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Subcommittee on the Administrative State, Regulatory Reform, and Antitrust

Hearing

The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption

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Summary Points

- Projected problems of shortages and imbalances in physician labor markets; along with the chronically low wages and long working hours that most resident physicians still face, necessarily raise warning flags about the dangers of concentrated market power
- The likely competition problems come not from the mathematical elegance and ingenuity of the MATCH algorithm per se, but rather from the program's related powers and conditions attached to it.
- The MATCH program does an excellent job in solving the wrong problem --- how to fix the resident market monopsony that the program only strengthens.
- The matching process delivers efficient sorting of bounded preferences, finality, and fewer unfilled positions. The main drawbacks, tied to legal objections, appear to be the vastly unequal bargaining power, wage compression and suppression, and onerous working conditions for residents that the program's interrelated rules and practices sustain

- At a minimum, this subcommittee and the current Congress should indeed seriously consider ways to limit, if not repeal, the current antitrust exemption first awarded in 2004 to the MATCH program.
- Even a legal determination that the MATCH program increases output as a procompetitive restraint may not survive rule of reason analysis without careful consideration of other potentially "least restrictive" alternatives
- A narrow focus on antitrust law will not solve all of the problems in physician labor markets, let alone the larger issues of cost, quality, and access throughout our overall health care system.
- Policymakers should consider a broader inventory of tools and levers that can shape not just the initial supply of new physicians but also facilitate how all health care providers can deliver more accessible, effective, and affordable care

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Thank you, Chairman Jordan, Subcommittee Chairman Fitzgerald, Subcommittee Ranking Member Nadler, and Members of the Subcommittee, for the opportunity to testify today on The MATCH Monopoly: Evaluating the Medical Residency Antitrust Exemption, and more generally on competition policy considerations involving physician licensing .

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior lecturing fellow at Duke University School of Law, senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations.

My remarks will focus first on the respective pros and cons of how the National Resident Matching Program (NRMP, or the "MATCH") has shaped the evolution of the market for post-graduate medical education, resident physician training, and physician services over the last seven-plus decades. Of course, developments in how its practices are treated under antitrust law have essentially been frozen since Congress enacted a rare legislation exemption in 2004, amid pending litigation. Such a lack of further scrutiny and monitoring through the legal system makes today's investigation by this subcommittee all the timelier and more overdue. Projected problems of shortages and imbalances in physician labor

markets; along with the chronically low wages and long working hours that most resident physicians still face, necessarily raise warning flags about the dangers of concentrated market power.

My testimony summarizes a number of potential legal remedies of different degrees and scales. Most of them presume reconsideration and modification, if not repeal, of the current statutory exemption. To be clear, the likely competition problems come not from the mathematical elegance and ingenuity of the MATCH algorithm per se, but rather from the program's related powers and conditions attached to it.

However, a narrow focus on antitrust law will not solve all of the problems in physician labor markets, let alone the larger issues of cost, quality, and access throughout our overall health care system. Policymakers should consider a broader inventory of tools and levers that can shape not just the initial supply of new physicians but also facilitate how all health care providers can deliver more accessible, effective, and affordable care. I will discuss a number of potential reforms that should rely more on reinvigorated competitive forces to do so.

How We Arrived at This Point (in Brief)

We are picking up on a previous trail of litigation that was frozen in time by congressional action. Jung, Llerena, and Greene v. Association of American

Medical Colleges (AAMC), National Resident Matching Program (NRMP), American Medical Association (AMA), American Hospital Association (AHA), American Board of Medical Specialties IABMS), Council of Medical Specialty Services (CMSS), Accreditation Council for Graduate Medical Education (ACGME), and over two dozen individual medical schools, hospitals, medical centers, and universities, was filed pursuant to the Clayton Act in federal district court in June 2002, as a class action of resident physicians seeking compensation for violations of section 1 of the Sherman Act

The essential claims were tied to how the NRMP used to assign medical students and other applicants to ACGME-accredited residency programs artificially fixed, depressed, standardized and stabilized resident physician compensation and other terms of employment in an unlawful manner. The primary means alleged for accomplishing this involved exchanging competitively sensitive information regarding resident physician compensation and other terms of employment, eliminating competition in recruitment and employment of resident physicians by assigning them through the NRMP, and establishing and complying with anticompetitive accreditation standards and requirements through the ACGME.

