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ANTITRUST LAW AND HEALTH PLANNING UNDER THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

In recent years one of the most intensely debated issues in the area of antitrust law has been the extent to which traditional antitrust principles apply to the health care industry.¹ Of primary concern to the legal and health care communities is the perceived conflict between antitrust laws and federal health planning legislation.² As the cost of health care increases at a rate faster than the rate of inflation,³ advocates of antitrust enforcement argue that the competitive market structure provided by the antitrust laws offers the most effective means of restraining spiralling medical costs.⁴ Health planning advocates, however, claim that defects

¹ See, e.g., M. THOMPSON, ANTITRUST AND THE HEALTH CARE PROVIDER 25 (1979) (application of antitrust laws to health planning activities is problematic); Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 966 (1981) (competitive approach to reforming medical care raises many policy issues); Drake & Kozak, *A Primer on Antitrust and Hospital Regulation*, 3 J. HEALTH POL., POL'Y & L. 328, 332 (1978) (unique characteristics of health care industry limit effectiveness of antitrust approach to market problems); Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 CUM. L. REV. 685, 685-86 (1979) (antitrust laws are incompatible with many practices in health provider system); Rosoff, *Antitrust Laws and the Health Care Industry: New Warriors into an Old Battle*, 23 ST. LOUIS U.L.J. 446, 449 (1979) (major obstacles exist in application of antitrust laws to health care field); Note, *Antitrust and Health Planning Under the 1974 NHPRD Act*, 7 J. CORP. L. 311, 311-12 (1982) (increases in antitrust litigation against health providers raise tension between health planning laws and antitrust principles) [hereinafter cited as *Health Planning*].

² See *infra* notes 101-62 and accompanying text (cases construing planning legislation and antitrust laws).

³ See N.Y. Times, Jan. 24, 1983, at A8, col. 1. The latest figures on the cost of medical care indicate that health care costs increased 11% in 1981 or almost three times as much as the Consumer Price Index for all items. *Id.* The 11% annual inflation rate was the third highest since the federal government began reporting on health care costs in 1935. *Id.* The leading medical expenditure was health insurance, which rose 15.9% in 1981. *Id.* One authority projects that spending in the health industry may reach \$500 billion by 1985, with approximately 40% of the expenditures devoted to hospital care. Reilly & Legge, *The Embattled Hospital: Cost Control Measures Versus Imperatives for Expansion*, 7 J. HEALTH POL., POL'Y & L., 254, 254-55 (1982).

⁴ See Leibenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927, 930-31 (1981) (increases in costs of medical and hospital care prompted reformers to consider market-oriented reforms); see also Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 304-05 (1978). Proponents of vigorous enforcement of antitrust laws against concerted health care actions argue that the antitrust laws could stimulate the growth of private cost-containment initiatives. *Id.* at 305. In light of the recent increase in antitrust litigation against the health care industry, advocates for change in the present system of health financing perceive real possibilities for the development of alternative modes of financing plans. *Id.*; see *infra* notes 194-98 and accompanying text (health delivery and financing plans developed as alternatives to current system of third-party payment plans).

in the health care market are curable only through a planning scheme that seeks to control costs and avoid unnecessary duplication of health services through allocation of resources and restriction of entry into the market.⁵ A fundamental antagonism thus exists between the anti-competitive elements of health planning regulation and the antitrust objective of regulation through the operation of competitive forces in the marketplace.⁶ The background for the conflict stems from the antagonism existing between the procompetitive provisions of the Sherman Antitrust Act of 1870⁷ (Sherman Act) and the anticompetitive provisions and policies of the National Health Planning and Resources Development Act of 1974⁸ (Planning Act).

⁵ See Note, *Health Law - The Conflict with Antitrust Law*, 18 WAKE FOREST L. REV. 591, 598 (1982) [hereinafter cited as *Conflict*]. Health planning advocates maintain that planning will cure present health care defects. *Id.* Planning proponents also hope that planning goals will achieve equity of access to quality care at a reasonable cost while improving the inadequate distribution of health services. *Id.*; see Blumstein & Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 6 (1978). In justifying health planning, planning proponents reason that the present medical market place perpetuates inefficiency, permits excessive cost escalation, and fails to curtail unnecessary duplication of health services. *Id.*

⁶ See *infra* notes 9-99 and accompanying text (elements of health planning regulation and antitrust laws).

⁷ 15 U.S.C. §§ 1-7 (1976 & Supp. V 1981) (Sherman Act); see *infra* notes 64-77 and accompanying text (discussion of Sherman Act). In addition to the Sherman Act, the Clayton Act of 1914 provides substantive antitrust law. See *id.* at §§ 12-27 (Clayton Act). Section 3 of the Clayton Act forbids exclusive dealings and tying arrangements where the effect of the illegal conduct may be to lessen competition substantially or tend to create a monopoly in any line of commerce. *Id.* at § 14. Section 7 of the Clayton Act prohibits corporate acquisitions where the effect may be to lessen competition substantially or to tend to create a monopoly. *Id.* at § 18. Section 7 is applicable to the health care industry when providers attempt to create joint venture corporations, to eliminate duplicate services, or to capture markets. M. THOMPSON, *supra* note 1, at 13. Congress limited remedies under the Clayton Act to treble damage actions and suits for injunctive relief. 15 U.S.C. §§ 15, 26 (1976 & Supp. v 1981).

In addition to the Clayton Act, Congress also passed the Federal Trade Commission Act (FTC Act) in 1914. See *id.* at §§ 41-58. The FTC Act empowers the Federal Trade Commission (FTC) to conduct investigations of possible unfair methods of competition and to issue trade regulation rules that establish standards preventing unfair and deceptive practices. *Id.* at §§ 45(m) (1) (A) & (B), 46, 46(g), 57a. The agency has extensive enforcement powers including injunctions, civil money penalties, voluntary agreements and consent orders. *Id.* at §§ 45(b), 45(1), 46. The Act's application to health care matters, however, is subject to a major limitation pertaining to the FTC Act's definition of a corporation. See *id.* at § 44. Under the FTC Act, the definition of corporation excludes entities that operate on a nonprofit basis. *Id.* Since many health care institutions are nonprofit entities, the FTC Act does not provide for FTC jurisdiction over substantial areas of potential antitrust activity. See M. THOMPSON, *supra* note 1, at 15 (FTC has no jurisdiction over nonprofit health care providers). The FTC does have enforcement jurisdiction, however, over nonprofit associations organized for the profit of their members, such as the American Medical Association. *Id.* See generally Rosoff, *supra* note 1, at 451-53 (discussion of Federal Trade Commission Act).

⁸ 42 U.S.C. §§ 300k-300t (1976 & Supp. V 1981). The National Health Planning and Resources Development Act (Planning Act) is not the first congressional attempt at legislating

The concept of health planning, as detailed in the Planning Act, is the result of congressional concern over the continued increases in the cost of health care and the misallocation of health services.⁹ Generally, proponents of health planning justify government involvement in the planning process on the basis of two rationales.¹⁰ The first rationale is that government intervention in the medical marketplace through planning is necessary because the health care sector deviates from traditional market principles.¹¹ The second rationale maintains that health planning can aid in achieving governmental health policy goals.¹²

health care planning. See M. THOMPSON, *supra* note 1, at 27-28 (synopsis of governmental health planning legislation). Congressional action on health care planning and control originated with the enactment of the Hill-Burton Hospital Survey and Construction Act of 1946 (Hill-Burton Act). Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified in scattered sections of 5, 8, 14, 24, 31, 33, 42, 46, 48, and 49 U.S.C. (1976)); see S. REP. No. 1285, 93d Cong., 2d Sess. 36, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7845 [hereinafter cited as 1974 SENATE REPORT]. The Hill-Burton Act resulted from Congress's recognition of the need to increase the capacity of the nation's health facilities. *Id.* at 39, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7878. The Depression, World War II, and the maldistribution of facilities among the states and between rural and urban areas were factors in producing an overall shortage of hospital beds. *Id.* at 19, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7859. To correct deficiencies in supply and allocation, the Hill-Burton Act authorized federal grants to the states to survey state needs and develop state plans for the construction of public and voluntary nonprofit hospitals and public health centers. *Id.* By 1974, however, state plan data on the status of health facilities indicated that a surplus of hospital beds existed in the nation. *Id.* at 24, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7864. The need still exists, however, for the modernization of existing facilities and for development of outpatient facilities. *Id.*

In 1966 Congress enacted the Comprehensive Health Planning and Public Health Services Amendments (CHP) to coordinate and control health care delivery through state and local planning agencies. See Pub. L. No. 89-749, 80 Stat. 1180 (1966) (codified at 42 U.S.C. § 242g, 243, 246, and 247(a) (1976)). The CHP requires that the states provide and encourage cooperative efforts among governmental or nongovernmental agencies in the fields of education, welfare, and rehabilitation. 42 U.S.C. § 246(a) (2) (b) (1976). The general shortcomings of the CHP that precipitated Congress' passage of the Planning Act were difficulties of understaffing, underfunding, lack of planning direction, and lack of federal assistance and monitoring. 1974 SENATE REPORT, *supra*, at 13, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7853.

⁹ See 1974 SENATE REPORT, *supra* note 8, at 39-40, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7878-79. The Senate Report emphasized the need for strengthened and coordinated planning for consumer health services in view of the health care industry's lack of response to traditional competitive marketplace principles. *Id.* at 39, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7878. The Senate Committee attributed the industry's failure to control rising medical costs to the highly technical nature of medical services and the third-party payment system. *Id.* A contributory factor to the anticompetitive nature of health care was the misallocation of health services and facilities, especially in the oversupply of urban areas as opposed to rural communities. *Id.*, *supra* note 8, at 39-40, reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7879.

¹⁰ Blumstein & Sloan, *supra* note 5, at 3; *Health Planning*, *supra* note 1, at 314.

¹¹ Blumstein & Sloan, *supra* note 5, at 3-4; see *infra* notes 13-26 and accompanying text (discussion of health care's departure from competitive ideals).

¹² Blumstein & Sloan, *supra* note 5, at 3-4; see *infra* notes 27-29 and accompanying text (rationale that health planning will help achieve governmental health policy goals).

Underlying the rationale that the health care market deviates from the competitive model is the fundamental assumption that consumers in the health care market lack sufficient knowledge to make informed judgments about health care services.¹³ Thus, patients must delegate decision-making authority to physicians who then are in a position to determine and control patient demand.¹⁴ Another assumption underlying the first rationale for health planning stems from the important role that non-profit institutions play in the health care field.¹⁵ In the competitive market system, the profit motive operates to encourage efficiency and low cost production while eliminating institutions that become overly inefficient.¹⁶ Nonprofit institutions, however, lack the profit motive necessary to achieve greater efficiency or to adjust output in order to achieve higher profits.¹⁷

¹³ Blumstein & Sloan, *supra* note 5, at 3-4; *see infra* note 14 (discussion of health care consumer).

¹⁴ Blumstein & Sloan, *supra* note 5, at 3-4; *see* Drake & Kozak, *supra* note 1, at 333-35. Health care deviates from the model market in the area of "consumer sovereignty," the consumer's ability to make decisions over what goods are sold and the price of goods sold. Drake & Kozak, *supra* note 1, at 333. Consumers of health services often delegate their consumer sovereignty to physicians because physicians have the knowledge and skills in medical treatments that consumers lack. *Id.* Physicians, therefore, are in a position to allocate services to each patient and to determine the costs of services rendered. *Id.* Because the physician influences both supply and demand for health services, the health care industry differs substantially from the market model where supply and demand forces exist independently of each other. *Id.*

Another factor emphasizing the uniqueness of the health care field is the relatively minor role that price plays in health care transactions as opposed to traditional market dealings. *Id.* The suspension of cost concerns in health situations occurs because the need for health care services frequently is impossible to anticipate or postpone. *Id.* at 334. Also, the pricing of services is difficult in a field in which the service offered is unique to each individual depending upon the patient's age, severity of illness, and other factors. *Id.* Furthermore, the emotional stress accompanying severe illnesses limits the individual's inclination to compare prices for services. *Id.*; *see also* Rosoff, *supra* note 1, at 447 (demand for health services frequently controlled by provider rather than by consumer).

¹⁵ Blumstein & Sloan, *supra* note 5, at 4. Voluntary nonprofit entities are the predominate form of hospital organization, accounting for 70% of all nonfederal, short term general, and other special hospital beds. Dimieri & Weiner, *The Public Interest and Governing Boards of Nonprofit Health Care Institutions*, 34 VAND. L. REV. 1029, 1032 n.18 (1981).

¹⁶ Blumstein & Sloan, *supra* note 5, at 4.

¹⁷ *Id.*; *see* Clark, *Does The Nonprofit Form Fit the Hospital Industry?*, 93 HARV L. REV. 1417, 1417-19 (1980). Among the criticisms of nonprofit health care institutions (nonprofits) are the problems stemming from operational inefficiencies, arbitrariness in response to service demands, and promotion of high technology medical care. Clark, *supra* at 1417-19. The current subsidization of and favoritism for nonprofits serves only to perpetuate the problems that nonprofits foster. *Id.* at 1418. To improve the situation, one proposal calls for a four-part program. *Id.* at 1488. The first part of the program would subject both profit and nonprofit institutions to the same legal standards, including property taxes. *Id.* The second proposal advocates adoption of legal rules that promote consumers' control of nonprofit hospitals. *Id.* The third part of the program proposes that payors to nonprofit hospitals have the right to object to a hospital's below-marginal sale of services. *Id.* The final proposal calls for legal reforms to promote informed consumer choice, including cost sharing by patients and mandatory disclosure about key medical procedures. *Id.* *See generally* Dimieri & Weiner, *supra* note 15, at 1033-63 (critique of nonprofit institutional system).

