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HEALTH PLANNING AND ANTITRUST LAW: THE IMPLIED AMENDMENT DOCTRINE OF THE *REX HOSPITAL* CASE

CLARK C. HAVIGHURST*

In its 1982 decision in *Hospital Building Co. v. Trustees of Rex Hospital*,¹ the U.S. Court of Appeals for the Fourth Circuit attempted to devise a special antitrust rule for evaluating hospital conspiracies that forestall competition by manipulating local health planning and state regulatory processes. The court's reason for wanting a special, more relaxed rule was its sense that Congress had encouraged competitors to collaborate to curb the excessive growth of the hospital industry. Thus, the court thought application of normal antitrust rules would punish conduct that Congress favored and would promote competition that Congress did not want unleashed. In *Rex Hospital*, the jury had awarded treble damages of \$7.3 million against defendants who had done little, if anything, that was not customary in the hospital industry at the time. Apparently the appeals court believed that it faced a difficult choice between either applying the law literally, thereby achieving an unjust and perverse result, or fashioning an exception to established antitrust principles.

This article argues that it was not necessary for the *Rex Hospital* court to create an unprecedented exception to well-founded antitrust rules in order to reach the result it wanted. The article's main topic, however, is the doctrinal soundness of the method by which the court arrived at a relaxed antitrust standard under which to examine the defendants' conduct. In particular, the discussion focuses on the court's idea that federal statutes encouraging voluntary health planning supply a basis for modifying antitrust law. The finding of an implied amendment to the antitrust laws in other federal legislation represents a potentially important doctrinal innovation, one that, though unprecedented, was arguably foreshadowed in a footnote in the

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1. 691 F.2d 678 (4th Cir. 1982), *petitions for cert. filed*, 51 U.S.L.W. 3738 (U.S. April 6, 1983) (No. 82-1633), *id.* at 3807 (U.S. April 28, 1983) (No. 82-1762).

Supreme Court's 1981 opinion in *National Gerimedical Hospital and Gerontology Center v. Blue Cross*.² Although the courts have always been willing to consider whether Congress, by enacting specific regulatory legislation, may have created an implied exemption from the antitrust laws in some narrow area made subject to regulatory oversight, the *Rex Hospital* decision embarks on a different line of statutory interpretation. The court appears to hold that, even when Congress has done nothing that compels an inference of antitrust immunity in a particular case, a legislative relaxation of antitrust doctrine may nevertheless be inferred from the policy implications of other federal laws. The interesting question raised by this decision is whether, in addition to the long-recognized "implied repeal" (or "implied exemption") doctrine, the courts now also recognize an "implied amendment" doctrine.

In order to address the general appropriateness of inferring amendments to the antitrust laws from other congressional actions, this article will eventually set aside the facts of *Rex Hospital* itself and examine the question in a different but closely related factual and legal context. The specific issue considered is whether naked agreements among hospitals to reduce competition *inter se*, which would normally be *per se* violations of the Sherman Act, can be defended on the ground that they advance goals specified by federally supported health planners. This specific issue—whether health planning goals can be implemented by anticompetitive agreements—is of considerable current importance and arises in a statutory and factual context more contemporary than *Rex Hospital* itself. Most importantly, it provides an excellent laboratory in which to test the implications of the *National Gerimedical* footnote and the *Rex Hospital* holding.

1. THE 1982 *REX HOSPITAL* DECISION: ESSENTIAL FACTS AND HOLDINGS

The issue before the court of appeals involved events occurring from 1971 to 1973. Although the case was originally filed in October 1972, it did not come to trial until the Supreme Court had resolved an important question of jurisdiction, which the lower federal courts had disclaimed but which the Supreme Court confirmed on the basis of the volume of interstate commerce affected by competition among hospitals.³ After plaintiff won its verdict in a six-week trial, the court of appeals reversed the judgment and remanded for another trial. Cross petitions for another writ of certiorari were currently denied by the

² 452 U.S. 378, 193 n.18 (1981).

³ *Hospital Bldg. Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976), *rev'g* 511 F.2d 678 (4th Cir. 1975).