As the initial litigation proceeded, a number of the original defendants were dismissed from the case, but early discovery revealed enough information to raise

the risk of substantial damages being awarded to the plaintiffs, as well as the need for changes in the NRMP's policies and practices. However, a rare exercise of congressional intervention to award a statutory exemption from antitrust liability essentially short circuited further proceedings in the lawsuit, as well as future efforts to revive such claims.

That did not deter further development of some robust academic literature debating the competitive advantages and disadvantages of the NRMP, as well as further modifications in some of its practices over the next two decades.

The MATCH Program's Pros & Cons

In broad terms, defenders of the MATCH portray it as a necessary remedy for previous market imperfections, and one that provides the maximum possible social benefit. They point to an older pre-MATCH period, mostly in the years just after World War II, and characterize it as a chaotic, "unraveling" market for resident physicians, plagued by increasingly earlier and earlier offers to medical students, exploding offer deadlines, and an "old boy" network of placement advantages for the most coveted positions. All of these practices were claimed to impose unreasonable uncertainties and pressures on young medical students. The

initial MATCH program was instituted in 1952, and it subsequently has been refined further.

The MATCH does deliver certain benefits in ensuring that a very high percentage of resident positions are filled. Most applicants succeed in gaining their (bounded) first or second choices. Defenders highlight overall consumer welfare benefits over the distributional disadvantages some individual applicants face when unable to negotiate their program participation terms more directly. The MATCH rules shift competition from the employment offer stage to the stage at which programs and applicants submit their respective lists of rank-order preferences. This later date of single-day competition can make use of all the information available in the market at that time.

Essential terms of employment for resident physicians such as starting salary and working hours lag well behind those of comparably skilled professionals, and they are offered essentially on a take it, or take it, basis. However, MATCH defenders point to the implicit tuition costs tied to training young residents, as well as program "prestige" factors, as part of the compensating differentials behind low resident salaries.

MATCH critics highlight the mutually reinforcing levers of market power tied to the program. The ACGME's exclusive power over accreditation standards for graduate medical education means that it can limit the number of resident

positions available and determine which programs qualify for MATCH participation. MATCH program rules then make its process the nearly exclusive source for gaining acceptance to those resident positions. Those positions, in turn, represent the sole gateway not just to specialty board certification but even state licensure as a general practitioner.

Parties cannot negotiate and form “early contracts” that might better express their respective intensity preferences or assist transition planning for international medical school graduates, Meanwhile, comprehensive databases of salary, benefits, and other employment terms for resident programs are widely shared within the graduate medical education program community. This not surprisingly leads to a narrow convergence in compensation and working hours across resident programs by various measures, providing plausible indicators of buyers coordinating to create employer monopsony power over resident compensation. Those compressed wages also reflect the status of resident programs as the sole gateway to a future career as a licensed physician in the U.S., further distorting more fluid supply and demand responsiveness.

MATCH critics focus more on the program’s secondary conditions than on the efficiency of its final pairing algorithm. Indeed, some “concede” that the MATCH does an excellent job in solving the wrong problem --- how to fix the resident market monopsony that the program only strengthens. In other words,

once wage bargaining is taken off the table and price mechanisms cannot clear resident program markets, contract timing issues become both more important, and more problematic. A uniform matching date, and preference coordination, then "solves' the problems its other rules aggravate.

Further ground for skepticism is suggested by the absence of similar single-date, exclusive-mechanism matching rules for most other graduates entering labor markets (e.g. from law schools, business schools, colleges, or high schools), despite the many informational uncertainties and imperfect information sources faced by those other prospective employers and employees. Allowing price and wage flexibility to operate still can go a long way elsewhere in determining the optimal amount of information needed to enter a mutually agreeable transactions.

Counter-arguments emphasize that the market for graduating medical students is different. However, consider how recent developments in competition law for other highly skilled and perhaps even more highly valued students – those participating in certain major college sports – already have loosened or stripped away university restrictions on their labor mobility and compensation choices, primarily as a result of legal challenges under antitrust law.

In any case, MATCH defenders value streamlined, uniform selection procedures that are virtually mandatory for medical students seeking resident physician positions, at the expense of more individualized employment

negotiations and choices. The process delivers efficient sorting of bounded preferences, finality, and fewer unfilled positions. The main drawbacks, tied to legal objections, appear to be the vastly unequal bargaining power, wage compression and suppression, and onerous working conditions for residents that the program's interrelated rules and practices sustain.

