STATEMENT FOR THE RECORD

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"The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption"
Hearing before the Subcommittee on the
Administrative State, Regulatory Reform, and Antitrust
Committee on the Judiciary
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Dear Chairman Fitzgerald, Ranking Member Nadler, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony today on the National Resident Matching Program ("MATCH") monopoly and the medical residency antitrust exemption codified in 15 U.S.C. § 37b (2004). I support repeal of the exemption, not only because it targeted and extinguished an antitrust lawsuit originated by me and my clients in 2002, but also because I witness daily the exemption's ongoing harm to medical residents, patients, taxpayers, rural hospitals, and the medically underserved public across the nation. In my view, it protects market distortions, undermines free-market principles, limits personal freedom and choice, prevents normal employment negotiations, shields wage suppression, and contributes to the nationwide physician shortage.

A. Introduction and Statement of Interest

My name is Sherman Marek, and I am the founder and principal attorney of Marek Health Law, a Chicago-based firm that focuses on representing medical residents in disputes with teaching hospitals through internal appeals, administrative proceedings, direct negotiations, mediation, and litigation when required. Over the past 25 years, my colleagues and I have represented more than one thousand residents nationwide. Our daily practice is dedicated to rescuing the careers of young physicians trapped in a monopolistic system that offers them no meaningful protections—and often no second chances.

In the late 1990s, I was hired by a group of medical residents whose teaching hospital had lost its accreditation due to negligence—costing my clients board-certification eligibility and jeopardizing their careers. Despite years of training and hundreds of thousands of dollars invested in their education, they had great difficulty transferring to another program. It soon became clear that their obstacles had nothing to do with their own personal academic or clinical shortcomings, but rather with anticompetitive restraints—chief among them, the National Resident Matching Program (NRMP or Match). These restraints held residents in place—and in doing so, shut my clients out.

The Match and related restraints, operated by teaching hospital associations and their affiliates, locked graduating medical students into a single position at a specific institution and program. Even in cases of unsafe working conditions, inadequate pay, incompatible supervisors, family or medical emergency, or simply changes in personal preference, the system offered no freedom or flexibility—no effective way for a resident to move to another program during his or her three- to five-year period of training, particularly without the consent of his or her assigned program.

I conducted a deeper investigation, which ultimately led to the filing of a federal antitrust class action in 2002: *Jung v. Association of American Medical Colleges*. Brought under Section 1 of the Sherman Act, 15 U.S.C. § 1, it challenged the Match system itself and related anticompetitive restraints. I served as co-lead counsel for the three named plaintiffs, who had courageously volunteered for that position at grave risk to their medical careers, and tens of thousands of putative class members.

The court upheld the viability of our claims in *Jung*, 300 F. Supp. 2d 119 (D.D.C. 2004), denying the defendants' motions to dismiss. However, following that ruling, Congress enacted a statutory exemption as part of an unrelated pension bill—without hearings, debate, or public consultation. That exemption terminated the litigation and has shielded the Match and associated entities from antitrust scrutiny ever since. *See Jung*, 339 F. Supp. 2d 26 (D.D.C. 2004). The court described the Match as the "unifying element" of the overarching anticompetitive activity. *See Jung*, 226 F.R.D. 7, 10 (D.D.C. 2004). No court has retracted those legal conclusions, and the exemption has extended what was already 50 years of judicial avoidance into 75 years of complete immunity.

B. 2004 Exemption Harm to Residents and Patients

Residency training is essential for any graduating medical student who intends a career in medicine. All states require one or two years of such training to qualify for a medical license. Additionally, all specialty certification boards require three to five years of residency to become eligible for board certification. "General practitioners" who provide patient care without board certification have become largely anachronistic, as board certification has increasingly become essential for hospital admitting privileges, insurance reimbursement, participation in physician groups, and other critical aspects of medical practice.

The Match is the monopolistic gatekeeper of residency positions. Virtually all residency programs in the United States fill their first-year positions through the Match, which in turn compels virtually all graduating medical students and other applicants to participate as well. Once in an assigned position, the Match contract technically locks in the resident for only a portion of the training duration, but practicalities, inertia, and supplemental restraints generally bind residents to their assigned position for the entire three- to five-year period of training. Among other things, there is widespread "blacklisting" and refusal to hire any resident who attempts to transfer without the consent of his or her current program director.

