25</sup> Growth rate =  $P_{2005} - P_{1985} / P_{1985} = (296,139,635 - 240,691,557) / 240,691,557$  ("P" equals population). See The World Bank, *United States* (1985, 2005) <https://perma.cc/R8NH-ABPY>.

<sup>26</sup> Association of American Medical Colleges, *Applicants & Matriculants Data Table A-16* (2017), <https://perma.cc/9T5A-GE33> (referencing 2015-2016 data, on file with author).

<sup>27</sup> See discussion *infra*; see also Association of American Medical Colleges, *Applicants & Matriculants Data Table A-16* (2017), <https://perma.cc/9T5A-GE33> (referencing 2015-2016 data, on file with author).

available. Finally, Part IV suggests that after *North Carolina Board of Dental Examiners*, there is, and should be, an avenue to address what is either opaque behavior or wrongdoing that costs Americans, both in terms of lower quality of healthcare, and monetarily—to the tune of millions of dollars each year.

## II. ANTITRUST JURISPRUDENCE IN THE UNITED STATES

The Sherman Antitrust Act prohibits certain anti-competitive practices, including monopolization. However, under Section 2 of the Sherman Act, being a monopoly is not in itself illegal; to trigger liability, an individual must actively monopolize, attempt to monopolize, or conspire to monopolize.<sup>28</sup> Analysis under Section 2 involves two distinct questions: (1) whether the entity in question has monopoly power in the relevant market; and (2) whether the acquisition of that power is distinguishable from growth or development that results from superior business acumen, the consequence of a superior product, or a historical accident.<sup>29</sup> Thus, analysis under Section 2 of the Sherman Act must be twofold.

The first inquiry centers on the question of economic substitutes: if the entity suspected of monopolization were to raise its prices, would consumers turn to an alternative seller or alternative product?<sup>30</sup> If the entity does not have the power to increase price above current levels (for example, an increase in price would drive customers to competitors or substitutes), we must then ask whether the entity has already raised prices above competitive levels.<sup>31</sup> This second inquiry focuses on the conduct used in acquiring the monopoly power and whether its purpose or effect is anti-competitive in nature. In cases where the conduct falls into certain proscribed categories presumed to have an anti-competitive effect, the analysis ends here.<sup>32</sup> For others we ask whether there are any

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<sup>28</sup> “Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . .” 15 U.S.C. § 2 (2012).

<sup>29</sup> *Id.*

<sup>30</sup> *United States v. Aluminum Co. of Am.*, 148 F.2d 416, 426 (2d Cir. 1945). Note that it is often the case that we exclude foreign markets from this analysis because there are additional barriers to entry into our market that must be overcome in order for the foreign product to be considered a viable substitute.

<sup>31</sup> *Id.*

<sup>32</sup> *See e.g., United States v. Socony-Vacuum Oil Co.*, 310 U.S. 350, 323 (1940) (“Any combination formed for the purpose or with the effect of raising,

pro-competitive, business justifications for the conduct in question.

### A. Accreditation Shield

The problem with regulating the AMA's<sup>33</sup> behavior under the aforementioned antitrust jurisprudence is twofold. First, generally accreditation policies, and the bodies that create them, have historically been granted a great deal of deference from the courts. Where schools have challenged an accrediting body's decision, those decisions, made pursuant to certain policies developed by the body, have been granted a great deal of leniency under the antitrust laws.<sup>34</sup> For a variety of reasons, all distinguishable from the situation at hand, courts have been reluctant to find that the Sherman Act aggressively polices accreditation.<sup>35</sup> Most importantly, among these distinctions is that this deference is based on a rationale that fails in this context. Courts have held that, despite imposing significant output restraints, accreditation does not necessarily prevent unaccredited institutions from competing.<sup>36</sup> This is true in the legal context, which was at issue in *Massachusetts School of Law at Andover, Inc.*<sup>37</sup> Many states provide alternative avenues for becoming a licensed attorney, but this is not so in the medical context.<sup>38</sup>

Even assuming *arguendo* that the logic from these accreditation cases is directly applicable here, it remains true that even when a particular group of persons is entitled to deference, even when they have successfully rebutted the presumption that they are engaged in behavior that is a *per se* violation of the Sherman Act, this does not end the inquiry.<sup>39</sup> Despite their protected status, leagues, and other joint ventures,

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depressing, fixing, pegging, or stabilizing the price of a commodity . . . is illegal *per se*.”).

<sup>33</sup> The Liaison Committee on Medical Education (LCME) is a sub-committee under the AMA and, as such, the AMA and the LCME will be used interchangeably throughout.

<sup>34</sup> See *Mass. Sch. of Law at Andover v. ABA*, 107 F.3d 1026, 1036 (3rd Cir. 1997) (holding that accreditation decisions made by the American Bar Association are not in violation of the antitrust laws).

<sup>35</sup> Matthew Struhar, *How to Dismantle a Virtual Cartel: The Promises and Pitfalls of Higher Education Reform in California*, 14 U.C. DAVIS BUS. L.J. 127, 137 (2013).

<sup>36</sup> See *e.g.*, *Mass. Sch. of Law at Andover*, 107 F.3d at 1030.

<sup>37</sup> *Id.*

<sup>38</sup> See discussion *infra* Section III.