Supreme Court.⁴

In its current posture, the case is factually and legally complex, and this article does not explicate it fully. Instead, it focuses on those facts and those aspects of the holding that relate to what the author refers to as the court's newly fashioned doctrine of "implied amendment." Among the issues in the case that are not discussed is an important question concerning the proper scope of the so-called *Noerr-Pennington* doctrine.⁵ That doctrine removes from antitrust scrutiny concerted efforts by competitors, through exercise of their rights in political, administrative, or judicial forums, to induce government to act in some lawful manner—however harmful to competition and competitors that governmental action might be. Many of the concerted practices that the jury relied upon in finding a violation in *Rex Hospital* were connected to efforts to influence the outcome of state administrative proceedings, and may therefore have been outside the reach of the antitrust laws as authoritatively construed.⁶

A. *The Facts*

Rex Hospital was triggered by events that occurred in connection with plans of the plaintiff, Hospital Building Co. (HBC), to replace its existing 40-bed hospital in Raleigh, North Carolina, by building a new facility. HBC alleged that defendant Rex Hospital (Rex), a nonprofit institution, and assorted co-conspirators—including Wake Memorial Hospital (Wake), the only other general hospital in Raleigh—had hampered its expansion efforts by activities of two kinds. First, defendants allegedly co-opted and manipulated the local health planning and state

4 See *supra* note 1. The Department of Justice filed a brief as *amicus curiae* asking the Court to grant plaintiff's petition and to deny defendants'.

5 See *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). See also Fischel, *Antitrust Liability for Attempts to Influence Government Action: The Basis and Limits of the Noerr-Pennington Doctrine*, 45 U. Chi. L. Rev. 80 (1977).

6 The specific issue raised is the scope of the so-called "sham" exception to the immunity that the *Noerr-Pennington* doctrine provides for competitors participating in administrative and judicial proceedings. See *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972). Compare *Federal Prescription Serv., Inc. v. American Pharmaceutical Ass'n*, 663 F.2d 253, 261-68 (D.C. Cir. 1981), with *Huron Valley Hosp. v. City of Pontiac*, 466 F. Supp. 1301, 1312-15 (E.D. Mich. 1979), *vacated*, 666 F.2d 1029 (6th Cir. 1981). Jury instructions on this issue were found to be too favorable to the plaintiff in that they permitted the sham exception to be invoked simply upon a finding of a larger conspiracy rather than upon a specific showing of abuse of process or denial of meaningful access to administrative or judicial forums. The court's discussion, 691 F.2d at 687-88, still seems to endorse a relatively broad construction of the sham exception, apparently permitting a jury to find that defendants' opposition to plaintiff's application before an administrative agency, their petition for a rehearing, and a single appeal of an adverse decision to the courts were "baseless, repetitive and brought with the intent to abuse the judicial process." *Id.* at 688. The court also narrowed the grounds upon which an attorney for the state could be found to have been brought into the conspiracy, destroying *Noerr-Pennington* immunity.

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regulatory processes to exclude plaintiff unfairly from the market. The second set of allegations called into question the hospital reimbursement policies of the local Blue Cross plan, which were allegedly formulated in concert with Rex and Wake in order to discourage plaintiff's initiative.

Plaintiff charged the co-conspirators with founding, in 1969, and dominating thereafter, the Joint Long Range Hospital Planning Committee of Wake County, a body comprised of leading citizens and engaged in voluntary hospital planning for the community. In early 1971, this committee drew up projections of future hospital needs in Raleigh, providing for the eventual replacement of Rex's 347 beds by a 500-bed new facility and for Wake's growth from 380 to 540 beds. According to this plan, plaintiff's 40-bed facility was projected to grow to 60 beds, but not to the 140-bed size that plaintiff had established as its own goal. In plaintiff's view, this projected allocation of future beds among the three Raleigh hospitals amounted to a plan to use the health planning system to prevent plaintiff from becoming a significant competitive factor in the Raleigh market. Plaintiff also argued that this plan served to illuminate subsequent events and to reveal the co-conspirators' anticompetitive purpose.

Defendants and their alleged co-conspirators were also charged with manipulating the state's certificate-of-need program to prevent or delay plaintiff's project. This regulatory program was enacted in mid-1971 in order to give teeth to voluntary health planning by conferring on a state agency the power to approve or disapprove hospital building proposals on the basis of "need." Need determinations were to be based on, among other things, recommendations by "areawide health planning agencies," which included the Health Planning Council of Central North Carolina, a private body financed in part by federal grants. The defendants allegedly brought the director of this agency into their conspiracy, misrepresented facts to the regulators, filed frivolous and dilatory appeals, and induced a lawyer for the state regulatory agency to assist their efforts behind the scenes. Although these efforts were not successful in getting the project turned down, they did delay it substantially, resulting in the damages awarded. In early 1973, before plaintiff had overcome the defendants' various challenges, the certificate-of-need law was declared unconstitutional,⁷ thereby removing the major legal roadblock to plaintiff's project.

Plaintiffs next alleged that the invalidation of the state regulatory program caused the defendants to shift their attention to using Blue Cross to forestall plaintiff's expansion. One month after the certificate-of-need law was ruled unconstitutional, Blue Cross adopted a policy of

⁷ *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973).