Aggravating the incentive problem is the system of third-party payment that characterizes present health insurance plans.¹⁸ Under the present system, insurance companies reimburse physicians and hospitals for the costs of health services.¹⁹ Consequently, only the third-party payor insurance companies have any incentive to control costs.²⁰ Despite the ad-

¹⁸ Blumstein & Sloan, *supra* note 5, at 4-5. Third-party payments presently dominate the health care financing system, with private insurers paying approximately 27% of all personal health care expenditures in 1978 and public entitlement programs paying approximately 39% of all expenditures. Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003, 1004 (1981). The structure of the third-party system furnishes the health provider with incentives to push resources beyond national limitations, regardless of productivity and efficiency concerns. See Reilly & Lage, *supra* note 3, at 261. Because the third-party payor and the consumer are liable for costs incurred, the reimbursement system involves minimal risks for provider inefficiency. *Id.* The reimbursement system therefore supports provider goals of supplying maximum care through the most expensive services and expansions of facilities. *Id.*

¹⁹ See Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 DUKE L.J. 645, 647 (1978). Under the customary reimbursement practice, doctors and hospitals submit bills for insurance companies to pay. *Id.* The reimbursement system thus offers little incentive for economic restraint since doctors know that the insurance company will pay for services rendered and patients, who pay only insurance policy premiums, feel that all care is essentially free. *Id.*

²⁰ *Id.* at 648. Several reasons exist why a third-party payor might want to impose price ceilings on providers. *Id.* at 648 n.9. One reason is that control of medical costs could reverse the problem of financial loss that many health insurance plans have experienced for a number of years. *Id.* Another reason is that an insurer who attempts to be cost effective could expect to capture a large segment of the health insurance market by reducing the price of the insurance coverages to consumers below the competitors' prices. *Id.* Furthermore, an efficient cost control program would remove the pressure caused by health care inflation from the insurance industry and place the burden on hospitals and doctors, who are in a better position to prevent cost increases. *Id.* Finally, an insurer cost control program would make medical insurance plans more consistent with the standard insurance practice of seeking to restrict payments. *Id.*

Fee schedules that limit what providers of health care may charge for services often come within the Sherman Act's ban on price-fixing. *Id.* at 654; see *infra* text accompanying notes 72-77 (discussion of per se unlawful restraints under Sherman Act, including price fixing). The Supreme Court recently decided a case involving efforts to contain health costs through the setting of maximum fees. See *Arizona v. Maricopa County Medical Soc'y.*, 457 U.S. 332 (1982). In *Maricopa*, the state of Arizona filed suit against two foundations for medical care (FMCs) and the county medical society associated with the foundations, challenging the FMCs' agreement to fix the maximum fees that physicians may claim for services to insureds of FMC-approved insurance plans. *Id.* at 339-42. The State of Arizona contended that the defendants engaged in illegal price fixing conspiracies because the upward revisions of the maximum fee schedules effectively stabilized the level of actual charges by physicians and, in addition, increased insurance premiums. *Id.* at 341-42. The foundations argued that the schedules operated to limit physicians' fees and to aid insurance companies in calculating more efficiently the risks the companies underwrote, thereby serving as an effective cost containment mechanism. *Id.* at 342. The Supreme Court held that the maximum fee agreements, as price fixing agreements, were per se unlawful under the Sherman Act. *Id.* at 346-48. By fixing maximum prices, the challenged agreements tended to provide the same economic rewards to all physicians regardless of skill or training. *Id.* at 348. The agreement also potentially discouraged entry into the market and deterred experimentation and new developments by individual entrepreneurs. *Id.* The Court found nothing in the nature of the medical profession or the health care industry that warranted the schedule's

vantages in holding charges down, the response of commercial insurers to health care inflation has been to increase premiums.²¹

Third-party payment schemes, nonprofit institutions, and unsophisticated consumers do not constitute all the factors underlying the proposition that the health market is inherently noncompetitive.²² The final factor that supports an argument for health planning is the existence of the traditional physician-hospital relationship.²³ A hospital's major source of patients is a roster of physicians with staff privileges.²⁴ Because physicians receive training to be clinical scientists as well as practitioners, a well-equipped hospital is essential to allow physicians to practice what the medical schools teach.²⁵ Hospitals therefore will vie for physicians by accommodating the physicians' requests for specialized equipment, which the hospitals often cannot justify acquiring under utilization projections.²⁶

Underlying the rationale that health planning can aid in achieving governmental health policy goals is the argument that competitive market techniques cannot cure defects in the health care system.²⁷ Without a national planning scheme, planning proponents contend that the medical marketplace would promote inefficiency, permit cost increases, and fail to curtail unnecessary duplication.²⁸ Proponents of health planning also argue

exemption from the per se rules against price-fixing. *Id.* at 348. See generally Shapiro, *Cost Containment in the Health Care Field and the Antitrust Laws*, 7 AM. J.L. & MED. 425, 428-35 (1982) (discussion of cost containment efforts and *Maricopa* case).

²¹ Kallstrom, *supra* note 19, at 648.

²² See *infra* text accompanying notes 23-26 (discussion of physician-hospital assumption).

²³ Blumstein & Sloan, *supra* note 5, at 5.

²⁴ *Id.*

²⁵ Reilly & Legge, *supra* note 3, at 261-62.

²⁶ Blumstein & Sloan, *supra* note 5, at 5; see Reilly & Legge, *supra* note 3, at 261-62.

In addition to clinically trained physicians, a number of other incentives prompt hospitals to add services. Reilly & Legge, *supra* note 3, at 261-62. One influence on resource consumption by the hospital is the definition of quality medical care that encompasses the notions of high technology and equipment, quantity of services, teaching, and research. *Id.* Under the influence of the definition of quality medical care, the medical profession rates community hospitals according to the degree of specialization and technological advancement, with large metropolitan teaching hospitals near the top of the ladder. *Id.* Small hospitals, thus, have incentives to add services and to provide more complex technology on site. *Id.*

Critics of the present state of the hospital care system suggest modification of public policies regarding medical manpower. See *id.* at 263-64. One area of policy reform involves withdrawing operational and research support from regional residency training centers to control the number of physicians and the increase of medical specialties. *Id.* at 264. Another policy reform is to allocate financial support in favor of medical schools and centers whose priorities concern the public interest and needs. *Id.* A third reform suggests that public entities designate which hospitals should perform specified levels of specialized services, on a reimbursement basis. *Id.* The final reform proposes to restructure educational loans to require public service commitments to state and local public health care agencies in order to ensure effective distribution of access to health care. *Id.*

²⁷ Blumstein & Sloan, *supra* note 5, at 6; see also *Conflict*, *supra* note 5, at 598 (citing Blumstein & Sloan).

²⁸ Blumstein & Sloan, *supra* note 5, at 6; see Bovbjerg, *supra* note 1, at 967. Many

that planning will rectify the unequal distribution of health services and achieve greater equality of access to medical facilities.²⁹

To achieve the major goals of health planning advocates and to remedy a number of deficiencies in earlier health planning laws, including the absence of planning procedures and the failure to define goals for success, Congress enacted the Planning Act in 1974.³⁰ The Planning Act corrects prior defects by establishing detailed processes and procedures for planning at federal, state, and local levels.³¹ At the federal level, the Planning Act requires the Secretary of the Department of Health and Human Services to establish guidelines concerning national health planning policy.³² Section 501(b) of the Planning Act states that guidelines must include standards regarding the appropriate supply, distribution, and organization of health resources, as well as a statement of national health planning goals.³³

At the local level, the Planning Act requires the establishment of Health Services Areas that define a geographic region for the planning and development of health services.³⁴ Within each area, a network of Health Systems Agencies (HSAs) contracts with the federal government to fulfill

noncompetitive elements of medical care appear to be inherent in the fundamental nature of the industry. *Id.* The most important element that makes medical care intrinsically different from other economic activities is that providers, including physicians and hospitals, eliminate resource allocation decisions in medicine. *Id.* Because providing medical care is a very technical field of which consumers largely are ignorant, consumer sovereignty over the kind of quality of care desired is difficult to exercise. *Id.* *But see Health Planning, supra* note 1, at 336-37. One commentator, however, rejects the conclusion that the health industry is a separate economic structure, existing outside the reach of market influences and antitrust laws. *Id.* at 336. Because health planning through CON enforcement fails to ensure that necessary services are available, the justifications for anticompetitive conduct in planning activities have little validity. *Id.*; *see infra* notes 49-53 and accompanying text (CON is enforcement mechanism of Planning Act which state law requires medical facilities to obtain before making capital expenditures on health care projects); *infra* text accompanying notes 169-75 (criticisms of CON legislation). The commentator advocates increased enforcement of medical antitrust actions, with stricter limitations on the application of antitrust exemptions in the health care area. *Health Planning, supra* note 1, at 330-37.

²⁹ Blumstein & Sloan, *supra* note 5, at 6.

³⁰ *See id.* at 8. In addition to the absence of planning procedures and the failure to define goals, previous health planning laws failed to grant sufficient planning powers to planning agencies, failed to provide an adequate professional staff, and depended excessively on local sources of funding. *Id.* For example, the CHP had little authority beyond commenting on and recommending uses for federal funds. *Id.* at 8 n.36; *see supra* note 8 (discussing CHP); *see also* 1974 SENATE REPORT, *supra* note 8, at 5-35 (discussion of previous planning legislation), *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS at 7846-82.

³¹ *See* 42 U.S.C. §§ 300k-n (1976); *infra* notes 32-48 and accompanying text (discussion of Planning Act provisions).

³² 42 U.S.C. § 300k-1(a) (1976).

³³ *Id.* § 300k-1(b)(1)-(2). Section 1501 of the Planning Act requires the Secretary of the Department of Health and Human Services to consult with and solicit recommendations from agencies and councils set up under the Planning Act, as well as from societies representing health care providers. *Id.* § 300k-1(c).

³⁴ *Id.* § 300l. In establishing the boundaries of the Health Service Areas, the Secretary must consult with the governor of each state. *Id.* § 300l(b) (a) (C). The designation of the boundaries then are subject to continuing review by the Secretary. *Id.* § 300l(b) (3) (B) (i)-(4).

planning and development functions.³⁵ The HSAs serve five major purposes under the Planning Act.³⁶ The purposes include improving the accessibility and quality of health services, restraining health care costs, preventing unnecessary duplication of health resources, and preserving and improving competition in the health services area.³⁷ The Planning Act also requires that HSAs develop a health systems plan that includes a detailed statement of goals established in accordance with national guidelines for health planning policy.³⁸ In addition, the Planning Act requires that the HSAs devise, review, and amend an Annual Implementation Plan, which identifies priorities and establishes objectives required to achieve the goals of the health systems plan.³⁹

The Planning Act accomplishes coordination between local and state planning activities by establishing a state health planning and development agency that devises a preliminary state health plan in accordance with the health system plans developed by the local HSAs.⁴⁰ The state agency must review periodically all the institutional health services that the state offers and make public any findings.⁴¹ The state agency also must submit to the local HSAs a detailed account of the reasons for any inconsistencies between actions taken by the agency and the goals of the health systems plan prepared by the HSA.⁴²

In addition to the state agencies, the Planning Act also establishes an advisory Statewide Health Coordinating Council which prepares, reviews, and revises a state health plan.⁴³ Interested parties may submit oral or written comments regarding the plan at specified public hearings.⁴⁴

³⁵ *Id.* § 3001-1. A Health Service Agency (HSA) may be organized as a nonprofit private corporation, a public regional planning body, or a single unit of general local government. *Id.* § 3001-1(b) (1). To qualify as an HSA, a nonprofit private corporation must exist as an independent entity, incorporated in the state in which the largest part of the population of the health service area resides. *Id.* § 3001-1(b) (1) (A). A public regional planning body, in order to qualify for designation, must have a governing body composed of a majority of elected officials of units of general local government or must receive state authorization to carry out health planning and review functions required of HSAs. *Id.* § 3001-1(b) (1) (B). Finally, a single unit of general local government receives HSA status if the unit's area of jurisdiction is identical to the health service area. *Id.* § 3001-1(b) (1) (C).

³⁶ *Id.* § 3001-2(1)(5) (1976 & Supp. V. 1981); see *infra* text accompanying note 37 (five purposes of HSAs).

³⁷ 42 U.S.C. § 3001-2(1)-(5).

³⁸ *Id.* § 3001-2(b) (2).

³⁹ *Id.* § 3001-2(b) (3).

⁴⁰ *Id.* § 300m-2(a) (2).

⁴¹ *Id.* § 300m-2(a) (6).

⁴² *Id.* § 300m-2(c).

⁴³ *Id.* § 300m-3(c) (2) (A). The state health plan must consist of the health systems plans of the HSAs within the state. *Id.*

⁴⁴ *Id.* § 300m-3(c) (2) (B). The Planning Act requires that agency officials issue announcements of public hearings giving the terms and place of the hearings at least 30 days in advance and in at least two newspapers of general circulation in the state. *Id.*

The state council also reports to the Secretary of the Department of Health and Human Services on the health system and annual implementation plans of each HSA within the state.⁴⁵

In 1979, Congress amended the Planning Act with the Health Planning and Resources Development Amendments of 1979⁴⁶ (1979 Amendments). One purpose of the 1979 Amendments was to direct the health planning process toward maintaining and improving competition in the health industry.⁴⁷ To achieve the planning goal, Congress amended a number of the Planning Act's provisions to require promotion of competition at local, state, and federal levels.⁴⁸

To enforce the health planning scheme, the Planning Act employs a mechanism known as a certificate of need or CON.⁴⁹ A CON is a license

⁴⁵ § 300m-3(c) (6).

⁴⁶ Pub. L. No. 96-79, 93 Stat. 592 (1979) (codified in scattered sections of 42 U.S.C. (1976 & Supp. V 1981) (1979 Amendments).