The crucial nature of completing residency training, coupled with inability to transfer elsewhere, gives institutions, programs, and individual supervisors incredible leverage over residents. It is no level playing field. Residents must accept whatever low pay, burdensome working conditions, and bullying that are imposed on them and have little to no ability to improve their situations because they are unable to resign and resume training elsewhere.

One obvious harm to residents is compensation far below not only the value of services they provide on behalf of the hospital to patients, but also far below what Medicare pays the hospital to train that resident under the Indirect Medical Education (IME) and Graduate Medical Education (GME) funding programs. While the exact amount paid for any given resident is unique to each hospital based on a complicated formula, the average paid by Medicare is generally accepted to be $150,000 to $180,000 per resident annually. By contrast, the average resident in the United States is paid about $65,000 annually.

In *Jung*, we provided the court with this information and much more. It subsequently denied the hospitals' and associations' motions to dismiss, ruling that "from these allegations, the Court concludes that plaintiffs adequately have alleged a common agreement to displace competition in the recruitment, hiring, employment and compensation of resident physicians and

to impose a scheme of restraints, which have the purpose and effect of fixing, artificially depressing, standardizing and stabilizing resident physician compensation and other terms of employment among a number of the named organizational defendants and those institutional defendants that participated in the Match Program." *Jung*, 300 F. Supp. 2d at 162.

The harmful impact of the Match on resident compensation was also confirmed by detailed independent research and studies, including Bulow, J. and Levin, J., "Matching and Price Competition," NBER Working Paper Series, National Bureau of Economic Research (2005). In that study, economic modeling showed that in the Match environment "salaries fall relative to any competitive equilibrium while profits rise by almost as much," and that the best hospitals "gain the most from the system while wages become compressed." *Id*., p. 2 Abstract. This aligns directly with our position in *Jung*, which revealed an industry-wide agreement to fix compensation and eliminate individualized negotiation—conduct that would be illegal in any other labor market.

The *Jung* case also pointed out that lack of competition among hospitals "permits employers to exploit resident physicians by routinely requiring 60 to 100 hours of work per week, or more, often including 36-hour and 48-hour shifts." Complaint pars. 96. Using exhausted residents to provide care obviously increases the risk of errors and corresponding danger to patients. This was reflected by the case of Libby Zion in New York, whose unfortunate death in connection with an overworked resident resulted in the adoption of a state law in 1989 that limited duty hours for residents. *See also*, Landrigan, C., et al., "Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units," The New England Journal of Medicine, 35a;18 (2004).

Even though *Jung* was prematurely extinguished by the 2004 exemption, its filing in 2002 was followed closely by the decision of hospitals and their associations to "voluntarily" adopt 80-hour work week limits in 2003. In a competitive environment, however, the average number of work hours for residents would likely be reduced to even safer levels as hospitals sought to attract and keep residents who value that reduction. Many studies confirm that even the 80-hour limits put patients at risk and there is substantial room for improvement. *See, e.g.,* Ulmer, C., et al., "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety," Institute of Medicine (2009).

Burdened by low pay, long hours, and a lack of mobility due to the Match and structural impediments to transfer, residents are increasingly turning to collective bargaining to address workplace conditions. This trend reflects a growing desire for representation and recourse in a

system where residents have little power to negotiate independently. Since 2023 alone, several thousand residents have unionized at more than ten major academic medical centers—and early evidence suggests these efforts have advanced their interests.

C. 2004 Exemption Harm to Taxpayers, Rural Hospitals, and the Public

In addition to significantly harming residents and their patients, the Match and other mechanisms protected by the 2004 exemption also harm taxpayers, rural hospitals, and the physician workforce pipeline nationwide. Medicare pays hospitals about $18 billion annually under the IME and GME funding programs, and many millions of that are wasted because no corresponding board-certified physician is ever produced as anticipated by the government. Rural hospitals have difficulty attracting medical school graduates to their residency programs, a difficulty exacerbated by the Match and related wage suppression that impedes unique incentive packages. The Match and related restraints also contribute significantly to the nationwide physician shortage, locking many partially-trained residents out of the system and preventing them from ever becoming board-certified.