<sup>39</sup> See generally *Associated Press v. United States*, 326 U.S. 1, 21 (1945).

many still violate the antitrust laws.<sup>40</sup> An association is well within its rights to limit its membership through certain policies or rules. Nothing in this paper suggests that the AMA should be prevented from adopting new or amended policies that restrict accreditation, those restrictions must, however, be reasonable and non-discriminatory.<sup>41</sup>

## B. State (*Parker*) Immunity

Second, notwithstanding a finding that the AMA is liable under the aforementioned framework, they may be entitled to state-action immunity.<sup>42</sup> On the one hand, the Liaison Committee on Medical Education (LCME), and by extension, the AMA, possesses a great deal of its power because of its monopoly status as the only accreditor of medical schools in the United States. On the other hand, it is this monopoly status that is granted by the state.<sup>43</sup> Each state grants the agency this power by choosing to license as doctors only students who have graduated from duly accredited medical schools. Obviously, the LCME lacks enforcement power, which also resides with the state.

State actors are given an exemption from liability for engaging in activity that might otherwise be a violation of the antitrust laws. This immunity applies to the state when it exercises legislative authority by

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<sup>40</sup> Compare *Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Okla.*, 486 U.S. 85, 100-01 (1984) (holding that while the NCAA was engaged in price fixing, leagues have protected status and, as such, courts should take a quick look to see if the behavior alleged is truly price-fixing before applying the per se rule), and *Clarrett v. Nat'l Football League*, 369 F.3d 124, 139-41 (2d Cir. 2004) (holding that notwithstanding the NFL's status as a league, eligibility rules that preclude certain adults from entering the draft are violations of the antitrust laws), with *United States v. Terminal R.R. Ass'n*, 224 U.S. 383, 411 (1912) (explaining that when a joint venture has control of a resource that is essential to enter and/or compete in an industry it has control of an essential facility and excluding others from access to the essential facility must be done on reasonable and non-discriminatory terms), and *Associated Press*, 326 U.S. at 19 (holding that "arrangements or combinations designed to stifle competition cannot be immunized by adopting a membership device accomplishing that purpose.").

<sup>41</sup> See *Associated Press*, 326 U.S. at 11-12, 19 (arguing that By-Laws passed by the Associated Press (AP) that prohibit members from joining the AP are not immunized by AP's joint venture status because they are designed to stifle competition).

<sup>42</sup> See generally *Parker v. Brown*, 317 U.S. 341, 350-52 (1943) (holding that state and municipal authorities are immune from federal antitrust laws for actions taken pursuant to a clearly expressed state policy).

<sup>43</sup> discussion *infra*; see also Appendix.

creating legislation that has anticompetitive effects, but also, and most importantly, to private actors (such as the LCME) when they act at the direction of the state and pursuant to that legislation. The general assumption is that, absent clear congressional intent to preempt, the Sherman Act should not invalidate state programs. Congress intended the Sherman Act to address private, business combinations, not state combinations.<sup>44</sup> As a result, in order to determine whether a particular state statute was intended to be preempted by the Sherman Act, courts will engage in a two-step analysis as directed by *Rice v. Norman Williams Co.*<sup>45</sup>

As an initial matter, courts must decide whether the legislation at issue actually encourages prohibited activity at all: whether it “mandates or authorizes conduct that necessarily constitutes a violation of the antitrust laws in all cases, or . . . places irresistible pressure on a private party to violate the antitrust laws in order to comply with the statute.”<sup>46</sup> Once it is decided that the legislation authorizes anti-competitive activity, courts will consider whether the state statute is entitled to immunity.<sup>47</sup> Again the court applies a two-part test: “First, the challenged restraint must be *one clearly articulated and affirmatively expressed as state policy*; second, the policy must be *actively supervised by the State itself*.”<sup>48</sup> However, where “the states are sovereign in imposing [the alleged anticompetitive restraints], the clear articulation and active supervision requirements . . . are inapplicable.”<sup>49</sup> The Court reasoned that when the acting entity is the sovereign itself, there is less need for scrutiny and concerns about the legitimacy of the action are reduced.<sup>50</sup> Thus, the test to determine whether there is sufficient state involvement to render the acting entity as a sovereign is

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<sup>44</sup> *Parker*, 317 U.S. at 359-60.

<sup>45</sup> 458 U.S. 654, 661 (1982).

<sup>46</sup> *Id.*; see also 324 Liquor Corp. v. Duffy, 479 U.S. 335, 345 n.8 (1987) (“Our decisions reflect the principle that the federal antitrust laws pre-empt state laws authorizing or compelling private parties to engage in anticompetitive behavior.”).

<sup>47</sup> *Parker*, 317 U.S. at 350-51.

<sup>48</sup> See, e.g., Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (emphasis added).

<sup>49</sup> Mass. Sch. of Law at Andover v. ABA, 107 F.3d 1026, 1036 (3d Cir. 1997); see also Sessions Tank Liners, Inc. v. Joor Mfg., 17 F.3d 295, 299 (9th Cir. 1994) (immunity from antitrust liability exists where the injuries for which the plaintiff is seeking recovery flow directly from government action).