⁴⁷ S. REP. NO. 96, 96th Cong., 1st Sess. 3 *reprinted in* 1979 U.S. CODE CONG. & AD. NEWS 1306, 1308 [hereinafter cited as 1979 SENATE REPORT] The House Report on the 1979 Amendments clarified the role of competition in the health planning scheme. *See* H. R. REP. NO. 190, 96th Cong., 1st Sess. 51-54 (1979) [hereinafter cited as 1979 HOUSE REPORT]. Recognizing the distortion of market forces for institution health services, the House Committee cited third-party reimbursement arrangements, high technology and the physician-patient relationship as the major contributors to the misallocation of health services. *Id.* at 51-52. The Committee also stated that the integration of competitive considerations is possible in health planning activities. *Id.* at 52. To facilitate competition, the Committee advocated evaluation of competitive factors by HSAs in conducting CON review. *Id.* at 52-53; *see infra* notes 49-53 and accompanying text (CON is license required by state before medical facilities can make capital expenditures on health care projects). A proper evaluation would entail the consideration of whether the effect of the new arrangement would operate to allocate the appropriate supply in response to consumer demand. 1979 HOUSE REPORT, *supra*, at 53. For health care services that do not operate on an effective market basis, the planning agencies would use the CON process to restrain increases in the cost of health services and prevent unnecessary duplication of health resources. *Id.*

The House Committee also considered the application of the antitrust laws to planning activities. *See id.* at 54-56. The Committee proposed the aggressive enforcement of antitrust laws to ensure a competitive economy in health care areas that respond to competition on the basis of price, quality, and service. *Id.* at 54. The Committee limited the antitrust initiative, however, by finding immunity from antitrust enforcement for planning agencies that carry out specific functions within the authority of the Planning Act. *Id.* at 54-55. Appropriate functions for agencies acting under the Planning Act include developing health plans, making review findings and recommendations and issuing CONs in appropriate circumstances. *Id.* at 55.

⁴⁸ *See* 42 U.S.C. § 300k-2 (1976), *amended by* 42 U.S.C. § 300k-2 (b)(3) (Supp. V 1981) (planning agencies should advance competition for health services in which competition appropriately allocates supply); *id.* § 3001-2, *amended by* 42 U.S.C. § 300k-2(a)(5)(1976) (one purpose of HSA is to preserve and improve competition in health service area). *See generally* H.R. CONF. REP. NO. 420, 96th Cong., 1st Sess. 57-58, *reprinted in* 1979 U.S. CODE CONG. & AD. NEWS 1422, 1425-26 (conference compromise on role of competition in health planning).

⁴⁹ *See Conflict, supra* note 5, at 599-600 (CON gives "teeth" to Planning Act's enforcement procedures).

required by a state before medical facilities can make capital expenditures on health care projects.⁵⁰ The rationale behind CON is twofold.⁵¹ First, by limiting health care services to only necessary items, CON laws will keep medical costs low.⁵² Second, CON will serve the public interest by allocating services to meet the needs of the area's population.⁵³

As a result of CON laws, any health care institution seeking to expand facilities, change services offered, make major purchases, or enter the marketplace must obtain a CON from the state by documenting that a need for the proposed service exists.⁵⁴ The institution submits the documentation of need to either a state reviewing agency or the HSA for approval.⁵⁵ The Planning Act provides that states that fail to designate agencies to perform CON review cannot receive federal funds for development, expansion, or support of health resources.⁵⁶ CON, as the regulatory mechanism of the Planning Act, represents Congress' determination to control supply of health resources in light of the inefficiencies and inequities produced by the health industry's lack of response to marketplace forces.⁵⁷ Through the control of supply, CON legislation grants significant

⁵⁰ *Id.* at 600. CON laws first appeared in New York in 1964, primarily to aid in health cost containment. See N.Y. PUB. HEALTH LAW § 2802 (McKinney 1977 & Supp. 1982) (application for construction of hospital required from state). Campaigns for CON laws spread throughout the states in the mid-1960s and early 1970s. Blumstein & Sloan, *supra* note 5, at 19. The first federal recognition of CON occurred in the Social Security Amendments of 1972. Pub. L. No. 92-603, 86 Stat. 1329 (1972) (codified in scattered sections of 42 U.S.C. (1976)); see D. ABERNETHY & D. PEARSON, REGULATING HOSPITAL COSTS: THE DEVELOPMENT OF PUBLIC POLICY 63 (1979) (government recognized CON concept through enactment of Section 1122 of Social Security Amendments). Section 1122 of the 1972 Amendments required the Secretary of HEW to enter into agreements with states willing to review the need for proposed capital expenditures. 42 U.S.C. § 1320a-1(b) (1976). In states that performed CON review, facilities making capital expenditures without state agency approval lost federal reimbursement for depreciation, interest, and return on equity. *Id.* § 1320a-1(d)(1).

Generally, CON laws involve state regulation of the building, expansion, and modernization of health care facilities and of the capital equipment of health care providers. See Blumstein & Sloan, *supra* note 5, at 19. CON's are reactionary in the sense that the process relies primarily on an institution's initiative in proposing a change in beds, facilities, or other services. *Id.* at 19-20. Actions by CON agencies to initiate capital projects in underserved areas, however, are rare. *Id.* at 20. See generally Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1150-55 (1973); Schonbrun, *Making Certificate of Need Work*, 57 N.C.L. REV. 1259, 1263-66 (1979) (discussion of CON laws).

⁵¹ See *Health Planning*, *supra* note 1, at 311 (discussion of CON ability to lower medical costs).

⁵² *Id.* at 311; see *infra* notes 169-75 (criticisms of CON ability to allocate resources effectively).

⁵³ *Health Planning*, *supra* note 1, at 311.

⁵⁴ Schonbrun, *supra* note 50, at 1264.

⁵⁵ 42 U.S.C. §§ 300m(d), 300m-2(a)(4)(B) (1976). The effect of the federal CON statutes has been the enactment of CON laws in every state except Louisiana as of early 1983. 11A HOSPITAL LAW MANUAL (Health L. Center) ¶ 1-5 (1981 & Supp. 1983).

⁵⁶ See 42 U.S.C. §§ 300k-300k-2 (1976) (congressional findings and national health goals set forth in Planning Act); Miller, *Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 GEO. L.J. 873, 874 (1980) (CON represents

market power to the regulatory body that oversees CON applications.⁵⁸ CON, consequently, permits monopoly by barring entry and limiting expansion in the health market.⁵⁹ Health planning through CON also requires health care providers, agencies, and competing institutions to participate in the planning process.⁶⁰ Although Congress viewed industry participation as important to any health care system,⁶¹ potential remains for industry control of the planning process.⁶² Consequently, certain elements of health planning are subject to attack under antitrust laws as being either monopolies or conspiracies in restraint of trade.⁶³

Charges that the health industry controls elements of the planning process through illegal restraints or monopolies in restraint of trade are subject to legal scrutiny under sections 1 and 2 of the Sherman Act.⁶⁴

government's determination to confront overutilization problem in light of industry's inability to ration services on its own).

⁵⁸ See Rosoff, *supra* note 1, at 448 (CON contributes to regulatory capture of health industry by health providers); *Health Planning*, *supra* note 1, at 312 (CON operates to grant market power through limiting investment in equipment and capital improvements only to institutions that receive CON approval).

⁵⁹ *Health Planning*, *supra* note 1, at 312.

⁶⁰ See U.S.C. § 3001-1(b)(3)(C) (1976 & Supp. V. 1981) The Planning Act encourages health providers to determine whether need exists for other providers' proposals by requiring that providers constitute at least 40% but no more than 49% of the membership of each HSA governing body. See *id.* at § 3001-1(b)(3)(C). The term "provider" includes health care professionals, institutions, and insurers, as well as fiduciaries of health care institutions, persons receiving 10% of their gross annual income from health-related sources, and immediate family members of providers. *Id.* § 300n(3). Congress deliberately defined health care provider. See 1974 SENATE REPORT, *supra* note 8, at 46 (intent of definition is to include any individual with existing or potential conflict of interest regarding recommendations of health planning agency), reprinted in 1974 U.S. CODE CONG. & AD. NEWS at 7885.

⁶¹ See 42 U.S.C. § 300k(a)(5) (1976). Congress noted that the health care provider is one of the most important participants in any health care system. *Id.* Health policy, therefore, must address the legitimate needs and concerns of the provider to achieve meaningful results. *Id.* Congress, therefore, stated that at all costs the provider should play an active role in developing health policy. *Id.*

⁶² See Miller, *supra* note 57, at 879-888. The potential for regulatory capture of the planning process exists because the Planning Act permits health providers to help determine whether need exists for other providers' proposals. *Id.* at 879; see *supra* note 60 (Planning Act requires that providers constitute at least 40% of membership of each HSA). While consumers also must participate in the planning process, the economic incentive to engage in anticompetitive behavior does not exist to the same degree as the incentives for providers. Miller, *supra* note 57, at 880; see 42 U.S.C. § 3001-1(b)(3)(C) (1976) (majority of members of HSA must be individuals representing area's economic, social, linguistic, and racial populations); *infra* notes 169-75 and accompanying text (criticisms of CON).

⁶³ See *infra* notes 101-62 and accompanying text (discussion of antitrust actions brought because of health planning activities).

⁶⁴ See 15 U.S.C. §§ 1-2 (1976 & Supp. V 1981). The sources of antitrust scrutiny vary. See Horan & Nord, *supra* note 1, at 715-18. Governmental enforcement agencies presently instigate a preponderance of medical antitrust actions. *Id.* at 715. The preeminent federal antitrust agency studying the medical market is the FTC. Marmor, Boyer & Greenberg, *supra* note 18, at 1022; see *supra* note 7 (discussion of FTC and Federal Trade Commission Act). Along with the FTC, the Antitrust Division of the Department of Justice is active

Under the broad language of section 1, any contract or conspiracy in restraint of trade is illegal.⁶⁵ Section 2 provides that any person who attempts to monopolize or conspire with others to monopolize is guilty of a felony.⁶⁶ Because a literal interpretation of section 1 would invalidate every contract or restraint necessary for the transaction of business,⁶⁷ courts interpreting section 1 have employed a "rule of reason" approach in determining that the Act applies only to unreasonable restraints of trade.⁶⁸ In *Standard Oil Co. v. United States*,⁶⁹ the Supreme Court first announced the rule of reason in holding that the Sherman Act forbids only conduct that unduly interferes with freely competitive markets.⁷⁰

in prosecuting traditional antitrust violations such as price fixing, group boycotts, and tying arrangements. Horan & Nord, *supra* note 1, at 15-16. Professionals presently bring most private suits, normally alleging some competitive disadvantages resulting from nonrecognition by the health care system. *See, e.g.,* Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d 286, 287 (5th Cir. 1982) (action by anesthesiologist charging illegal tying arrangement with respect to application for admission to hospital medical staff); Dos Santos v. Columbus-Cuneo-Cabrini Med. Center, 684 F.2d 1346, 1348 (7th Cir. 1982) (action by anesthesiologist charging illegal exclusive dealing agreement for provision of anesthesia services at hospital); McElhinney v. Medical Protective Co., 549 F. Supp. 121, 124-25 (E.D. Ky. 1982) (action by surgeon charging illegal group boycott by hospital staff in denial of hospital privileges).

In addition to private suits, the Antitrust Improvements Act of 1976 authorizes state attorneys general, in their *parens patriae* capacity, to institute civil antitrust suits on behalf of individuals residing in the state. *See* Pub. L. No. 94-435, 90 Stat. 1383 (codified in scattered sections of 15, 18, & 28 U.S.C. (1976)) (Antitrust Improvements Act). The *parens patriae* suit thereby provides a mechanism for classwide relief while avoiding the difficulties involved in satisfying the requirements for class relief under the Federal Rules of Civil Procedure. Horan & Nord, *supra* note 1, at 716-17; *see* FED. R. CIV. P. 23 (class action provision). Upon a finding of antitrust liability, the state may seek injunctive relief. *See* Burch v. Goodyear Tire & Rubber Co., 554 F.2d 633, 634 (4th Cir. 1977) (state attorney general has standing to sue for injunctive relief in antitrust suit filed in *parens patriae* capacity). The state also may recover treble damages for injury to the state's citizens, plus litigation costs and attorneys fees. 15 U.S.C. § 15c(d)(2) (1976). The court has discretion to require that the state either distribute the recovery to the injured individuals or retain the recovery as general state revenues. *Id.* § 15e.

⁶⁵ 15 U.S.C. § 1 (1976 & Supp. V 1981).

⁶⁶ *Id.* § 2.

⁶⁷ Thompson, *Health Planning and Antitrust Exemptions: New Developments*, 2 WHITT. L. REV. 649, 650 (1980) [hereinafter cited as *New Developments*]; *see infra* note 70 (language of Sherman Act gives standard by which courts may measure the challenged restraint's impact on competitive conditions).

⁶⁸ *See* Muenster Butane, Inc. v. Stewart Co., 651 F.2d 292, 295 (5th Cir. 1981) (restraint imposed by distributor of televisions on dealer is vertical restraint and therefore tested under the rule of reason); Tose v. First Pennsylvania Bank, 648 F.2d 879, 891 (3d Cir.) (bank attempt to force distress sale analyzed for violation of antitrust laws under rule of reason), *cert. denied*, 454 U.S. 893 (1981).

⁶⁹ 221 U.S. 1 (1911).

⁷⁰ *Id.* at 63-64. The *Standard Oil* Court stated that Congress did not intend a literal application of the Sherman Act to every contract and agreement. *Id.* Rather, the Court concluded from the generic use of terms in the Sherman Act and the lack of a definition of restraint of trade that Congress designed the Sherman Act to fix a standard, leaving courts to determine by the rule of reason whether any particular act or contract was within the statute's scope. *Id.* at 64.

Under the rule of reason approach, courts consider economic evidence about the industry to determine whether a restrictive agreement unduly hampers competition.⁷¹ Beginning with *Standard Oil*, however, the Supreme Court has declared that the lower courts conclusively may presume certain agreements to be unreasonable and therefore illegal without the need for supporting economic analysis.⁷² A "per se" violation of the Sherman Act thus arises when the challenged restraints are so inherently anticompetitive and lacking in redeeming virtue that the courts may declare the practices unreasonable as a matter of law.⁷³ The Supreme Court has listed among the practices deemed per se unlawful price fixing,⁷⁴ division of markets,⁷⁵ group boycotts,⁷⁶ and tying arrangements.⁷⁷

The primary defenses against antitrust prosecution available to persons involved in health planning activities are immunities created implicitly by judicial interpretations of antitrust laws.⁷⁸ The basic exemptions con-

⁷¹ See *National Soc'y of Prof. Engineers v. United States*, 435 U.S. 679, 688 (1978) (analysis under rule of reason entails determination of facts peculiar to business, history of restraint, and reasons imposed); *United States v. Topco Assocs., Inc.*, 405 U.S. 5, 606-07 (1972) (rule of reason adopted in lieu of narrow reading of § 1 of Sherman Act); *Board of Trade of City of Chicago v. United States*, 246 U.S. 231, 238 (1918) (true test of legality under rule of reason is whether restraint promotes or suppresses competition); see also Bork, *The Rule of Reason and the Per Se Concept: Price Fixing and Market Division*, 75 YALE L.J. 373, 375-76 (1966) (rule of reason only invalidates restraints with anticompetitive results that exceed desirable effects, such as increased efficiency or availability of goods).