When residents leave their current programs and are unable to transfer in elsewhere to complete their training, federal taxpayers lose their significant financial investment in that resident. More specifically, multiples of the $150,000 to $180,000 annual Medicare payment mentioned above. In my law practice, I have handled several cases in which a resident has been terminated as late as their fourth or fifth year of training for some reason having nothing to do with their academic knowledge, clinical skills, or other characteristics relevant to how they would perform as a board-certified physician. Instead, it was due to improper retaliation, or a minor infraction, or a personality conflict with an influential attending or program official. These residents, and the taxpayers who funded their advanced clinical training, deserve a pathway to continuation and completion at some other institution.

The Match also puts rural hospitals at a disadvantage in recruiting residents—a concern reflected in published data, even if not always recognized or stated publicly by those institutions themselves. Among other things, the Match reports "match rates" for each hospital; low match rates are commonly interpreted by candidates as reflecting poor program quality and thereby reduce applications; and rural hospitals have historically had lower match rates than urban hospitals. *See*, Longenecker, R., et al., "A Match Made in Rural: Interpreting Match Rates and Exploring Best Practices, Family Medicine, Vol 55, Issue 7, 426-432 (2023).

Additionally, the Match and related restraints impede the flexibility of rural hospitals and prevent them from directly recruiting their preferred candidates with tailored incentives such as signing bonuses, relocation reimbursement, subsidized housing, or structured post-residency employment agreements designed to encourage longer-term commitment to the rural community. "Although rural family medicine programs are effective in preparing and placing trainees into rural practice, many struggle to recruit students to their programs." *Id*., at 426.

The Match and related anticompetitive restraints also exacerbate the nation's worsening physician shortage. According to reliable projections, the United States may face a shortfall of more than 100,000 physicians by 2034, with particularly acute deficits in primary care, rural medicine, and underserved urban communities. Each resident who exits the training pipeline prematurely and is unable to reenter due to structural impediments—rather than clinical inadequacy—represents a lost opportunity to address this national crisis. Each medical school graduate who does not complete residency equates to the loss of tens of thousands of future patient visits. The inability to transfer means that otherwise qualified and committed physicians are systematically excluded from completing their training, contributing to workforce gaps at a time when demand for care is surging due to population growth, aging demographics, and rising chronic disease burdens. The resulting shortages strain hospitals, delay treatment, increase provider burnout, and compromise patient outcomes.

D. The Remedy of Repeal and Conclusion

Repealing the 2004 exemption would not require Congress to decide the merits of any legal or factual claims. It could simply represent a return to consistency in federal law and a reaffirmation of sound legal and economic policy. Repeal may also have the salutary effect of prompting teaching hospitals and their associations to initiate systemic reforms on their own—as the adoption of work-hour limits shows they can do. If such voluntary changes prove insufficient to bring their practices into alignment with antitrust law, repeal will restore the courts' ability to evaluate the facts and legal claims through established judicial procedures and apply more than 130 years of precedent under the Sherman Act.

If Congress ultimately disagrees with the outcome of court proceedings—or with voluntary reforms undertaken by hospitals and their associations—it retains full authority to remedy the matter through legislation. In doing so, it can ensure that its expectations are met with respect to all relevant stakeholders: residents, patients, hospitals, taxpayers, and the public. Unlike in 2004, however, such legislation would be grounded in a fully developed factual and legal record, shaped by open proceedings and judicial findings.

In my opinion, this is a watershed opportunity for Congress—and for this Subcommittee—to restore core American legal and economic values: fair competition, individual opportunity, and accountability under the law. Based on my role in the *Jung* litigation and years of firsthand experience with the Match system's structural flaws and harmful consequences, I strongly support repeal of the 2004 antitrust exemption and the restoration of competition in residency training—for the benefit of all.

Sincerely,

/s/ Sherman Marek

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