<sup>50</sup> *Mass. Sch. of Law at Andover*, 107 F.3d at 1036.

unnecessary when the state legislature or state supreme court acts directly. Closer analysis is only required “when the activity at issue is not directly that of the legislature or supreme court, *but is carried out by others pursuant to state authorization . . .*”<sup>51</sup> However, in *North Carolina State Board of Dental Examiners v. FTC*,<sup>52</sup> the Supreme Court held that a state occupational licensing board primarily composed of active market participants in the very market the board sought to regulate only had immunity when actively supervised by the state. Because the dentists controlled the licensing board, the antitrust laws applied in full force and effect, particularly in light of the risks licensing boards dominated by market participants may pose to the free market.<sup>53</sup>

The LCME and, by extension the AMA, are acting under a directive from each of the states that authorize it to accredit medical schools. An attack on how the AMA lobbied to get that power is immune from antitrust liability.<sup>54</sup> However, state involvement is irrelevant when those making the decisions are (1) market participants and (2) they are making decisions outside of the scope of the clearly articulated policy of the state. Finally, a state that is not diligently performing its duties as sovereign by actively supervising those making the decisions, state immunity is inapplicable. It is the application of this exception that is discussed in Part IV.

### III. LIABILITY UNDER SECTION 2

Becoming a doctor in the United States requires a commitment of at least twelve years of medical education. Students must first pursue a degree from an accredited college or university. To complete that degree, students must usually complete courses in biology; physics; calculus; human anatomy; general and organic chemistry; biochemistry; as well corresponding laboratory courses. Students looking to continue on to medical school must maintain a high grade point average, achieve a competitive score on the Medical College Admission Test (MCAT),

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<sup>51</sup> *Hoover v. Ronwin*, 466 U.S. 558, 568 (1984) (emphasis added).

<sup>52</sup> 135 S.Ct. 1101 (2015).

<sup>53</sup> *Id.* at 1104 (“Because a controlling number of the Board’s decision makers are active market participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here, that requirement is not met.”).

<sup>54</sup> Aside from certain exceptional *shams*, attempts to lobby the government to act are not subject to the antitrust laws. See *generally* *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961).

and successfully complete admissions interviews. After four years of medical school, students must complete a one-year internship (most students opt to complete an internship longer than the one-year minimum), a three-to-four year residency program, and a fellowship.<sup>55</sup>

Medical schools must have an accredited hospital where they can train their students.<sup>56</sup> A doctor must, as a requirement for their insurance, be Board Certified for their specialty, and must also be licensed to practice medicine by the state and take the Hippocratic Oath.

Each state controls its own licensure requirements, and while the requirements “vary” among the states, every single state requires a candidate to have attended a properly accredited medical school.<sup>57</sup> Empowering the states to decide their own licensure requirements serves the medical community by providing, at least in theory, for experimentation and local governance. States are free to establish their own expert bodies to evaluate whether medical schools are producing graduates worthy of licensure. This is precisely the procedure that states have adopted for law schools.<sup>58</sup> However, every state in the country has foregone the potential benefits of a state-centric approach by abdicating their power to determine accreditation, opting instead to defer to the Liaison Committee on Medical Education (LCME). The LCME, a committee of doctors inside the American Medical Association, is therefore the sole body overseeing the accreditation of American medical schools.<sup>59</sup>

### A. Market Power

There would be no medical schools in America without the American Medical Association, and there would be no licensure of

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<sup>55</sup> The accreditation process of these residency programs vary based on the specialty. *Id.*

<sup>56</sup> The Joint Commission on the Accreditation of Hospitals controls this particular accreditation process. Interview with H. Richard Beresford, Adjunct Professor of Law, Cornell Law School (Dec. 2, 2015).

<sup>57</sup> If a student attends a foreign school, that student must meet a separate set of requirements, which involve more testing of the doctor-applicant. *See* Appendix.

<sup>58</sup> *But see* Mass. Sch. of Law at Andover v. ABA, 107 F.3d 1026, 1036 (3rd Cir. 1997).

<sup>59</sup> *See generally* American Medical Association (AMA), *Council Reports* (Mar. 5, 2017, 9:20 PM), <https://perma.cc/LV6P-CSU8>; *see also* AMA, *Council on Medical Education Liaison Committee for Specialty Boards* (Mar. 5, 2017, 9:20 PM), <https://perma.cc/2LJR-9569>; *see also* AMA, *About the Council on Medical Education* (Mar. 5, 2017, 9:20 PM), <https://perma.cc/ET2Z-PTTD>.

doctors without the state. Even between these two actors, the AMA controls more of the process because the AMA controls the medical schools directly. If the LCME issued additional rules, such as mandatory payment of a five million dollar accreditation fee, medical schools would be forced to pay this fee. There is no alternative in order to give your graduating students opportunity for licensure by the state. However, it is important to think of medical schools as sellers operating in two distinct markets. They are sellers of a medical education to potential medical students. They are also *sellers* of doctors to the states for their licensure, who then license the sale to the community at large.

In considering medical schools as in the former market, we must first ask how they would behave if they were rational, self-interested actors. How many students would they sell to under hypothetical, less restrictive circumstances? The reason that we must artificially bifurcate our analysis and consider medical schools only sellers in this market at first is because, assuming self-interested rationality, the school would not be concerned about the *selling* of doctors to the state,<sup>60</sup> and then the community at large, because they normally would not stand to profit off of that transaction. This means, in theory, that medical schools would have very little incentive to want to limit the overall supply of doctors.<sup>61</sup> In theory, the institutional incentives should align such that every medical school matriculates at capacity. Medical schools might harbor concerns about the *marketability* of their students if their students underperform to the point of threatening their accreditation status, but those concerns should be intermittent, as accreditation only occurs once every five years.<sup>62</sup> Even accreditation is only a concern insofar as it makes the medical school a good choice for potential students. Really, a

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<sup>60</sup> Just as law schools, for better or worse, are not concerned with how their students fare in the market for lawyers.