⁷² See *Standard Oil Co. v. United States*, 221 U.S. 1, 64-65 (1911). The Supreme Court in *Standard Oil* ruled that the effect and character of some acts clearly are restraints of trade, thereby creating a conclusive presumption of illegality under the Sherman Act. *Id.* at 65; see also *Mendelovitz v. Adolph Coors Co.*, 693 F.2d 570, 576-77 (5th Cir. 1982) (courts conclusively presume restraints exhibiting deleterious effect on competition as per se illegal).

⁷³ *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958). The *Northern Pacific* Court noted that the per se rule avoids the necessity for complicated and prolonged economic investigations into the entire history of an industry, as well as related industries. *Id.* Under the per se rule, once courts recognize that a particular practice is a per se violation, the plaintiff government only need prove the existence of the practice to obtain a judgment and thereby preclude the defendant from introducing evidence to justify the practices. Comment, *Horizontal Territorial Restraints and the Per Se Rule*, 28 WASH. & LEE L. REV. 457, 460 (1971); see *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1, 19-20 (1979) *reh'g denied* 450 U.S. 1050 (1979). In *Broadcast Music*, the court declared that the focus of judicial inquiry under the per se rule is on whether the effect of the practice threatens the proper operation of the free market economy by restricting competition or decreasing output. *Id.*

⁷⁴ See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221, 223 (1940) (any combination formed for purpose of raising, depressing, fixing, pegging, or stabilizing price of commodity in interstate or foreign commerce is illegal per se).

⁷⁵ See *United States v. Topco Assocs., Inc.*, 405 U.S. 596, 608 (1972) (market division per se illegal).

⁷⁶ See *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 213 (1959) (group boycott not tolerated just because victim is small business with little economic impact on market).

⁷⁷ *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 6 (1958) (tying arrangements that condition sale of one product on purchase of another are illegal per se when party restrains free competition in market for tied product).

⁷⁸ M. THOMPSON, *supra* note 1, at 19. A number of regulated industries can avoid the

stitute three general types.⁷⁹ The first type of antitrust exemption, known as the "implied repeal doctrine," states that courts can repeal the antitrust laws by implication when a clear repugnancy exists between the regulatory scheme and the antitrust law, but only to the minimum extent necessary to allow the regulatory scheme to operate.⁸⁰ Overshadowing the implied repeal doctrine is the Supreme Court's caveat in *United States v. Philadelphia National Bank* that courts do not favor immunity from antitrust laws and, therefore, courts should not imply antitrust immunity lightly.⁸¹

A second exemption available to the health care industry is the "state action doctrine," which exempts from antitrust liability practices compelled by the state through direct action of the state's executive, legislative, or judicial branches.⁸² In *Bates v. State Bar of Arizona*,⁸³ the Supreme Court emphasized the requirements that distinguish state actions that will immunize conduct from antitrust attack.⁸⁴ One requirement the *Bates* Court noted is that a clearly defined state policy must exist that compels the practice in question.⁸⁵ Another requirement is that the state actively super-

standard application of the antitrust laws if the industry falls within an express or implied statutory exemption. See L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST 743 § 239 (1977). Regulated industries that are exempt from antitrust laws include utilities, rail, banking, and communication industries. *Id.* at 744; see *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 627 (1974) (antitrust standards must take into account federal and state regulatory restraints on banking); *Utility Users League v. Federal Power Comm'n*, 394 F.2d 16, 21 (7th Cir.) (merger of electric and gas company not violation of antitrust laws since State Commissioner considered public interest), *cert. denied*, 393 U.S. 953 (1968). Antitrust exemptions created in the Planning Act provide limited immunity for members and employees of specific public agencies. See 42 U.S.C. § 3001-1(b)(4) (1976). In addition, § 300-1(b)(4) provides a limited immunity only for members and employees of health service agencies. *Id.*

⁷⁹ *New Developments, supra* note 67, at 650-51; see *infra* notes 80-99 and accompanying text (discussion of antitrust exemptions).

⁸⁰ *New Developments, supra* note 67, at 650-51; see *Gordon v. New York Stock Exchange*, 422 U.S. 659, 682 (1975) (implied antitrust immunity justified only by showing of clear repugnancy between antitrust laws and regulatory system); *Silver v. New York Stock Exch.*, 373 U.S. 341, 357 (1963) (implied repeal permissible only if necessary to make regulatory scheme operate and then only to minimum extent necessary).

⁸¹ See *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 350-51 (1963) (courts do not favor immunity from antitrust laws. See also *National Gerimedical Hosp. and Gerontology Center v. Blue Cross*, 452 U.S. 378, 388 (1981) (same); *United States v. First City Nat'l Bank*, 386 U.S. 361, 368 (1967) (same).

⁸² See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 790 (1975) *reh'g denied* 423 U.S. 886, (1975). In *Goldfarb*, the Supreme Court held that the threshold inquiry in determining whether certain conduct qualifies for a state action exemption is whether the state as sovereign actually requires the conduct. *Id.*; *New Developments, supra* note 67, at 651 (state action doctrine may protect certain conduct compelled by the state); see also *Parker v. Brown*, 317 U.S. 341, 352 (1943) (Sherman Act applies to individual and not to state action).

⁸³ 433 U.S. 350 (1977) *reh'g denied* 434 U.S. 881 (1977).

⁸⁴ *Id.* at 361-62.

⁸⁵ *Id.* at 361.

wise the practice.⁸⁶ In subsequent decisions, the Supreme Court has applied the state action exemption narrowly.⁸⁷ In *Cantor & Seldon Drugs Co. v. Detroit Edison Co.*,⁸⁸ for example, the Court held that when the regulated party causes the state to adopt an anticompetitive rule, the rule does not suffice to confer the state action exemption.⁸⁹ The Court also held in *City of Lafayette v. Louisiana Power & Light Co.*⁹⁰ that lesser governmental entities, including municipalities, do not enjoy automatic antitrust immunity and cannot confer a state action exemption unless the execution of the challenged conduct is pursuant to a state regulation policy.⁹¹

In addition to the implied repeal doctrine and the state action doctrine, the Supreme Court has recognized another exemption involving the anticompetitive effects of government activity.⁹² The exemption, known

⁸⁶ *Id.* at 362; see *Community Communications Co. v. City of Boulder*, 455 U.S. 40 (1982). In *Community Communications*, a cable television operator sued the city of Boulder, alleging that an ordinance prohibiting him from expanding business for three months while the city council drafted a model cable ordinance and invited new businesses to enter the market violated the Sherman Act. 455 U.S. at 43-46. The Supreme Court held that the ordinance was not exempt under the state action theory since the city acted without any regulation by the state. *Id.* at 54-56.

⁸⁷ See *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 412-13 (1978) (municipalities do not enjoy automatic antitrust immunity); *Cantor & Seldon Drugs Co. v. Detroit Edison Co.*, 428 U.S. 579, 596-98 (1976) (activity merely permitted and not part of conscious policy of state does not confer automatic antitrust immunity).

⁸⁸ 428 U.S. 579 (1976).

⁸⁹ *Id.* at 582-83, 597-98. In *Cantor*, the plaintiff, a retail druggist selling light bulbs, claimed that the defendant utility company used its monopoly power in the distribution of electricity to restrain competition. *Id.* at 581. The company, a private utility that was the sole supplier of electricity for the area, also furnished residential customers with free standard-sized light bulbs under a practice antedating the state's regulation of electric utilities. *Id.* at 582-84. After the state began regulation of electric utilities in 1909, the state implicitly approved of the defendant's light bulb program. *Id.* at 583. The defendants alleged that the purpose of the program was to increase consumption of electricity in the area. *Id.* at 584. The plaintiff claimed, however, that the effect of the program was to prevent competition in a substantial segment of the light bulb market. *Id.* The Court refused to apply the state action exemption to the utility's practice, finding that the state's implicit approval of the light bulb program did not implement any state policy relating to light bulbs. *Id.* at 597-98. The Court inferred, therefore, that the state's policy was neutral on the question of whether a utility should operate the type of program challenged in *Cantor*. *Id.*

⁹⁰ 435 U.S. 389 (1978).

⁹¹ *Id.* at 412-13. The *Lafayette* Court noted that to extend the state action doctrine to municipalities would be inconsistent with the doctrine. *Id.* The court speculated that serious economic dislocation could result if cities were free to place municipal interests above the nation's economic goals in antitrust laws. *Id.*

⁹² See *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 510-11 (1972) (antitrust immunity extends to cover concerted efforts before adjudicatory bodies based on first amendment right to petition government); *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965) (joint effort to influence public officials does not violate antitrust laws even though intended to eliminate competition); *Eastern R.R. Presidents Conference*

as the "Noerr-Pennington doctrine,"⁹³ protects attempts by private parties to influence governmental units and instrumentalities in order to obtain legislation, redress, or action favorable to particular interests, even if the parties intend the efforts at persuasion to produce or actually result in an anticompetitive effect.⁹⁴ The Supreme Court views the attempts at persuasion as falling within the protections offered by the first amendment right to speak freely and to petition the government.⁹⁵ A basic exception to the first amendment privilege exists, however, when conduct that apparently seeks to influence government action actually is a sham to cover an attempt to interfere directly with the operations of a competitor.⁹⁶ Furthermore, the exemption fails to operate if the parties endeavor to influence a public official who actually is a coconspirator in

v. Noerr Motor Freight, Inc., 365 U.S. 127, 138-39 (1961) (concerted effort to influence legislation not invalid under Sherman Act simply because of anticompetitive effect).

⁹³ See *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 128-39 (1961). *Noerr* was the first case exempting from the Sherman Act joint activities aimed at achieving anticompetitive governmental decisions. *Id.* In *Noerr*, several railroads lobbied state legislators and the governor in an effort to influence legislation that would eliminate trucking companies as competitors in the long distance heavy freight business. *Id.* at 142-43. The railroads' publicity campaign used front organizations that sent letters to government officials making public sentiment appear to be against the truckers. *Id.* at 133. The railroads succeeded in obtaining the desired legislation and the trucking companies brought an antitrust suit based on the railroads' anticompetitive purpose and fraudulent publicity campaign. *Id.* at 129-30. The Supreme Court held that the railroads' activities did not violate the Sherman Act for two reasons. *Id.* at 137-38. First, the Sherman Act regulated monopolistic business practices and not political behavior. *Id.* Second, the case would raise important first amendment issues regarding the right to petition the government if the Court held that the Sherman Act covered the railroads' lobbying activities. *Id.* The Court issued a caveat to the antitrust exemption policy, stating that the court may refuse to grant antitrust immunity if the challenged activities were a mere sham to cover an attempt to interfere directly with the business relationships of a competitor. *Id.* at 144.

In *United States Workers v. Pennington*, the Court again faced the question of antitrust immunity for joint efforts directed at government officials. See 381 U.S. 657, 65-60 (1965). In *Pennington*, large mine owners and the mine worker's union lobbied with the Secretary of Labor to persuade the Secretary to use his authority to set higher wages for employees of firms selling coal to the TVA, in order to force the smaller operators out of business. *Id.* at 660. The group also urged the TVA to reduce its purchases of coal from small coal operators in the market. *Id.* at 660-61. The Supreme Court held that the activities of the mine owners and the union were immune from the antitrust laws. *Id.* at 670. The Court also extended the *Noerr* principle in stating that joint efforts to influence "public officials" do not violate the antitrust laws even through intended to eliminate competition. *Id.*

⁹⁴ See *supra* note 93 (discussion of *Noerr-Pennington* doctrine).

⁹⁵ See *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 510-11 (1972) (recognizing constitutional right to petition government as exempting some concerted efforts to influence government action).

⁹⁶ See *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 144 (1961) (antitrust immunity denied if activity is direct attempt to interfere with competitor's business); see also *Otter Tail Power Co. v. United States*, 410 U.S. 366, 372 (1973) (repetitive litigation and insubstantial claims that abuse judicial process are within sham exception to *Noerr-Pennington* doctrine).

some other capacity.⁹⁷ The Noerr-Pennington doctrine arises frequently in antitrust litigation in the health care field because professional groups regularly lobby state and federal governments in an attempt to influence legislation and regulatory action.⁹⁸ If the legislature or appropriate administrative agency approves the proposed action, the resulting law may restrict competition and thereby be subject to scrutiny under the antitrust laws.⁹⁹

The Noerr-Pennington doctrine, as well as the state action and implied repeal antitrust exemptions, have been the subject of several cases challenging the anticompetitive consequences of health planning.¹⁰⁰ In *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*,¹⁰¹ the Supreme Court considered for the first time the issue of implied immunity from the Sherman Act based on the Planning Act.¹⁰² Petitioner National Gerimedical Hospital (National) was a private hospital erected in 1978 in metropolitan Kansas City.¹⁰³ One year prior to comple-

⁹⁷ *United Mine Workers v. Pennington*, 381 U.S. 657, 670-71 (1965); see *Duke & Co. v. Foerster*, 521 F.2d 1277, 1282 (3d Cir. 1975). In *Duke* a manufacture and seller of malt beverages claimed that three municipal corporations, three private corporations, and a county commissioner conspired to boycott the plaintiff's product. The Third Circuit sustained the allegations, relying on the fact that both *Noerr* and *Pennington* involved suits against private parties and not against the government entity in promoting the conspiracy. *Id.* at 1282.