The Limits of Antitrust Litigation, and Antitrust Exemptions

Standard methods for investigating the competitive effects on physician employment ordinarily would involve antitrust enforcement and private litigation. However, a unique congressional intervention with little advance notice and minimal explanation halted that process in April 2004, despite early discovery providing evidence of serious problems. Absent the sweeping antitrust exemption enacted under statutory law, further litigation under rule of reason analysis would have helped assess the net competitive effects of the MATCH program at that time, or even later as its practices evolved.

Such litigation and enforcement can often be blunt tools and not fully insulated from political factors either. Antitrust law and enforcement trends are subject to periodic swings of the legal pendulum, too. However, restoring that

avenue for challenging potentially anticompetitive policies can deter excesses, facilitate compromises, and stimulate alternative remedies.

In this case, the final result of reviving the older legal challenge to the MATCH program would be far from a sure thing in either direction. But the most revealing "tell" regarding the program's legal vulnerabilities two decades ago was provided by the desperate scramble to cement such unusual legal immunity, by attaching it at the lastminute in conference committee to an unrelated piece of pork-barrel legislation, with no prior debate and little subsequent explanation.

Antitrust exemptions --- particularly through federal legislation -- are rarely provided. Those granted are viewed skeptically and narrowly by courts. They operate essentially as legalized monopolies, and they usually reflect the efforts of power and privilege to gain or preserve special commercial advantages. Most limited antitrust exemptions also presume other regulatory mechanisms to monitor and police anticompetitive aspects of the activities otherwise protected.

Hence, at a minimum, this subcommittee and the current Congress should indeed seriously consider ways to limit, if not repeal, the current antitrust exemption first awarded in 2004. Reliance interests and transition rules remain necessary, limiting considerations. The scope of potential financial liabilities for future defendants would extend only to post-exemption-repeal conduct. In all likelihood, substantial pressure to rebalance the competitive playing field for

resident physician selection and employment would lead to more nuanced adjustments, short of abandonment of all MATCH-like mechanisms.

We already have seen how working conditions such as maximum weekly hours and shift durations have been modified for residents in recent decades, but only to forestall the imminent likelihood of other federal regulation or legislation. Resident physicians employed at teaching hospitals and medical centers also have resorted more frequently to unionization as a means to collectively bargain for better work benefits and environments.

Potential Reforms to Head Off Future Legal Liabilities

What sort of modulated changes in MATCH program rules might head off future legal liabilities if the current exemption is repealed or limited? Even a determination that the MATCH program increases output as a procompetitive restraint may not survive rule of reason analysis if it is not seen as the "least restrictive" alternative.

More modest proposals to modify MATCH program practices include:

- Ensuring that all medical resident applicants have the opportunity to review the terms of their prospective contracts, with accurate and accessible information, before they must enter into any binding agreements,
- Imposing a date before which resident programs are prohibited from making offers (although this has been criticized as an insufficient remedy, the evidence is mostly based on much older history from more than 70 years ago),
- Setting mandatory minimum periods for holding offers open, to deter "exploding offer" abuses,
- Encouraging, if not mandating, opportunities for contingent contract negotiations between applicants and programs, before final rank-order preferences are submitted,
- Incorporating a separate early decision period for applications and acceptances, outside of the later MATCH process, to signal intensity preferences more effectively,
- Allowing applicants to receive two possible matches, with a set period of time to negotiate further, before making a final choice,
- Limiting the availability of comprehensive resident program compensation information to individual resident programs

All or some of the above would represent changes to improve competition within a reformed MATCH program, rather than displace it completely. They might be added as conditions to retain the current antitrust exemption, or inserted within a newly granted one.

Getting Beyond the Usual Tools and Stopping Points

This hearing is framed within the context of alleged monopoly insulated by an antitrust exemption. It makes for some good opening storylines. Legislative committee jurisdiction also is a factor. But from a broader policy reform vantage point, we should remain cautious in addressing complex problems, such as those in health care, too narrowly. The proverbial Law of the Hammer warns of cognitive bias in trying to fix many things with only the tools that are readily at hand. Overreliance in this case on a combined judicial and regulatory hammer of antitrust law as a familiar public policy tool follows from the saying, "If the only thing you have is a hammer, it is tempting to treat everything in the way as if it were a nail." Antitrust enforcers certainly seem to see a lot of nails out there. But wild swings at the wrong targets not only might hit something else by mistake along the way. They might also miss some other targets.