<sup>61</sup> This is relevant insofar as it concerns the possibility that the medical schools are also liable under the Sherman Act. Section 1. Agreement liability jurisprudence would suggest that one can infer an agreement to fix prices where prices are above competitive levels, where there is parallel conduct, and where firms act in ways that would be against their self-interest absent an agreement (there would be a great deal of risk associated with this conduct if other's were not participating). Especially where one firm acts as a facilitator in achieving such an agreement (also known as a "Hub and Spoke" Conspiracy). *See, e.g., Interstate Circuit v. United States*, 306 U.S. 208, 227 (1939); *Toys "R" Us, Inc. v. FTC*, 221 F.3d 928, 935, 937 (7th Cir. 2000).

<sup>62</sup> *See LCME, Rules of Procedure*, AM. MEDICAL ASSOC. 1, 12 (March 2016), <https://perma.cc/YR4S-FHJM>.

medical school's bread and butter is to take pre-med students and turn them into doctors for the low price of \$300,000. The more students that an administration can get to matriculate at their school in any given year, the bigger their class size is, the higher the turnover any given medical school has from student to doctor and, in turn, the more revenue they can raise in any given year.

Mercifully for the medical schools, the education that they provide is not really a resource that operates under the same scarcity schema that is the basis of normal supply and demand, as long as they have the seats, they can pack more students into a lecture hall and more doctors onto a rotation. Obviously, student-to-faculty ratios are important in judging the quality of education one might receive in any given institution, so matriculating above capacity is not an ideal situation for the student, the consumer, nor truly for the school. Understanding how the institutional incentives would align without as restrictive of rules, its understood that (1) the AMA must control the number of matriculating medical students in any given year; (2) the AMA needs to control the students that each individual medical school admits; and (3) the AMA must control the rate at which students consume medical education. It is precisely this control that ensures that students receive a quality education and that quality doctors are treating patients in this country. The question then becomes, how strict ought those requirements be?

There are reasons why medical professional licensure ought to be more competitive than licensure in other fields. First, doctors exert enormous control over the health and well-being of their patients, often in life or death situations. Whether it is making a routine diagnosis, ordering a brain scan, or cutting open the human body, there are serious costs to inadequate competency. Similarly, faith in the competence of medical professionals may be more critical than faith in professionals in other industries because society benefits from a commitment on the part of all of its members to seeking preventive and corrective care diligently and promptly. The whole process of accreditation, and later licensure, is presumably to ensure that only students of a certain caliber gain access to that kind of power and responsibility.<sup>63</sup>

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<sup>63</sup> Compare this with the lawyers in the legal profession. There have been countless articles about how immoral and fraudulent the accreditation process is. A simple Google search for "law school scam" produces over one million results. See, e.g., Paul Campos, *The Law-School Scam*, THE ATLANTIC (Sept. 2014), <https://perma.cc/7LN4-82TU>.

## B. How the Free Market Would Address These Problems

Of course, what is described above is a medical school's ideal situation, but the market for students would clearly repress this urge. Any freshman economics major can explain the principles of supply and demand. Absent any outside interference, the point at which medical schools would sell educations to pre-med students would be determined by the demand for doctors. Presumably, students care about the quality of the university and the quality of the university is tied to the quality of education. This metric may also be tied to how competitive it is to go to school there. Presumably, too, the market would set a price for doctors, which would be sold by the schools, albeit indirectly, by virtue of loans being repaid and by virtue of their degrees being in higher demand. Society highly values this work. Medical school is expensive. The influx of medical students would react to this price point. Unfortunately, this is not actually how the market for potential medical students currently operates, and that is a huge problem.

## C. Monopolization Market Manipulation

The reason that the market does not operate the way it should is because the AMA, through the LCME, controls the number of medical students that can matriculate in any given year. They do this by conditioning accreditation decisions, at least partially, on the number of proposed matriculates. If a medical school administration considers increasing its class size by fifteen students or 10%, a number meant to include transfers (people who have already been admitted into medical school), whichever is smaller, they must inform the LCME via petitioning for such a change.<sup>64</sup> The AMA controls the supply of

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<sup>64</sup> See Provost Fin. Admin., *Strategic Plan for Enrollment Growth 2010-2020*, UTMB HEALTH 1, 9 (2011), <https://perma.cc/DU9G-V5DJ> (“Appropriate balance between student enrollment and the total resources of the institution, including faculty, physical facilities, appropriate numbers and mix of patients, and the operating budget. Significant modifications to the educational program, or substantial changes in student enrollment, or variations in the resources of the institution may distort this balance.”) (quoting *Guidelines for Increasing Class Size in Medical Schools Accredited by the LCME or the CACMS*). It is impossible to know for certain how important this factor is in accreditation decisions because the decisions made by the subcommittee on graduate medical education are subject to the strictest confidentiality. Here, where the state's ability to oversee and ensure that proper decisions are being made is dependent

doctors in this country by instituting a cap on enrollment below capacity as a condition of accreditation for any medical school. There are many detrimental resultant effects that include an effect on supply of doctors in the United States and an increase in the cost of a medical education, but a corresponding decrease in the quality of medical care. It is the latter cost that makes our artificial bifurcation important once again.<sup>65</sup> Finally, the manipulation causes an increase on the price of healthcare in the United States. I address each of these effects in turn.