⁹⁸ See *Feminist Women's Medical Center, Inc. v. Mohammad*, 586 F.2d 530, 538-39 (5th Cir. 1978). In *Mohammad*, the Fifth Circuit held the Noerr-Pennington defense inapplicable to certain attempts by a group of physicians to block the operation of an abortion center. *Id.* at 542. The attempts consisted mainly of complaints to the state board of medical examiners, the local medical society, and the organized medical staffs of two hospitals that the center's facilities were inadequate for back-up medical services. *Id.* at 536-38. The Court found that only the communications addressed to the medical examiners were exempt under the Noerr-Pennington doctrine. *Id.* at 542-43; see also Rosoff, *supra* note 1, at 471. Professional groups that attempt to influence health care legislation include physicians who lobby state legislatures to adopt or retain laws that exclude less qualified physicians from engaging in specialized health care activities. *Id.* Professional organizations also may lobby Congress to certify only persons with specified qualifications as competent to render certain types of care under Medicare, Medicaid, and other federal health programs. *Id.*

⁹⁹ See Rosoff, *supra* note 1, at 471-72. The policy issue in considering whether proposed standards violate the antitrust law is what balance between competition and the maintenance of quality by passage of standards best serves the public interest. *Id.*

¹⁰⁰ See *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 392-93 (1981) (Planning Act does not create blanket repeal of antitrust laws in health planning area); *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 691 F.2d 678, 685 (4th Cir. 1982) (modified per se rule applicable to antitrust analysis of planning activities of health providers); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 505-06 (1982) (Blue Cross pharmacy agreements are novel restraints subject to judicial analysis under rule of reason); *Huron Valley Hosp., Inc. v. City of Pontiac*, 666 F.2d 1029, 1032 (6th Cir. 1981) (no implied immunity for planning activity involving refusal to issue CON for hospital construction).

¹⁰¹ 452 U.S. 378 (1981).

¹⁰² *Id.* at 380.

¹⁰³ *Id.*

tion, National applied to Blue Cross for a participating contract, which would enable the hospital to receive reimbursement directly from the Blue Cross Plan.¹⁰⁴ Blue Cross refused to enter into an agreement with National because of a preexisting policy barring participation by any new hospital that did not receive construction approval from the area HSA.¹⁰⁵ In a prior announcement, the local HSA stated that the agency would not approve any additional hospitals of the type National intended to provide.¹⁰⁶ As a result of the announced policy, National did not seek HSA approval for construction, leading to the refusal of participating hospital status by Blue Cross.¹⁰⁷

National brought suit against Blue Cross alleging a wrongful refusal to deal and a conspiracy between Blue Cross and the HSA.¹⁰⁸ The district court granted Blue Cross's motion for summary judgment, holding that Blue Cross acted pursuant to the Planning Act and the antitrust laws, and that, consequently, Blue Cross was immune under the implied repeal doctrine.¹⁰⁹ The Eighth Circuit affirmed the district court's holding that the doctrine of implied immunity applied to Blue Cross' action in requiring National to obtain construction approval from the area HSA.¹¹⁰

On appeal, the Supreme Court reversed, finding no clear repugnancy between Blue Cross's actions taken within the provisions of the Planning Act and the antitrust law.¹¹¹ The Court noted, however, that the merits of the antitrust claim remained for the parties to litigate on remand, when the trial court should consider the economic factors underlying the alleged conspiracy and refusal to deal.¹¹² In denying antitrust immunity for Blue Cross's actions, the Court reviewed the structure and function of the Plan-

¹⁰⁴ *Id.* Under the participating hospital agreement, participating hospitals received direct reimbursement of the full cost of covered services rendered to individual Blue Cross subscribers. *Id.* When subscribers receive care in nonparticipating hospitals, Blue Cross pays only 80% of the cost directly to the subscriber, rather than directly to the hospital. *Id.*

¹⁰⁵ *Id.* Blue Cross's policy provided that new participating hospitals must meet a clearly evident need for health services in a defined service area. *Id.* at 381 n.3. The policy further provided that the area health planning agency would approve the health care institutions and services under the Planning Act. *Id.*

¹⁰⁶ *Id.* The local HSA in *National Gerimedical* determined that a surplus of beds existed in the area and therefore the agency would not approve any addition of acute-care beds in area hospitals. *Id.*

¹⁰⁷ *Id.* at 382.

¹⁰⁸ *Id.* Plaintiff National sought treble damages and an injunction to prevent future violations. *Id.*

¹⁰⁹ *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 479 F. Supp. 1012, 1024 (W.D. Mo. 1979); see *supra* notes 80 & 81 and accompanying text (discussion of implied repeal doctrine).

¹¹⁰ *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 628 F.2d 1050, 1055-56 (8th Cir. 1980). The Eighth Circuit determined that Congress, in passing the Planning Act, intended to immunize from the antitrust laws the type of action challenged in *National Gerimedical*. *Id.*

¹¹¹ 452 U.S. at 393.

¹¹² *Id.* at 393 n.19.

ning Act.¹¹³ The Court also noted that the 1979 amendments to the Planning Act, requiring the promotion of competition in the health industry, indicated congressional recognition of a distinction between areas in which competition was useful and areas in which an allocation of resources was necessary.¹¹⁴ Considering National's claim that the Planning Act implied a repeal of the antitrust laws, the Court emphasized that no governmental regulatory body compelled or approved Blue Cross's action in denying participating hospital status.¹¹⁵ Because the state of Missouri had not implemented the Planning Act at the time the events of the case occurred, the Court considered the function of the local HSA to be no more than the function of a private planning body.¹¹⁶ The Court found the lack of an established state regulatory agency to be crucial because of the general principle that disfavors antitrust repeals when a governmental entity does not consider the antitrust implications of a business decision.¹¹⁷

The *National Gerimedical* Court also rejected National's claim that Congress intended the Planning Act to immunize all private conduct taken in response to health planning activities.¹¹⁸ The Court noted that the 1979 Amendments advocated competition in the health system without changing the basic planning structure.¹¹⁹ The Court held, therefore, that any incompatibility between the Planning Act and antitrust concerns was not sufficiently great to create a blanket repeal of the antitrust laws.¹²⁰ The Court noted in a footnote, however, that the holding did not foreclose future claims of antitrust immunity in other factual contexts.¹²¹ The Court,

¹¹³ *Id.* at 383-88. The *National Gerimedical* Court noted that Congress intended the Planning Act's elaborate structure to remedy deficiencies in the performance of the healthcare industry. *Id.* at 386. The deficiencies included the anticompetitive effects of the medical marketplace that precluded cost efficiency and the maldistribution of health care facilities. *Id.*

¹¹⁴ *Id.* at 387; see 42 U.S.C. § 300k-2(b)(1) (1976 & Supp. V 1981) (planning agencies should give priority to action that strengthen effect of competition on supply of health services; *supra* notes 46-48 and accompanying text (1979 Amendments to Planning Act to improve competition in health industry).

¹¹⁵ 452 U.S. at 389-40.

¹¹⁶ *Id.* at 390.

¹¹⁷ *Id.* The *National Gerimedical* Court refused to hold that an HSA recommendation justifies antitrust immunity because such a holding would give the recommendation greater force than Congress intended. *Id.* at 391.

¹¹⁸ *Id.* at 391-92. The *National Gerimedical* Court recognized the argument that Congress, in passing the Planning Act, did not consider competition to be a relevant factor in the health industry. *Id.* at 392. The Court considered meritorious the argument that Congress intended cooperation and planning in the health industry without the interference of antitrust suits. *Id.* In *National Gerimedical*, however, the Court found that the plaintiffs failed to make the showing that regulation was necessary for an exemption of all actions of health care providers. *Id.* In refusing a blanket exemption, the court found no indication that Congress intended a different result with respect to the health care industry. *Id.*

¹¹⁹ *Id.* at 392-93; see *supra* notes 46-48 and accompanying text (discussion of 1979 Amendments).

¹²⁰ 452 U.S. at 392-93.

¹²¹ *Id.* at 393 n.18.

as an example, cited the situation in which an HSA advocates a form of cost-saving cooperation among providers.¹²²

The *National Gerimedical* holding was the basis for the Sixth Circuit's recent decision in *Huron Valley Hospital, Inc., v. City of Pontiac*,¹²³ involving a dispute over a state health agency's issuance of a CON.¹²⁴ Huron Valley Hospital, Inc. (Huron) was a nonprofit organization formed for the purpose of building a new hospital.¹²⁵ In 1976, Huron applied for a CON requesting approval for construction of the hospital.¹²⁶ The state health agency for Michigan, upon the recommendation of the local HSA, refused to issue a CON to Huron and instead issued a CON allowing a competitor, Pontiac General Hospital (Pontiac) to rebuild its existing hospital.¹²⁷ Huron brought an antitrust action, alleging that Pontiac conspired with the planning agencies to bar Huron from entering the market.¹²⁸ The district court held, on the merits, that the Planning Act provided the defendants with a blanket exemption from antitrust liability.¹²⁹ In an alternative holding, the district court concluded that the state action exemption and Noerr-Pennington doctrine shielded the defendants from antitrust liability.¹³⁰

On appeal, the Sixth Circuit relied on *National Gerimedical* to hold that the Planning Act did not effect an implied repeal of the antitrust laws.¹³¹ The *Huron* court noted that the issue left open in *National Gerimedical*, whether actions taken directly pursuant to mandatory planning statutes are immune from antitrust liability, was present on the facts of *Huron*.¹³² The Sixth Circuit, however, declined to decide the merits of

¹²² *Id.* The *National Gerimedical* Court noted that the situation surrounding the mandated planning activities of an HSA differs significantly from the situation in the *National Gerimedical* case. *Id.* The conduct at issue in *National Gerimedical* was not cooperation among providers, but an insurer's refusal to deal with a provider that failed to follow the advice of an HSA. *Id.*

¹²³ 666 F.2d 1029 (6th Cir. 1981).

¹²⁴ *Id.* at 1031.

¹²⁵ *Id.* at 1030.

¹²⁶ *Huron Valley Hosp., Inc. v. City of Pontiac*, 466 F. Supp. 1301, 1304 (E.D. Mich. 1979).

¹²⁷ *Id.* at 1305-06.

¹²⁸ *Id.* at 1306.

¹²⁹ *Id.* at 1312. The district court in *Huron* based the blanket exemption of health planning activities on the legislative history of the Planning Act. *Id.*; see 1974 SENATE REPORT, *supra* note 8, at 39 (health care industry does not respond to classic marketplace forces) reprinted in 1974 U.S. CODE CONG. & AD. NEWS, 7842, 7878.

¹³⁰ *Id.* at 1311-12.

¹³¹ 666 F.2d at 1033-34. The Sixth Circuit in *Huron* cited the Supreme Court's decision in *National Gerimedical*, holding that the Planning Act is not so incompatible with antitrust concerns that the Act creates a pervasive repeal of the antitrust laws. *Id.*; see *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 392-93 (1981) (Planning Act does not create blanket repeal of antitrust laws in health planning area); *supra* notes 101-122 (discussion of *National Gerimedical*).

¹³² *Id.* at 1031. The *Huron* court noted that the conflict between the regulatory action and the Sherman Act in *Huron* was more direct than the conflict confronting the Supreme Court in *National Gerimedical*. *Id.*; cf. *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 114 (1981) (*National Gerimedical* is weak case

Huron's antitrust action, pending the outcome of state proceedings.¹³³

Courts that refused to find implied immunity for conduct that the plaintiff alleges violates antitrust laws must decide whether to analyze the challenged conduct under a per se or rule of reason approach.¹³⁴ In *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*,¹³⁵ Medical Arts Pharmacy (Medical) brought an action against Blue Cross charging that Blue Cross's pharmacy agreements were per se illegal price fixing arrangements in violation of section 1 of the Sherman Act.¹³⁶ Under the Blue Cross program, subscribers could obtain prescription drugs from pharmacies at little or no cost beyond the payment of premiums.¹³⁷ A contract between Blue Cross and the participating pharmacy set forth the terms under which the pharmacy would provide prescription drugs to Blue Cross subscribers.¹³⁸ The pharmacy agreement also provided a maximum billable amount that Blue Cross would reimburse participating pharmacies for any drug sold.¹³⁹

The district court in *Medical Arts* denied Medical's motion for summary judgment, holding the per se rule of illegality inapplicable to the

for deciding immunity question because no regulatory structure existed at time of case).

¹³³ *Id.* at 1035-36. In *State of North Carolina ex rel Edmunsten v. P.I.A. Asheville, Inc.*, the United States District Court for the Western District of North Carolina found implied antitrust immunity on facts involving a direct conflict between mandatory planning statutes and the antitrust laws. See 1982-2 Trade Cas. (CCH) ¶ 64,764, 71,706 (W.D.N.C. 1982). In *P.I.A. Asheville*, North Carolina's Department of Human Resources granted a CON to the corporate operator of a psychiatric hospital in Asheville to operate a second hospital in the area. *Id.* at 71,702-03. Considering charges of monopolistic practices against the defendant corporation, the district court held that a repugnancy existed between the regulatory provisions governing hospital acquisitions in the state and the antitrust laws and, therefore, the hospital acquisition was exempt from antitrust scrutiny. *Id.* at 71,706. The district court, noting the Supreme Court's reasoning in *National Gerimedical*, found that antitrust review of the hospital acquisition was needless and inappropriate because a regulatory body, in the form of the State Department of Human Resources, considered the antitrust implications of the acquisition. *Id.* at 71,707; see *National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 389-91 (1981) (courts should reject claims for immunity when no governmental or regulatory body compelled or considered antitrust implications of challenged action).

¹³⁴ See *infra* notes 135-62 and accompanying text (discussion of antitrust cases analyzing different approaches).

¹³⁵ 675 F.2d 502 (2d Cir. 1982).

¹³⁶ *Id.* at 504; see *supra* text accompanying note 75 (price fixing is per se illegal under Sherman Act); note 65 (§ 1 of Sherman Act).

¹³⁷ 675 F.2d at 503.

¹³⁸ *Id.* Blue Cross's pharmacy program provided for a contract between Blue Cross and individual subscribers to determine the level of benefits for each insured. *Id.* The subscriber contract permits the insured to obtain prescription drugs from either a participating or nonparticipating pharmacy.