Most policy interventions aimed at rebalancing competitive forces within physician labor markets face resistance not only from the powerful interest groups benefiting from the longstanding status quo. They also can trigger fear of disruption of well-established practices in the complex system used to train and select new physicians and timing mismatches in any transition toward alternative mechanisms. Long lead times are required to train each class of fully licensed and board-certified physicians – four years of medical school, and generally from three to seven years in internship and residency programs for specialty certification. Medical school and resident positions, along with the staff and facilities needed to train them, cannot be expanded (or reduced) substantially overnight. Unfilled positions are costly as well. However, older tales of excessive pressure by residency programs to fill slots as early as possible in the pre-MATCH era stem from more than 70 years ago, when the total number of positions exceeded applicants, unlike the opposite case in more recent years. Nevertheless, any significant policy changes should be calibrated and phased in carefully.

A different set of policy conflicts may arise from federalism concerns. States have traditionally been viewed as the natural constitutional stewards of physician licensing, as part of their traditional police powers. We should remember that any individual state already can step forward and reform its medical licensing system on its own, through various means:

- Maximizing scope of practice freedom for other licensed health care providers,
- Providing increased reciprocity or at least accelerated entry for out-of-state licensed practitioners,
- Reducing regulatory barriers to interstate telemedicine,
- Reducing hurdles to licensing of international medical graduates and foreign-licensed physicians,
- Supporting accelerated methods of medical training and licensing, such as assistant physician apprenticeships, or
- Considering new competing sources of accreditation for physician training and specialty certification.

More forward-looking initiatives recognize that the overall policy goal should not be construed as narrowly as just increasing the front-end production of young physicians newly trained at U.S. resident programs. They need to trigger nearer-term supply responses. This will require consideration of other policy tools to expand the entire health care workforce and provide greater flexibility to improve delivery of more valuable health care services and better health outcomes as soon as possible. One useful rationale for eroding rigid professional silos is to maximize

the use of the most highly skilled (but also the most expensive) medical professionals to the more challenging tasks and roles for which their extensive training and qualifications are best suited. That necessarily entails substituting other less-costly health care providers for some of those other tasks by practicing at the top of their own licenses, effectively but less expensively. Comparative advantage works in domestic markets, even as it faces renewed political challenges internationally.

Some states have led on this front, such as through interstate compacts to lessen barriers to their own markets, but not enough of them have done so as rapidly and thoroughly as they might. Hence, arguments for an increased federal government role in, at least, providing stronger incentives to do so. Federal and state governments still provide substantial financial support for graduate medical education and training. That funding could be retargeted to provide new incentives to ensure more competitive practices and policies, such as those suggested above.

The MATCH program's nationwide competition for resident positions was only an early sign of eroding geographic boundaries for health care labor markets. The modern digital era and early arrival of artificial intelligence tools will erode them further for more health care services. The continuing shift from physicians as independent business professionals to employees of larger health care companies will further transform health care labor market relationships.

We may wish to stop short of alternative federal licensing of physicians to provide different options, but that potential tool remains in the background as leverage. Impatience with the pace and depth of state-level reforms provides stronger temptations to nudge further with federal alternatives. Whether through more aggressive use of its commerce power, conditions of spending, or federal preemption, the issue is not whether Congress and the federal government has the power to be more assertive, but whether it decides it needs to do so absent more effective state-level actions. Even older legal immunities insulating state-government licensing from antitrust challenges, under the state action doctrine, have been carved back to some degree by clear articulation and close supervision requirements imposed in recent court cases. If state officials wish to preserve their own anti-competitive licensing regimes, they may at least have to speak more clearly.

In the event that Congress finds the will to do more in the physician licensing arena, it will have the ways to do so. For example, simply changing the rules of reimbursement for different types of physician services through federal health programs, particularly Medicare, could go a long way in redirecting young physicians toward primary care practices rather than specialties. But given the contemporary hurdles to overcome in finding sufficient resolve, compromise, and consensus to legislate on all but the most urgent issues, we still should expect the

more expedient resort to remain leaving such matters to litigation, regulation, and other administrative actions.

Of course, our broader chronic problems in health care policy go far beyond supply and demand for physicians' services, but that is an even larger topic for another day and another hearing.