*i. Effect on Supply: Resulting in Increased Market Price for Medical Doctors*

Let us first address the problem of market price for doctors and potential students' reaction to that market price. To analogize, consider the oil market. Rudimentary economics tells us that an oversaturation of oil in the market would drive costs of oil down. It would drive oil companies out of business, and result in decreased access to oil over time. On the other hand, an artificial restriction of oil into the market would drive prices up. It is so clear that this relationship exists that price-fixing in the United States is synonymous with restricting supply.<sup>66</sup> The market addressed in this paper is more complicated than the oil market because doctors are being consumed on two different levels. We must first consider the primary market, a doctor's ability to be gainfully employed by a hospital or in private practice. To restrict supply of doctors as such would tend to have an impact on the selling price for medical services upon the completion of a doctor's education.<sup>67</sup> In 2015, the average primary care physician earned \$195,000 for patient care, while the

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on the availability of this information, that information is presumably unavailable without the authority to investigate. The inference that this factor is important is warranted given the additional form and the small margin of increased enrollment before a petition becomes mandatory (under threat of un-accreditation).

<sup>65</sup> See Campos, *supra* note 63. Because of this schema, schools now stand to profit from behavior that if other schools were not participating in, would be risky from a rational, self-interested actor's point of view. This is by virtue of their engagement in the market for medical school educations. It is under this theory that the antitrust laws, as well as the AMA may capture their conduct.

<sup>66</sup> *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

<sup>67</sup> Not measured by completion of the M.D. degree, but rather completion of all of the requirements of becoming a doctor including the internship year(s), residency training, and fellowships.

average specialist earned \$284,000.<sup>68</sup> Pediatricians were the only type of

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<sup>68</sup> This number only reflects patient care activities. The sum is supplemented by the amount earned for non-patient care activities (an amount between \$6,000 and \$29,000, annually).

The average supplement across physicians is \$14,885. Such activities include expert witness duties, product sales, speaking engagements, and the ordering of patient-care salaries, which all look remarkably similar to this scale. See Robert L. Phillips, Jr. et al., *Specialty & Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices*, THE ROBERT GRAHAM CTR. 1, 41 (2009), <https://perma.cc/82L9-QBAK>.

There is strong comparative analysis data and information on income of medical students and professionals. See Venis Wilder, et al., *Income Disparities Shape Medical Student Specialty Choice*, INST. OF MEDICINE 1, 1 (2010), <https://perma.cc/YQH9-B3X2> (discussing income disparities effecting students' choices of focus area); see also Margaret Edmunds et. al., *Geographic Adjustment in Medicare Payment—Phase I: Improving Accuracy*, INST. OF MEDICINE 1, (2012), <https://perma.cc/PK7L-5YJL> (highlighting the impact of medicare on the medical profession); Ya-Chen Tina Shih & Thomas R. Konrad, *Factors Associated With the Income Distribution of Full-Time Physicians: A Quantile Regression Approach*, 42 HEALTH SERVS. RESEARCH 1895, 1906 (2007), <https://perma.cc/VW85-VG4B>; see also Kathryn Dill, *The Richest and Poorest States in 2014*, YAHOO FINANCE (Oct. 13, 2014, 12:12 PM), <https://perma.cc/DV32-B7LX> (demonstrating the diverse finance situations of the states); see also Tom Florence, *Trends in Physician and Advanced Practitioner Employment*, MERRITT HAWKINS (Jun. 30, 2014, 11:28 AM), <https://perma.cc/ELT6-L3LQ>; see also Leigh Page, *12 Changes that will Affect Doctors' Income in 2015*, MEDSCAPE BUSINESS OF MEDICINE (Nov. 25, 2014), <https://perma.cc/W6EX-TCZM> (discussing forthcoming changes in medical professional's income); see also BUREAU OF HEALTH PROFESSIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *THE PHYSICIANS WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND* 23 (2008), <https://perma.cc/M358-PYZF>; see also Karen Sibert, *Don't Quit This Day Job*, THE NEW YORK TIMES (Jun. 11, 2011), <https://perma.cc/82LP-BX3Z> (discussing the number doctors and how it impacts the ability for professionals to get fulltime and full paying jobs); see also Susan Pollart et al., *Characteristics, Satisfaction, and Engagement of Part- Time Faculty at U.S. Medical Schools*, 90 ACAD. MED. 355, 360 (2015), <https://perma.cc/72SF-9K7W>; see also Sheri Porter, *What's All the Buzz About Direct Primary Care?*, AAFP NEWS (May 6, 2014, 8:45 PM), <https://perma.cc/JC26-FJSM>; see also Megan Brooks, *Less Money, More Rules for US Physicians in 2015*, MEDSCAPE MEDICAL NEWS (Jan. 2, 2015), <https://perma.cc/8STR-NG7A>; see also Douglas Staiger et al., *Trends in the Work Hours of Physicians in the United States*, 303 JAMA 747, 752 (2010), <https://perma.cc/5YP3-UPMX>; see also Peter Ubel et al., *Full Disclosure-Out-of-Pocket Costs as Side Effects*, 369 N. ENGLAND J. OF MED. 1484,

doctors to earn less than the \$195,000 number, the average one taking home \$189,000.<sup>69</sup> The top earners were orthopedic specialists, who earned an average yearly salary of \$421,000. The amount that doctors are paid obviously factors into the cost of a medical education in this country as well as how highly people value doctors. Perhaps most notably, there is a variation in amounts paid to medical doctors, even controlling the medical field in which a doctor might practice.