¹³⁹ *Id.* If the subscriber purchases the drugs from a nonparticipating pharmacy, Blue Cross reimburses the subscriber in an amount no greater than the reimbursement amount paid to a participating pharmacy. *Id.* If the subscriber selects a participating pharmacy, Blue Cross directly reimburses the pharmacy, while the subscriber receives the drug at no out-of-pocket expense. *Id.*

Blue Cross pharmacy agreement because the agreement was not price fixing within the scope of the per se prohibition.¹⁴⁰ On appeal, the Second Circuit held that the district court properly declined to apply the per se rule because Blue Cross pharmacy agreements are novel restraints with potential procompetitive effects, and, therefore, the courts should analyze the agreements under the rule of reason.¹⁴¹ The Second Circuit emphasized that the pharmacy agreements were not manifestly anticompetitive or formulated for the purpose of restraining competition among the individual pharmacies.¹⁴²

While the Second Circuit in *Medical Arts* dealt with the per se rule concerning the activities of third-party payors, the Fourth Circuit in *Hospital Building Co. v. Trustees of Rex Hospital*¹⁴³ recently considered whether courts properly may apply the per se rule to measure allegations of refusals to deal concerning the planning activities of private health service providers.¹⁴⁴ Hospital Building Company (HBC), corporate operator of a small proprietary hospital, brought an antitrust action against Rex Hospital (Rex), a nonprofit hospital, alleging that Rex and other coconspirators acted in concert to block the planned relocation and expansion of Mary Elizabeth Hospital, which HBC operated.¹⁴⁵ HBC asserted that the conspirators planned to bar the expansion by preventing HBC from receiving a CON for construction of the new hospital.¹⁴⁶ In addition, HBC attempted to prove that a secondary plan provided for the imposition of a discriminatory reimbursement schedule to reduce HBC's profits.¹⁴⁷

The district court dismissed the action on the ground that HBC's business was local and, therefore, the plaintiff had failed to show a sufficient connection between the alleged Sherman Act violations and interstate

¹⁴⁰ *Id.* at 503-04; *Medical Arts Pharmacy of Stanford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 518 F. Supp. 1100, 1107 (D. Conn. 1981). The district court in *Medical Arts* held that the agreement was not price fixing within the scope of the per se prohibition because Blue Cross was a purchaser of the prescribed drugs and, therefore, simply was contracting with other parties to sell goods. *Id.*

¹⁴¹ 675 F.2d at 505-06.

¹⁴² *Id.* at 506. The business of insurance is exempt from antitrust scrutiny under the McCarran-Ferguson Act. See 15 U.S.C. §§ 1011-1015 (1976) (Sherman Act applies to business of insurance to extent that the state does not regulate the challenged insurance practice). To qualify for the exemption, the anticompetitive practices must be part of the business of insurance. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211, 215-21 (1979) (Court limits business of insurance exemption to insurance contracts between insurers and insured, risk spreading activities, and practices limited to entities within insurance industry). Another requirement for the McCarran-Ferguson exemption is that state law must regulate the anticompetitive practice. *Id.* § 1012. In addition, the exemption does not extend to any agreement to or act of boycott, coercion, or intimidation. *Id.* § 1013(b).

¹⁴³ 691 F.2d 678 (4th Cir. 1982).

¹⁴⁴ *Id.* at 686.

¹⁴⁵ *Id.* at 682-83.

¹⁴⁶ *Id.* at 683.

¹⁴⁷ *Id.*

commerce.¹⁴⁸ The Fourth Circuit affirmed the dismissal¹⁴⁹ and the Supreme Court granted certiorari.¹⁵⁰ The Court reversed the lower court's dismissal, holding that the plaintiff's allegations were sufficient to satisfy the jurisdictional requirements of the Sherman Act.¹⁵¹ The Court found that the allegations, if proven, could show that the conspiracy resulted in unreasonable burdens on the free and uninterrupted flow of interstate commerce.¹⁵² On remand to decide the antitrust claims, the district court entered treble damages judgments against the defendants.¹⁵³

On appeal, the Fourth Circuit noted that courts generally regard concerted refusals to deal and allocation schemes as per se violations of the antitrust laws.¹⁵⁴ The court decided, however, to apply a narrow rule of reason approach to permit the defendants to show, if possible, that planning activities, otherwise in violation of the Sherman Act, might not be unreasonable in certain circumstances.¹⁵⁵ The Fourth Circuit based its modification of the per se rule on Congress' intent to encourage participation by private health care providers in the planning process.¹⁵⁶ In defining the scope of the modified rule, the Fourth Circuit specified that planning activities of private health services providers are not unreasonable restraints if the activities are undertaken in good faith to prevent needless duplication of health care resources in an affected area.¹⁵⁷

The Fourth Circuit noted that the critical question in the application of the narrow rule of reason is whether the duplication of resources, ostensibly avoided by planning, is in fact needless duplication.¹⁵⁸ Proper application of the rule, therefore, requires the fact-finder to determine that urgency of the health care needs in relation to the health needs of the consumer public in the market area at the time in question and not in relation to the economic or other needs of the planners.¹⁵⁹ The Fourth Cir-

¹⁴⁸ *Id.*

¹⁴⁹ Hospital Bldg. Co. v. Trustees of Rex Hosp., 511 F.2d 678, 682 (4th Cir. 1975).

¹⁵⁰ Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976).

¹⁵¹ *Id.* at 739-40.

¹⁵² *Id.* at 746. The Fourth Circuit found that the complaint was sufficient to establish a claim under the Sherman Act without requiring allegations that the conspiracy threatened out-of-state businesses or that the conspiracy affected market prices. *Id.* at 746-47.

¹⁵³ Hospital Bldg. Co. v. Trustees of Rex Hosp., 511 F.2d 678, 683 (4th Cir. 1975).

¹⁵⁴ *Id.* at 684. The *Rex* court noted that under the per se rule, the court presumes the anticompetitive impact of the alleged offense. *Id.* Under the rule of reason, the Fourth Circuit added, the plaintiff must prove the anticompetitive effect. *Id.*

¹⁵⁵ *Id.* at 685.

¹⁵⁶ *Id.* at 685-86. The Fourth Circuit in *Rex* noted that health planning legislation anticipated participation in planning by health care providers. *Id.* at 685. The court found participation desirable because of the waste and impracticability of engaging in health care planning without drawing on the expertise of local hospital administrators and physicians. *Id.*

¹⁵⁷ *Id.* at 686. The *Rex* court cautioned that courts cannot interpret statutory authority to allow the use of planning laws as a means by which providers could act to avoid competition. *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

cuit also decided that courts employing the narrow rule of reason should specify that the defendant has the burden of establishing as an affirmative defense the reasonableness of the challenged planning activities.¹⁶⁰ The plaintiff initially would bear the burden of establishing a prima facie case by demonstrating that certain planning conduct constituted a per se violation of section 1 of the Sherman Act.¹⁶¹ The burden then would shift to the defendant to persuade the trier of fact by a preponderance of the evidence that the challenged conduct served only to avoid a needless duplication of health care resources.¹⁶²

The policy issues that health care antitrust cases raise reflect the genuine conflict between antitrust principles and health planning activities.¹⁶³ The conflict seems likely to continue until Congress expressly repeals the application of the Sherman Act to the health care industry or indicates that the antitrust laws apply to health planning activities.¹⁶⁴ Two divergent principles lie at the root of the conflict, one principle advocating competition through the enforcement of the Sherman Act and the other claiming that health care regulation is necessary even if regulation clashes with the antitrust laws.¹⁶⁵ Critics of the feasibility of the antitrust approach question whether the antitrust ideal of free and unfettered competition is an appropriate goal in a field in which policy considerations concerning human lives are at stake.¹⁶⁶ Competition as an answer to the problem of rising health care costs also raises questions about the workability and fairness of competitive proposals for the poor, elderly, and uninsured.¹⁶⁷ Antitrust advocates cannot ignore the legitimate

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See *supra* text accompanying notes 1-8 (conflict between antitrust and health care laws).

¹⁶⁴ See *id.* (same).

¹⁶⁵ See *supra* notes 4 & 5 and accompanying text (divergent views on solutions to health care problems).

¹⁶⁶ See Marmor, Boyer, & Greenberg, *supra* note 18, at 1026. Critics of the application of antitrust laws to the health industry note that antitrust actions seek to encourage competition without regard to the impact that competitive forces might have on costs and professionalism of medical practice. *Id.*

¹⁶⁷ See Dunham, Morone, & White, *Restoring Medical Markets: Implications for the Poor*, 7 J. HEALTH, POL., POL'Y & L. 488, 488-90 (1982). Current proposals for injecting competition in health care may reduce significantly the health services that the poor receive. *Id.* at 488. Two elements of procompetitive proposals threaten the development of a two-tier medical system for the affluent and the poor. *Id.* First, the proposals advocate the use of vouchers, which allow members of group health plans and recipients of Medicare and Medicaid to select alternative insurance packages. *Id.* at 490-91. Most plans propose to measure the cost of vouchers at the mean expenditure of the general population for health care plans. *Id.* Because the average cost of serving the poor is greater than the current national expenditure, the voucher may set prices below the expected cost of adequate health service. *Id.* at 490. Providers as a result would be unwilling or unable to serve the poor properly. *Id.*

The second element of procompetitive proposals that threatens health care for the poor

concerns that recent medical antitrust actions raise particularly in view of the potential effect of antitrust actions on the quality of health care.¹⁶⁸

Despite the legitimacy of the concerns raised by critics of the antitrust approach, the damaging fact remains that health planning proponents are unable to demonstrate that the Planning Act as enforced through CON legislation is effective in keeping costs down or allocating resources.¹⁶⁹ Justifications for CON legislation are difficult to evaluate because the substantial lag time between the CON process and the date at which the CON-approved facility begins service means some effects are not immediately observable.¹⁷⁰ The effectiveness of CON legislation also is difficult to evaluate because many CON statutes contain "grandfathering" clauses that allow projects initiated before the effective date of the statute to proceed without CON review.¹⁷¹ Consequently, any research data on the effects of CON laws are tentative and often contradictory.¹⁷² Another

are Health Maintenance Organizations (HMOs) and other competing systems of health care delivery. *Id.* at 488-489; see *infra* notes 195-97 and accompanying text (discussion of HMOs). HMOs, despite sensible and innovative features, affect only some of the causes of health inflation and, therefore, are not likely to halt the rise in medical costs. *Id.* at 489-90. With rising costs unchecked, the government's main alternative to control of expenditures would be controlling the vouchers of the poor and elderly. *Id.* at 493. If increases in voucher prices do not keep pace with the real increase in medical costs, the poor's ability to purchase access to care would decline. *Id.* at 494. Even if the government does not index the voucher to the Consumer Price Index, drastic cuts in monetary support programs for the poor may result. *Id.* at 492-93; see also Sigelman, *Palm-Reading The Invisible Hand: A Critical Examination of Pro-Competitive Reform Proposals*, 6 J. HEALTH, POL., & L. 578, 593 (1982) (under voucher system, undersubsidization of high-risk, low-income persons could result).

¹⁶⁸ See Rosoff, *supra* note 1, at 478. The medical antitrust enforcement issue leaves open the question of how many changes the health care section can absorb before serious deterioration of quality will result. *Id.* One proposal is antitrust legislation tailored to the special needs of the health industry. *Id.* at 479-80.

¹⁶⁹ *Health Planning, supra* note 1, at 317; *infra* text accompanying notes 170-75 (difficulties in assessing efficiency on CON legislation).

¹⁷⁰ Blumstein & Sloan, *supra* note 5, at 23. The youth of many CON programs combined with the lag-time problem makes some effects of CON not immediately observable. *Id.* CON programs, furthermore, may develop effectiveness only with the experience gained over time. *Id.*

¹⁷¹ *Id.* In addition to lag-time and grandfathering clause problems, evaluation of CON's effectiveness requires the employment of special statistical techniques. *Id.* at 23-24. Another difficulty of CON evaluation is the interaction between CON and other regulatory mechanisms, such as Section 1122 of the Social Security Amendments of 1972. *Id.* at 24. Finally, the impact of a CON law may depend on the political environment of the state and the state's previous experience with various forms of regulation. *Id.*

¹⁷² See Benjamin & Downs, *Evaluating the National Health Planning and Resources Development Act: Learning from Experience?*, 7 J. HEALTH, POL., POLY & L. 707, 709-20 (1982). As critical as the accurate assessment of the Planning Act is for the development of an improved technology of health planning, major problems exist in evaluating the effectiveness of the legislation. *Id.* at 709. Among the difficulties in assessing health planning is an inability to predict the full consequences of planning decisions because of unanticipated consequences that accompany broad policy decisions. *Id.* at 710. In addition, the broad responsibilities assigned health planning agencies by the Planning Act makes the collection of

difficulty in justifying CON legislation is the potential for domination of the planning process by the health industry.¹⁷³ Because CON laws require industry participation in health planning, industry representatives have the opportunity to implement anticompetitive strategies and to manipulate favorable determinations of need.¹⁷⁴ Furthermore, CON legislation does not address many of the major problems underlying the health care crises, including the inefficiencies of third-party programs and the special characteristics of the physician-hospital relationship that reduce cost-effective incentives.¹⁷⁵

The criticisms of CON legislation indicate a need to remove obstacles to open competition and give free market forces a chance to work.¹⁷⁶ Antitrust law offers the most effective means at present to increase competition in the medical industry.¹⁷⁷ Other procompetitive reform proposals advanced as solutions to the existing health regulatory problem contain critical deficiencies that make antitrust enforcement an attractive alternative.¹⁷⁸

data both time consuming and expensive. *Id.* at 709. The decentralized nature of the planning system, the limited amount of regulatory control vested in HSAs, and the latitude granted the planning agencies to implement the Planning Act's provisions also contribute to the difficulty in measuring health regulation. *Id.* at 713.

¹⁷³ See Miller, *supra* note 5, at 917. In controlling the planning process, providers can block competing providers' proposals and advance personal interests. *Id.* Government intervention in health planning thereby becomes more difficult to justify, either politically or economically. *Id.* Furthermore, the potential for damage under regulatory capture is great because government involvement in planning constitutes a formidable obstacle to reform. *Id.*; see *supra* note 62 (potential for industry domination exists because providers participate in need determination); C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY, 1711 (1982) (local health planning exhibits characteristics of cartel) [hereinafter cited as INDUSTRY].

¹⁷⁴ See *supra* note 62 (Planning Act requires industry participation).

¹⁷⁵ See *Health Planning, supra* note 1, at 318 (CON addressed only symptoms of health care problem and not cause); *supra* notes 13-26 and accompanying text (deficiencies of health care market).

¹⁷⁶ See *supra* notes 169-75 and accompanying text (criticisms of CON legislation).

¹⁷⁷ See *infra* notes 207-21 (arguments in favor of application of antitrust laws to health care industry).

¹⁷⁸ See STAFF OF HOUSE COMM. ON WAYS AND MEANS, 97TH CONG., 1ST SESS., DESCRIPTION OF PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE 1-12 (Comm. Print 1981) [hereinafter cited as STAFF DESCRIPTION] (review of present health care laws and explanation of proposed changes contained in each procompetitive bill). Proponents of the procompetitive approach introduced a number of proposals in the 97th Congress including H.R. 850 National Health Reform Act of 1981 introduced by Representative Gephardt; S. 139 Comprehensive Health Care Reform Act of 1981 introduced by Senator Hatch; and S. 433 Health Incentives Reform Act of 1981 introduced by Senator Durenberger. STAFF DESCRIPTION, *supra*, at 1. Procompetitive advocates argue that a significant factor in the recent rise in health care costs is the present method of payment in the health care system. *Id.* Inflationary payment schemes cited by reformers include third-party payments that insulate consumers from the real cost of health care, fee-for-service reimbursement to physicians that encourages physicians to increase the quantity and price of services, cost reimbursements to hospitals, and tax deductions and exclusions that encourage employers and employees to choose the most costly health care plans. *Id.*; *infra* notes 179-88 (critique of alternative procompetitive reform proposals).

One type of reform proposal advocates consumer sovereignty by making the consumer responsible for a greater proportion of health insurance costs and by reducing or eliminating tax subsidies for the purchase of health insurance.¹⁷⁹ The theory underlying consumer cost-sharing is that consumer responsibility for significant proportions of the cost of health care will alert the patient to the need for economizing measures.¹⁸⁰ One means to make patients and doctors aware of the actual costs of medical care is to reshape health insurance by creating tax incentives for consumers to select more cost-efficient insurance plans.¹⁸¹ The Internal Revenue Code (Code) currently provides that employees and other taxpayers may claim deductions for their health insurance contributions and certain medical expenses.¹⁸² The Code further permits employers to deduct as a business expense employer contributions to employee health plans.¹⁸³ In addition to tax deductibles for health expenses, the Code provides that an employer's contribution to his employee's health insurance plan is not included in the employee's gross income for income tax purposes.¹⁸⁴ Some procompetitive approaches propose either to reduce or eliminate the medical expense and employer business expense deductions or to convert the medical expense deduction to a tax credit.¹⁸⁵ Another feature of many procompetitive reform proposals is a limitation on the tax subsidy for provision of health insurance by employers.¹⁸⁶

Criticism of consumer cost-sharing stems from evidence that cost-sharing may be more expensive than health care costs under the present system because consumers covered by cost-sharing plans tend to postpone

¹⁷⁹ Marmor, Boyer & Greenberg, *supra* note 18, at 1011-12.

¹⁸⁰ *Id.* at 1012.

¹⁸¹ *Id.*

¹⁸² I.R.C. § 213 (P-H 1983). The Internal Revenue Code (Code) limits itemized deductions up to \$150 per one half of the amount of the taxpayer's health insurance contributions. *Id.* The Code permits deductions for medical expenses, including insurance premium amounts, and drug expenses, to the extent that the expenses exceed three percent of the individual's adjusted gross income. *Id.* § 213.

¹⁸³ *Id.* § 162.

¹⁸⁴ *Id.* § 160.

¹⁸⁵ STAFF DESCRIPTION, *supra* note 178, at 4.

¹⁸⁶ *Id.* Procompetitive advocates claim that the current tax subsidy for provision of health insurance by employers encourages employers and employees to choose plans that are more costly than is necessary. *Id.*; see Sigelman, *supra* note 167, at 579-80 (under employer contribution plans employees have no immediate incentive to select less expensive, lower-option plans). By placing a limit on the contribution which the employee may exclude, reform proponents argue that employees will be more cost conscious in selecting a health plan because any amount paid by the employer in excess of the exclusion limitation is taxable to the employee. STAFF DESCRIPTION, *supra* note 178, at 4; see Marmor, Boyer & Greenberg, *supra* note 18, at 1013 (elimination of tax subsidy for employer contributions will lead consumers to purchase economically rational level of coverage). As an additional incentive to purchase low cost health plans, many procompetitive proposals provide that an employee who chooses a health plan in which the premium is less than the employer contribution amount would receive a cash rebate on his benefits. STAFF DESCRIPTION, *supra* note 178, at 4. See generally, INDUSTRY; *supra* note 173, at 387-96 (overview of tax treatment of employer-paid health insurance premiums).

preventative outpatient physician visits until they require more costly inpatient care.¹⁸⁷ Consumers also may compromise the effectiveness of cost-sharing programs by choosing to purchase supplementary insurance to fill gaps in reduced cost-sharing provisions.¹⁸⁸ Cost-sharing plans furthermore may impose federal regulation over the currently state-regulated health insurance industry.¹⁸⁹ Because unregulated marketing of health insurance plans poses a potential threat to the program's ability to control provider prices,¹⁹⁰ the cost-sharing approach would restrict entry into the health insurance plan system by federal CON legislation.¹⁹¹ The federal government, therefore, would decide whether a proposed plan meets the requirements for benefits and coverage.¹⁹² As a result, the cost-sharing scheme would exchange the present system of federal health controls for another, more expensive system, and, in addition, could exacerbate at the federal level the problems associated with CON legislation.¹⁹³

While consumer cost-sharing reforms propose to control health care costs, other procompetitive reforms propose to restructure the existing form of fee-for-service (FFS) delivery into primarily prepaid group practices that would compete with FFS providers on the basis of adequate delivery of service at competitive prices.¹⁹⁴ One of the alternative forms

¹⁸⁷ See Sigelman, *supra* note 169, at 583-84. Cost-sharing plans containing increased deductibles, coinsurance, and copayment provisions tend to reduce patient-initiated medical services, particularly for lower income individuals and families. *Id.* at 584. Individuals who postpone needed outpatient treatment until they require hospitalization face the steep costs of important treatment, which could offset any savings gained by lower physician utilization rates. *Id.*

¹⁸⁸ See Sigelman, *supra* note 167, at 583 (cost control promise of consumer cost-sharing programs compromised by supplementation of reduced coverage); Marmor, Boyer, & Greenberg, *supra* note 18, at 1015 (same).

¹⁸⁹ *Id.* at 581; see *infra* text accompanying notes 189-93 (federal CON legislation proposed for health insurance plans).

¹⁹⁰ Sigelman, *supra* note 167, at 581. The fear of an unregulated, free market approach to health care plans stems from the belief than an oversupply of health care packages would split the medical market into several factions, thereby destroying any significant leverage over providers' behavior. See *id.* at 603 n.25 (citing ENTHOVEN, COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 347 (W. Greenberg ed. 1978) (too many third-party intermediaries will not permit any one party to sufficiently represent hospitals' or physicians' business in order to influence providers' behavior)).

¹⁹¹ Sigelman, *supra* note 167, at 581.

¹⁹² *Id.*

¹⁹³ See *id.* at 583 (competitive strategies merely trade one sweeping regulatory regime for another); *supra* notes 169-75 (deficiencies of CON legislation).

¹⁹⁴ Marmor, Boyer & Greenberg, *supra* note 18, at 1016-17. A broad definition of prepaid group practice is a medical care delivery system that accepts responsibility for the organization, financing, and delivery of health care services for a defined population. Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 901 (1971). The prepaid group practice combines a prepayment financing mechanism with a group practice system of delivery by means of a managerial-administrative organization that provides service to an enrolled population. *Id.* The strategy underlying the provision of multiple packages of comprehensive health care is that consumers will choose the plan which

of financing and delivery schemes are Health Maintenance Organizations (HMOs), which propose to charge subscribers an annual fixed fee in exchange for health service based on need, and thereby control costs while creating competition among providers.¹⁹⁶ Congress passed the Federal Health Maintenance Organization Act of 1973¹⁹⁶ (HMO Act) to support and encourage the development of an efficient health care system.¹⁹⁷ The HMO Act enabled the Department of Health, Education and Welfare to spend up to \$375 million for grants and loans to support the planning and operation of 300-500 new HMOs throughout the United States.¹⁹⁸ Another form of delivery service is the Consumer Choice Health Plan (CCHP), which offers consumers a choice of different health packages on the premises that consumers will choose less expensive plans.¹⁹⁹

provides adequate coverage at the lowest cost. STAFF DESCRIPTION, *supra* note 178, at 1. Procompetitive proposals frequently require an employer to offer a choice of health benefit plans to his employees with an equal contribution by the employer to each plan. *Id.* at 4. If the employer fails to offer a choice of qualified health plans, the proposals would deny the employee tax subsidy for employer contributions to health plans or deny the employer's business expense deduction. *Id.* at 4-5. The major requirements for the employer's contributions to qualify for the exclusion or deduction include a minimum benefit package, family coverage to include the beneficiary's spouse and children, continuity of coverage in case of death or changes in marital or employment status, and catastrophic coverage in which the plan pays the full amount of any covered expenses once the beneficiary's out-of-pocket expenses reach a specified annual limit. *Id.* at 5.

¹⁹⁵ Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487, 488 (1978). HMOs may threaten the noneconomic interests of FFS physicians because of the different nature of HMO goals and methods. *Id.* at 490. One distinctive characteristic of HMOs is the organization's comprehensive and intergrated provision of insurance and provider services that allows the organization to budget further in advance. *Id.* at 490. A fixed budget creates greater incentives to deliver services economically than any incentives existing in the FFS section. *Id.* Another characteristic of the HMOs is the quality improvements that could result from the program's financial and organizational structure. *Id.* HMO physicians, for example, should have fewer incentives than FFS physicians to refrain from referrals or consultations because HMO physicians paid on a salaried basis will lose less income from referrals or consultations than their FFS counterparts. *Id.* at 490-91. A final characteristic of HMOs that may threaten FFS providers is the HMO use of clinical forms of medicine and delegation of medical functions to nonphysicians. *Id.* at 491. The HMOs' distinctively commercial attitude toward the delivery of medical care could influence public perceptions on the nature of medical practice and also could threaten the physician's sense of personal security and relative social positions in the community. *Id.*

¹⁹⁶ 42 U.S.C. § 300e (1976 & Supp. V 1981).

¹⁹⁷ See *id.* (HMO legislation).

¹⁹⁸ *Id.* at § 300e-8. Amendments to the Federal Health Maintenance Organization Act in 1976 attempted to expand qualification standards for the program's organization. See Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, 90 Stat. 1945 (1976) (codified in scattered sections of 21, 26, 29, 40, and 42 U.S.C (1976)).

¹⁹⁹ See Lynk, *Regulation & Competition: An Examination of the Consumer Choice Health Plan*, 6 J. HEALTH, POL., POLY & L. 625, 626 (1982). The Consumer Choice Health Plan (CCHP) proposes to facilitate the consumer choice of different health packages by removing checks on competition among suppliers of health care financing plans. *Id.* The principal features include a maximum ceiling established on the amount of nontaxable employer's contribution per employee for health care, federal certification of all proposed health coverage

The conclusion that competitive delivery systems can provide health care more efficiently than FFS services raises several reservations and qualifications.²⁰⁰ One reservation is whether HMOs actually reduce health care costs.²⁰¹ Another criticism of the competitive delivery system is the charge that consumer cost efficiency incentives will have limited effects on the health care system because most health care inefficiencies result from provider decisions.²⁰²

A further obstacle to the development of alternative delivery systems is the predominant position of uniform health insurance plans offered by employers to employees.²⁰³ The medical profession also continues to resist attempts to provide alternative health financing plans for quality care reasons and also because present third-party payment schemes foster consumer demand for medical services.²⁰⁴ The strong resistance to alternative

plans with employer contribution to a nonqualifying plan treated as taxable income to the employee, and a minimum of three coverage options offered by an employer to each employee. *Id.* at 626-27.

²⁰⁰ Homer, *Some Pitfalls in Creating Competition between HMOs and Fee-for-Service Delivery*, 7 J. HEALTH POL., POLY & L. 686, 686-87 (1982); see *infra* notes 200-06 and accompanying text (qualifications on effectiveness of competitive delivery systems).

²⁰¹ *Id.* at 687-89. Several qualifications exist concerning the HMOs ability to control health care costs effectively. *Id.* First, most of the cost-savings through HMO programs stem from the program's lower use of hospital services. *Id.* at 687. Second, the independent practice association (IPA) variant of the HMO is not less costly than FFS health care, yet, IPA's growth rate is greater than other HMO forms. *Id.* Third, the studies on effectiveness often use inconsistent measures, which makes reaching a conclusion on the issue difficult. *Id.* at 687-88. A fourth reservation on the ability of HMOs to contain costs is evidence that HMOs reduce hospital use by eliminating not only unnecessary care, but also by skimping on the use of necessary hospital care. *Id.* at 688-89. The final qualification on HMO effectiveness in containing costs is evidence that HMO programs have approximately the same costs per unit of service as FFS providers, resulting, therefore, in a growth of costs only slightly slower than the FFS system. *Id.* at 689.

²⁰² See Homer, *supra* note 199, at 703. Experience with HMOs demonstrates that provider incentives are more important than consumer ones. *Id.* Under the transition from FFS to HMO programs, evidence shows that consumer incentives produce slight increases in outpatient care use while provider decisions drastically reduce hospital care. *Id.* Procompetitive programs that emphasize changing consumer incentives in the purchase of care, therefore, are not practical solutions to the increasing costs of medical care. *Id.* One proposal for the realistic treatment of HMOs is to recognize the program's value in delivering health care at slightly lower costs than the FFS system, rather than using the program as a tool in building a competitive system. See generally Christianson, *The Impact of HMOs: Evidence and Research Issues*, 5 J. HEALTH, POL., POLY & L. 354, 354-66 (1980) (issues identified for future research on influence of HMOs on health care); Rushefsky, *A Critique of Market Reform in Health Care: The "Consumer-Choice Health Plan"*, 5 J. HEALTH, POL., POLY & L. 720, 737 (1981) (CCHP directly affects consumer as weakest link in health care system and only indirectly affects more effective components of insurers and providers).