To continue our comparison to the market for new lawyers, this lack of uniform pricing suggests that medical doctors, even controlling for field of medicine, have increased bargaining power relative to their legal counterparts. This difference is significant as it prompts the question: Why? The lack of bargaining power for new associates is often attributed to the oversaturation of new lawyers each year, and not due to collusion on behalf of the large firms. Lack of uniform pricing, even over time, suggests that the market is not leveling out the way one would expect it to. An explanation for this is an artificially increased bargaining power for medical doctors upon their completion of their requirements. Further evidence of this increased bargaining power includes some hospitals' willingness to take over the student loan obligations of a newly employed physician.<sup>70</sup> This perk can be valued at an average \$61,000 yearly over the repayment period.<sup>71</sup>

ii. *Effect on Consumer: Increased Costs of Healthcare*

Limiting the ability of medical schools to take on as many students as their capacity allows the AMA, through the LCME, to engage in monopsony and monopoly behavior. They alone control access to medical educations through the accreditation process. The AMA, through the LCME's regulation of medical schools, engages in this anti-competitive behavior by controlling the output of doctors.

They artificially suppress the supply of doctors through their

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<https://perma.cc/553J-RWUR>.

<sup>69</sup> Phillips, Jr., et al., *supra* note 68, at 21-22.

<sup>70</sup> The terms of these agreements often pay the debt off completely within three years.

<sup>71</sup> According to the most recent, publicly available data, the average medical student's debt obligation is \$176,000, and the median debt obligation is 180,000. See generally *Medical Education Debt Fact Card*, AAMC (Oct. 2014), <https://perma.cc/7J4F-W3AF>.

accreditation policies. By refusing to accredit necessary medical schools and capping medical school attendance below capacity, they arbitrarily exclude from the profession those who are qualified. The effect of this arrangement is that employers of doctors must pay more than they otherwise would for that doctor's services and doctors can charge more to patients for their services. This is exacerbated at the specialist level. Furthermore, this increases the cost of all healthcare, not just patient visits.

iii. *Lack of Pro-Competitive Justifications:  
Quality of Care*

Between 1986 and 2005, only one medical school was accredited in the United States.<sup>72</sup> One medical school closed during that time, and two schools merged, resulting in the number of medical schools falling from 126 to 124.<sup>73</sup> Between October 2005 and 2012, that number increased slightly to 141.<sup>74</sup> At the same time, the population in the United States increased from 240 million in 1986, to 296 million in 2005, and to 313 million in 2012.<sup>75</sup> This, combined with the fact that medical schools have had to petition for the right to increase their class size as a condition of continuing accreditation,<sup>76</sup> suggests that the supply of doctors is thus not properly responding to the increase in demand. This lack of response is profitable to existing doctors because it makes them, and their services, more desirable. On the other hand, one can see how the market for potential medical students does respond to this increased demand, as the number of applications to medical schools has increased. Despite this, the ratio of applicants to matriculates has decreased, and the number of matriculates has remained largely stagnant.<sup>77</sup> The effects are twofold: (1) it is more profitable to be a medical school, and (2) there is an increase in the market price for healthcare.

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<sup>72</sup> See *A Snapshot of the New and Developing Medical Schools in the U.S. and Canada*, AAMC (Oct. 2012), <https://perma.cc/UH8N-8C9K>.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> See *Population Growth*, THE WORLD BANK (Feb. 6, 2017), <https://perma.cc/82FJ-GQW8>.

<sup>76</sup> See discussion *infra*; Association of American Medical Colleges, *Applicants & Matriculants Data Table* (2017), <https://perma.cc/9T5A-GE33> (referencing 2015-2016 data, on file with author).

<sup>77</sup> *Id.*

Medical schools are not truly doing their job if someone who spends four years learning, takes and passes a national test, does at least one year of an internship, completes three to four years of a residency, completes a fellowship, and gets board certified on top of all of that, is not qualified to provide essential healthcare services to the American public. Notwithstanding that fact, the argument advanced for restricting the amount of students who can be admitted and who can matriculate to medical schools in America is that we must ensure that the physicians are duly qualified and that healthcare outcomes are positive.

As explained above, in Part I, the United States healthcare system is the most expensive of any industrialized nation and the most expensive of any in the world. At the same time, most reports show that the United States consistently underperforms relative to other countries on most dimensions of performance.<sup>78</sup> According to a study from John's Hopkins University, the United States also ranks behind most countries on many measures of health outcomes, quality of care, and efficiency.<sup>79</sup> The major findings include: compared with the other countries studied, the U.S. has lower scores on safe and coordinated care that tend to pull the overall U.S. quality score down.<sup>80</sup> On indicators of efficiency, the U.S. ranks last. The U.S. also has poor performance on measures of administrative costs as well as on measures of administrative hassles.<sup>81</sup> There is more avoidable emergency room use in the United States, as well as duplicative medical testing.<sup>82</sup> People of a higher degree of illness in other countries are less likely to visit the emergency room for a condition that could have been treated by a regular doctor, *had one been available*.<sup>83</sup> Finally, the U.S. ranks last overall on all three indicators of a healthy life: mortality access to medical care, infant mortality, and healthy life expectancy at age sixty.<sup>84</sup>

#### IV. *DENTAL EXAMINERS: A NEW HOPE*

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<sup>78</sup> See generally Karen Davis, et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Healthcare System Compares Internationally 2014*, THE COMMONWEALTH FUND (June 2014), <https://perma.cc/4J4Y-GARN>.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* (emphasis added).