²⁰³ Marmor, Boyer, & Greenberg, *supra* note 18, at 1018. Advocates of alternative delivery systems seek to loosen the employer grip over health insurance by limiting or eliminating the tax subsidy of employer-provided health insurance benefits. *Id.*; see *supra* note 179 (efforts to reshape health insurance through creation of tax incentives).

²⁰⁴ See Havighurst, *supra* note 4, at 305-06. The medical professions' resistance to the development of procompetitive health care plans centers on attempts to alter the FFS system of payment, to create physician panels as competitive alternatives to traditional insurance

health plans raises doubts whether the plans can alter the health system on the scale necessary to develop significant competition between providers.²⁰⁵ Development of HMOs, for example, has not been rapid or widespread.²⁰⁶ Estimates reveal that at current rates, HMOs could cover only ten percent of the population by 1990.²⁰⁷

The deficiencies of the two major types of procompetitive reforms lend credence to the argument that the establishment of a competitive health care market through antitrust enforcement is the most viable alternative to regulation.²⁰⁸ The significant potential for regulatory capture of the planning process by health providers suggests the vigorous application of the antitrust laws that Congress designed specifically to prohibit anticompetitive activities of the type engaged in by providers.²⁰⁹ Unlike other procompetitive measures, the procedures already exist to implement antitrust action without requiring massive new regulatory measures.²¹⁰ Furthermore, antitrust laws give the private sector a chance to pursue cost-containment policies through suits brought by private citizens.²¹¹ Enforcement of antitrust laws also may help remove anticompetitive obstacles barring the development of HMOs.²¹²

plans which provide free choice of physician, and to impose administrative checks on physician and patient decisions that affect the expenditure of insurance funds. *Id.* at 306. Professional attempts to frustrate innovative health plans include the use of health planning and CON mechanisms, organizing competing physician-sponsored health plans, and state and local medical societies' efforts to control changes in insurers' benefit packages. *Id.* at 317-18; see also *supra* note 187 (characteristics of HMOs that threaten medical society).

²⁰⁵ Marmor, Boyer & Greenberg, *supra* note 18, at 1021.

²⁰⁶ See Havighurst, *supra* note 4, at 305 (medical profession successfully resists HMO development); Kissam, *supra* note 195, at 488-89 (HMO development may continue to face variety of anticompetitive restraints from FFS physicians and allies); Rosoff, *Phase Two of the Federal HMO Development Program: New Directors After a Shaky Start*, 1 AM. J. L. & MED. 209, 211-12 (1975) (spread of HMOs face barriers including physician and hospital opposition, prohibitive financial organizing costs, consumer ignorance of HMO system, and state laws that prohibit prepaid group practice programs). *But see* Harrison & Kimberly, *Private and Public Initiatives in Health Maintenance Organizations*, 7 J. HEALTH, POL., POL'Y & L. 81, 81-93 (1982). The policy debates over the cost effectiveness of HMOs do not overshadow the fact that HMOs will be forces in the health care sector in the 1980s. *Id.* at 80. Mature HMOs plans that developed as a result of private interest over the medical care aspects of prepaid practice and recent commercial investment interest in HMOs will form the basis for consolidation and growth of HMO plans. *Id.* at 82-84. For the future, the greatest source of enrollment growth will be private investment in large, established plans with the operating efficiencies and managerial experience to be competitive. *Id.* at 92.

²⁰⁷ Marmor, Boyer, & Greenberg, *supra* note 18, at 1021.

²⁰⁸ See *supra* notes 179-206 and accompanying text (deficiencies of consumer cost-sharing and alternative health financing and delivery plans); *infra* notes 207-21 (arguments advocating antitrust enforcement in health industry).

²⁰⁹ See *supra* notes 65-77 (Sherman Act prohibits activities that are monopolistic or conspiracies in restraint of trade); notes 60-62 and accompanying text (providers may dominate health planning process).

²¹⁰ See Marmor, Boyer, & Greenberg, *supra* note 18, at 1025 (antitrust proposals have immediate potential for implementation because no explicit legislative initiative is necessary).

²¹¹ See *supra* note 64 (private parties may bring antitrust action).

²¹² See Marmor, Boyer, & Greenberg, *supra* note 18, at 1007 (antitrust action may serve

Judicial support for antitrust enforcement in the health care market is apparent from the Supreme Court's refusal in *National Gerimedical* to grant a blanket repeal of the antitrust laws regarding voluntary planning activities.²¹³ Congress, while silent on the issue of antitrust in both the Planning Act and the 1979 Amendments, did advocate health care competition without altering the basic planning structure of the Planning Act.²¹⁴ If Congress had intended to immunize health planning from antitrust scrutiny, significant precedent existed in other regulated fields for Congress explicitly to create the immunity.²¹⁵

Whether mandatory planning activities, however, are subject to the antitrust laws remains an open question.²¹⁶ In the 1979 Amendments, Congress recognized a distinction between areas in which competition serves a useful purpose and in which competition would not allocate supply efficiently.²¹⁷ The *National Gerimedical* Court noted that the voluntary nature of the planning activity in the case was decisive in the holding to reject antitrust immunity.²¹⁸ Neither Congress' nor the Supreme Court's observations, however, effectively mandate that regulatory planning activities are exempt from the antitrust laws.²¹⁹ More persuasive from

to eliminate barriers to the development of competing groups of providers); see also Kissam, *supra* note 195, at 489. Application of antitrust laws to the variety of anticompetitive restraints from FFS providers may protect HMO development from unfair resistance. *Id.* Among the anticompetitive restraints that HMOs face are boycotts and refusals to deal with procompetitive physicians and price discrimination by hospitals for hospital services that HMOs must purchase in order to provide comprehensive insurance. *Id.* at 503-20; see *supra* note 187 (reasons why HMOs threaten FFS providers).

²¹³ See *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 393-94 (1981) (*National Gerimedical* Court denies blanket repeal of antitrust law); *supra* text accompanying notes 101-22 (discussion of *National Gerimedical*).

²¹⁴ See *supra* notes 46-48 and accompanying text (discussion of 1979 Amendments).

²¹⁵ See 49 U.S.C. § 1384 (1976) (Congress explicitly exempted parties affected by certain orders under the Federal Aviation Act from liability under antitrust laws).

²¹⁶ See *supra* text accompanying notes 98-129 (*National Gerimedical* and *Huron* decisions leave open issue of immunity for mandatory planning activities).

²¹⁷ See 42 U.S.C. § 300k-2(b)(2) (1976) (planning agencies must allocate supply for health services that do not respond to competitive market forces); *id.* § 300k-2(b)(3) (planning agencies must promote competitive actions for health services that respond to competitive market forces); *supra* note 47 (House Committee advocates distinction in conducting CON reviews).

²¹⁸ *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 390 (1981); see *supra* text accompanying note 113 (antitrust repeals disfavored where governmental entity does not consider antitrust effects of action).

²¹⁹ See *INDUSTRY*, *supra* note 173, at 159-63. The House Committee Report considered the potential conflict between antitrust principles and planning activity in considering the 1979 Amendments. *Id.* at 160; see 1979 HOUSE REPORT, *supra* note 47, at 54-56 (Committee proposed enforcement of antitrust laws in health care areas that respond to classic competitive forces). The 1979 Amendments, however, are silent on the matter of antitrust and thus provide no basis for implying that Congress intended to give planning agencies power to insulate activities from antitrust scrutiny. *INDUSTRY*, *supra* note 173, at 160. The *National Gerimedical* Court's decision attached significance to several factors whose absence or presence in a later, more difficult case might indicate the finding of an implied exemp-

a policy perspective is the argument that courts should apply the antitrust laws to both voluntary and mandatory planning activities to ensure a comprehensive scheme of competition among providers.²²⁰ An important factor to consider in the context of mandatory planning activities is that the regulatory program, as administered, is subject to industry domination and special party interests.²²¹ Abdicating judicial control over antitrust enforcement by authorizing the consideration of antitrust concerns in CON hearings will not promote a competitive market approach, particularly when provider groups have little inclination to promote competition by self-regulation.²²²

Criticism of the judicial role in health planning through enforcement of antitrust laws centers on the difficulty of distinguishing procompetitive from anticompetitive activities.²²³ The conclusion that judicial enforcement of antitrust principles in the health care industry is the preferable solution to health care problems, however, does not preclude judicial flexibility in administering the antitrust laws.²²⁴ Accounting for the advantages gained by allocating the supply of health services, antitrust enforcers have the means to weigh the anticompetitive effects of challenged health planning activities against the need to enforce the competitive market structure.²²⁵ The traditional antitrust exemptions retain substantial validity

tion. *Id.* at 162-63. In *National Gerimedical*, Blue Cross acted unilaterally as a private party, so that state action and other defenses were not available. See *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 391 (1981) (Blue Cross denied participating hospital status to *National Gerimedical* in capacity of private business working in conjunction with HSA). Furthermore, Missouri lacked a law at the time of the case that would establish a CON program or a state health planning agency. *Id.* at 390 n.15. No regulatory structure existed in the case that could support a finding of implied repeal. *Id.* The local HSA was nongovernmental, advisory planning body, with no authority to require Blue Cross to act pursuant to its recommendations. *Id.* at 392. The *National Gerimedical* case, therefore, provided the court the opportunity to make a decision on the blanket immunity issue based on a very narrow set of facts. See *id.* at 393 (*National Gerimedical* holding that Planning Act did not create implied blanket antitrust immunity for planning activities).

²²⁰ See *INDUSTRY*, *supra* note 173, at 175-76 (any attempt to ameliorate effect of antitrust laws in health sector might result in planning agencies' return to noncompetitive habits).

²²¹ See *supra* notes 167-68 and accompanying text (discussion of regulatory control by providers).

²²² See *New Development*, *supra* note 67, at 656 (CON hearings should determine merits of competition in proposed conduct.) But see *supra* text accompanying note 168 (providers may dominate CON hearings).

²²³ See *INDUSTRY*, *supra* note 173, at 175. Legal difficulty in distinguishing whether a challenged activity operates to discourage competition may result in decisions that find unlawful arrangements that actually are efficient. *Id.* The claims of frustrated efficiency are not proven, however, and may be the exaggerations of industry interests and planners who are reluctant to encourage competitive strategies. *Id.*

²²⁴ See *M. THOMPSON*, *supra* note 1, at 35-36 (because antitrust law is not inflexible the peculiarities of health care industry may affect application of traditional antitrust rules).

²²⁵ See *infra* text accompanying notes 225-37 (means to weigh anticompetitive effects of health planning activities).

for exempting some providers from regulatory controls.²²⁶ The state action doctrine will protect planning activities compelled by state law while the Noerr-Pennington exemption will protect parties seeking to influence health planning decisions.²²⁷ The judiciary should invoke antitrust exemptions cautiously, however, to prevent abuses of the exemption privilege.²²⁸ To police the exemption policy, courts should analyze carefully the Supreme Court's limitations on the state action doctrine, as expressed in the *Cantor*²²⁹ and *City of Lafayette*²³⁰ decisions, as well as consider the possibility of a sham action in connection with the Noerr-Pennington doctrine.²³¹

The best method for weighing the anticompetitive effects of planning activities challenged by antitrust action is the rule of reason approach.²³² Under the rule of reason analysis, courts may consider evidence that the restraint in question is not unreasonable under the circumstances.²³³ The application of the rule of reason, as exemplified by the *Medical Arts*²³⁴ and *Rex Hospital*²³⁵ decisions, thus allows a court to consider the defendant's justifications for the anticompetitive practice rather than rejecting the activity on a per se basis.²³⁶ A disinterested judiciary system using the rule of reason, therefore, is able to balance the competing interests of the planning laws and antitrust laws.²³⁷ By properly focusing judicial attention on the justification for the challenged practice, the rule of reason

²²⁶ See *supra* text accompanying notes 78-99 (antitrust exemptions).

²²⁷ See *supra* text accompanying notes 82-99 (state action and Noerr-Pennington exemptions).

²²⁸ See *Health Planning*, *supra* note 1, at 337 (liberal application of antitrust exemptions of health sector protects anticompetitive health planning from liability).

²²⁹ *Cantor & Seldon Drugs Co. v. Detroit Edison Co.*, 428 U.S. 579 (1976); see *supra* notes 87 & 88 and accompanying text (discussion of *Cantor* holding that state action exemption does not exist when party causes state to adopt anticompetitive rule).

²³⁰ *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978); see *supra* notes 90 & 91 and accompanying text (discussion of *City of Lafayette* holding that lesser governmental entities do enjoy automatic antitrust immunity).

²³¹ See *supra* notes 93-99 (discussion of Noerr-Pennington doctrine that protects attempts by private parties to influence governmental units).

²³² See *supra* text accompanying notes 67-71 (discussion of rule of reason approach).

²³³ See *supra* note 71 and accompanying text (courts employing rule of reason analysis may consider economic evidence about industry to determine if anticompetitive effects exist).

²³⁴ *Medical Art Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2d Cir. 1982); see *supra* notes 135-42 and accompanying text (discussing *Medical Arts*).

²³⁵ *Hospital Bldg. Co. v. Trustees of Rex Hospital*, 691 F.2d 678 (4th Cir. 1982); see *supra* notes 143-62 and accompanying text (discussion of *Rex Hospital*).

²³⁶ See *supra* text accompanying notes 135-62 (discussion of *Medical Arts* and *Rex Hospital* decisions).

²³⁷ See *INDUSTRY*, *supra* note 173, at 175-76 (antitrust laws serve as useful check on planning agencies' tendency to encourage cartel behavior and providers' preference for collaboration).

insures that the courts actively will seek to achieve the best interest of the consumer public by considering all the relevant factors pertaining to the planning activity.²³⁸

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²³⁸ See *supra* text accompanying notes 160 & 162 (defendant bears burden of establishing that challenged conduct was reasonable restraint).