<sup>84</sup> *Id.*

The Liaison Committee on Medical Education is made up of doctors who stand to profit from a decreased supply of doctors. They are active market participants under *Dental Examiners*. This is evident not only from the make up of the panel, but also because of the expertise required to make accreditation decisions. The interesting question, therefore, is whether the decisions that they are making are immune because they fall within the clearly articulated policy from the states. There is a range in each of the sovereign's statement, from "properly accredited by an approved accrediting agency" to "accredited by the LCME". Whether this is a clear directive almost certainly depends on whether one believes the state's articulated policy to be one of quality control. Is the state saying to the LCME, "We want you to only let in very good doctors, *even if that means your rules unreasonably restrict the supply of doctors in this state?*" This would be a clearly articulated policy if it were not for the reality that it is lacking from any state's legislative directive.

While unreasonably restricting the supply of doctors is probably not what the state desires, it is at least an open question whether that is indeed what the state is directing the LCME to do. Notwithstanding that directive, the sovereign must still actively supervise the entity it directs. The state currently fails to supervise the LCME, in fact, it lacks the ability to adequately supervise the board. Of course, on some level it must be true that the state wants to ensure that only qualified doctors are licensed to practice in their state, but what is unclear is whether the directive authorizes the current restriction level. Ultimately, the state must ask itself this question: is it better to have a shortage of doctors<sup>85</sup> or is it better to perhaps have lesser qualified doctors but no shortage thereof? Hopefully the state is able to find the sweet spot in between the two. It is precisely this reason that active supervision or, in the alternative, competition is required.

Upon looking at these statutes, reproduced in Appendix I, one will find that legislatures often use "an accredited school" as a proxy for qualified to train a student to become an adequate doctor. From that statement alone, it is not clear whether the states mean "make sure that your medical schools are competitive" or rather, "ensure that you only train the top undergraduates". This is thus not a clearly articulated policy of the state and would fail our analysis here. Despite this, one can imagine it to mean that the accrediting board should ensure a high quality of doctors, it is not clear that this directive implies *even if the practices*

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<sup>85</sup> Best estimates put the shortage at 90,000 fewer doctors than we need to adequately service the population.

*unreasonably restricts supply*. This option is accompanied by the problems our currently failing system faces, chief of which is the inflated cost incurred by the consumer (patient). *Dental Examiners* makes it clear that the presumption is states do not intend to restrict the application of the Sherman Act.<sup>86</sup> Even more, it is clear from the directive that what is of utmost importance is that patients are adequately treated. If one is restricting supply, invariably at some point patients are not being treated adequately by literal definition. The only reading that could justify the status quo is if a state, indeed *every state*, is directing the LCME to “train only what you consider to be the best candidates, whatever the cost to our healthcare outcomes and/or the cost to our citizens.”<sup>87</sup>

There are not enough doctors. Because of this shortage, the doctors that do practice do not have enough time to adequately assess the health condition of their patients. They are not getting enough sleep. They can only see a patient for fifteen minutes. They need to undercut their relationship with their patients by getting quickly to “the point” and interrupting them after twelve seconds of communication. It is not clear enough that the statute provides a directive to restrict access to medical school even if it means an unduly restricted supply of doctors, but by doing so, they might actually be running afoul of the actual articulated policy that the board is meant to carry out. Moreover, even if patients were not being harmed, preventing competition and creating barriers to entry if they are not within the State’s command scope is still wrong and runs afoul of the articulated aim of the Sherman Act. The doctors that are forced to be educated elsewhere because they did not get into medical schools in the United States is enough of a social harm to warrant change. The patient harm is salt in the proverbial wound. Even if quality of healthcare were constant, this behavior would still be a violation of the Sherman Act insofar as it harms would-be competitors to this degree.

Is the current regime acceptable to the sovereign? *De facto*, no state can possibly actively supervise this. The states do not have an apparatus with the requisite expertise; there is no state Surgeon General. That is why it is so interesting that each state law is, at its basic level *whatever the LCME wants*. While a clever defense attorney would argue every state has chosen to use this one committee and thus the LCME gets more supervision than anyone, this argument fails because, while

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<sup>86</sup> See e.g., *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S.Ct. 1101, 1110-12 (2015).

<sup>87</sup> And even if this conjecture were true, the LCME would still need to be actively supervised by every state to ensure compliance with the directive and thus grant them immunity.

theoretically the states could issue guidance through their guidance their respective Attorneys General, they cannot, because they have never applied any variation to any LCME decision. In practice, the states lack the requisite expertise to adequately supervise this apparatus. In order to do so, the states would be required to have medical professionals supervising the regulation for medical schools in their state. If the states were actually supervising the schools, might one state disagree on an accreditation decision? Many states have tweaked the American Bar Association model rules. Many states have even tweaked the Uniform Commercial Code. However, coincidentally, all states actively agree with every comma in every decision made by the LCME? Every accreditation decision made by the American Bar Association is published. This stands in stark contrast to the LCME, in which all decisions are subject to the strictest of confidentiality. There literally is no process. How can there be supervision when the decision-making process is so intentionally opaque?

## V. CONCLUSION

The cost of healthcare in America is an ongoing concern. Efforts to increase access to adequate care will fail unless the cartel that governs the decision of how many doctors to produce in America is adequately supervised or broken up—subject to competition in that market forces their actions to comply with what is in the best interest of society and not what will line their own pockets. If *Dental Examiners* is applied literally, it should apply to every licensing board across medical specialties. In this case, it is not the licensing board that is acting anti-competitively, but rather the agency that the licensing board defers to. While it could be argued that this additional step provides a shield the Sherman Act may not be able to penetrate, it plays no functional role. The question is whether it should play a substantive role. It should not.

## VI. APPENDIX: LICENSURE REQUIREMENTS BY STATE

### New York's Licensure Requirements, in relevant part:

#### §6528. Qualification of certain applicants for licensure.

1. Notwithstanding any other provisions of this article or any law to the contrary, an individual who at the time of his enrollment in a medical school outside the United States is a resident of the United States shall be eligible for licensure in this state if he has

satisfied the requirements of subdivisions one, five, six, seven and eight of section sixty- five hundred twenty-four of this chapter and:

has studied medicine in a medical school located outside the United States which is recognized by the World Health Organization; has completed all of the formal requirements of the foreign medical school except internship and/or social service; has attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the state board for medicine, and has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; has completed the post-graduate hospital training required by the Board of all applicants for licensure; and has passed the examination required by the Board of all applicants for licensure.

2. Satisfaction of the requirements of paragraphs (1), (2), and (3) of subdivision (a) of this section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.
3. Satisfaction of the requirements of paragraphs (1), (2), and (3) of subdivision (a) of this section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of subdivision (a) of this section.
4. No hospital licensed by this State, or operated by the State or a political subdivision thereof, or which receives state financial assistance, directly or indirectly, shall require an individual who has satisfied the requirements of paragraphs (1), (2), and (3) of subdivision (a) of this section, and who at the time of his enrollment in a medical school outside the United States is a resident of the United States, to satisfy any further education or examination requirements prior to commencing an internship or residency. A document granted by a medical school located outside the United States which is recognized by the World Health Organization issued after the completion of all the formal requirements of such foreign medical school except internship and/or social service shall, upon certification by the medical school in which such training was received of satisfactory completion by the person to whom such document was issued of the requirements listed in paragraph (3) of

subdivision (a) of this section, be deemed the equivalent of a degree of doctor of medicine for purposes of licensure and practice as a physician in this State.

California Licensure Requirements, in relevant part:

Cal. Code Regs. Tit. 16, § 1314. Approved Schools.

- (a) Those medical schools accredited by the Liaison Committee on Medical Education of the Coordinating Council on Medical Education or the Council on Medical Education of the Canadian Medical Association shall be deemed to be approved by the division for the giving of resident professional instruction in medicine.
- (b) A current list of such medical schools shall be maintained on file in the Sacramento office of the division.
- (c) Nothing in this section shall be construed to prohibit the division from disapproving a medical school which does not comply with Section 2089 of the code.

Statutory Authority:

Section 2018, Business and Professions Code. Reference: Sections 2005, 2037 and 2084, Business and Professions Code.

Florida Licensing Requirements, in relevant part:

Fla. Stat. §458.311. Licensure by examination; requirements; fees.

- (1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:
  - (a) Has completed the application form and remitted a nonrefundable application fee not to exceed \$500.
  - (b) Is at least 21 years of age.
  - (c) Is of good moral character.
  - (d) Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331.
  - (e) For any applicant who has graduated from medical

school after October 1, 1992, has completed the equivalent of 2 academic years of pre-professional, postsecondary education, as determined by rule of the board, which shall include, at a minimum, courses in such fields as anatomy, biology, and chemistry prior to entering medical school.

- (f) Meets one of the following medical education and postgraduate training requirements:
- 1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education<sup>88</sup> or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;
  - 1.b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and
  - 1.c. Has completed an approved residency of at least 1 year.

### Texas Licensure Requirements, in relevant part

Tex. Occ. Code § 155.003. General Eligibility Requirements.

- (a) To be eligible for a license under this chapter, an applicant must present proof satisfactory to the board that the applicant:
- (1) is at least 21 years of age;
  - (2) is of good professional character and has not violated Section 164.051, 164.052, or 164.053;
  - (3) has completed:
    - (A) at least 60 semester hours of college courses, other than courses in medical school, that are

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<sup>88</sup> See UNITED STATES DEPARTMENT OF EDUCATION, CURRENT LIST OF ACCREDITING AGENCIES & THE CRITERIA FOR RECOGNITION BY THE U.S. SECRETARY OF EDUCATION 15-16 (2008), <https://perma.cc/U5GG-62EL>.

- acceptable to The University of Texas at Austin for credit on a bachelor of arts degree or a bachelor of science degree;
- (B) the entire primary, secondary, and premedical education required in the country of medical school graduation, if the medical school is located outside the United States or Canada; or
  - (C) substantially equivalent courses as determined by board rule;
- (4) is a graduate of a medical school located in the United States or Canada and approved by the board;