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refusing to reimburse the capital costs, including a return on equity capital, of hospitals constructed without the approval of the voluntary health planners. Plaintiff charged that this policy and Blue Cross's allegedly discriminatory method of reimbursing proprietary institutions were in furtherance of a long-standing conspiracy between Blue Cross and nonprofit hospitals to exclude proprietary firms, such as HBC, from doing hospital business in the state.

B. *The Rulings*

The trial court concluded that the alleged practices, if proved, would constitute per se violations of the Sherman Act and instructed the jury accordingly. On the basis of this ruling, the defendants were denied an opportunity to defend their involvement in the voluntary health planning effort as a constructive effort to prevent the unnecessary duplication of health care resources in the Raleigh area. On appeal from the jury verdict for the plaintiff, the court of appeals found that the trial court's instruction improperly precluded the defense that the defendants engaged in health planning in good faith and not for anticompetitive purposes and were similarly motivated in participating in the regulatory process. The court was less than clear about whether the alleged conspiracy with Blue Cross could likewise be excused if defendants' motives were pure, but appears to have so held.

The court of appeals carefully recognized only a narrow exception to the usual rule that the antitrust laws do not permit defenses based on either the inappropriateness of competition in a particular market context or the worthy purposes for which competition was curtailed.⁸ Despite the narrowness of the usual rule-of-reason inquiry, however, the court reasoned that, because Congress had itself revealed some doubts about the desirability of unbridled competition in the hospital industry and had taken substantial steps to foster voluntary health planning as a partial antidote to the problem of excessive nonprice competition among health care providers, a broader inquiry would be appropriate in cases involving hospitals and health planning. As a consequence, it spelled out an affirmative defense that defendants should be allowed to offer at a new trial:

We think a very narrow 'rule of reason' is required in order to permit defendants to show, if they can, that participation in certain planning activities that would otherwise violate § 1 might not under the circum-

8. This rule received its most forceful explication in *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978), where the Society had argued that competitive bidding for engineering contracts, which it had prohibited by an ethical canon, was likely to lead to inferior and unsafe construction. The Supreme Court stated flatly in reply that "statutory policy precludes inquiry into the question whether competition is good or bad." *Id.* at 695. See *infra* note 24 and text accompanying note 58.

stances have been an unreasonable restraint on trade. The appropriate rule, we find, is simply that planning activities of private health services providers are not 'unreasonable' restraints under § 1 if undertaken in good faith and if their actual and intended effects lay within those envisioned by specific federal legislation in place at the time of the challenged activities as desirable consequences of such planning activities.⁹

In a confusing passage, the court stated that a finding of "good faith participation in planning activities aimed at avoiding the needless duplication of health care resources" could be made only if the fact finder found that "the 'duplication of resources' sought to be avoided by planning . . . is in fact 'needless' duplication."¹⁰ Because the health planners themselves had agreed that Raleigh needed additional hospital beds, it is hard to see why there was any doubt that HBC's project, which was subsequently granted a certificate of need, did not unnecessarily duplicate facilities. The only real question was who would be allowed to provide the needed additional beds—HBC, Rex, or Wake—and in what proportion. If that was the issue, it is also hard to see why Rex and Wake had not, on the facts presented, already violated the court's precept that "'planning' under this special rule of reason is not 'reasonable' if its purpose or effect is only to protect existing health care providers from the competitive threat of potential entrants into or expanders within the same 'market.'"¹¹ It is also hard to understand why the jury, in finding defendants guilty of a conspiracy to monopolize under section 2 of the Sherman Act, had not already found that the defendants lacked the good faith essential to their defense.

Perhaps the court was saying in these passages nothing more than that participation in federally encouraged health planning is not objectionable per se and cannot be the basis for a finding of anticompetitive intent. Under the antitrust rule of reason, a showing of competitors' anticompetitive intent can support an inference of probable harm to competition, that is, a restraint of trade. As the following discussion shows, it is not at all troublesome as antitrust doctrine to require that findings of conspiracy to monopolize and of harm to competition be based upon more than the co-conspirators' involvement in health planning. It is ironic that the court of appeals failed to appreciate that the

⁹ 691 F.2d at 685.

¹⁰ *Id.* at 686.

¹¹ *Id.* Although this language can be read to suggest that the defendants could claim that their motives in seeking to exclude a competitor were pure and that their actions were beneficial to the public, the court stressed repeatedly the narrowness of the defense it was allowing. Permitting the defendants to justify an explicit conspiracy to exclude plaintiff on such grounds as that its hospital was inefficiently small or that its for-profit status compromised quality or the access of indigent patients to health care would not amount to "only a modest practical modification of the *per se* rule applied below." *Id.*

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result it wanted could probably have been reached without inventing a new approach to construing federal antitrust legislation.

C. Was Doctrinal Innovation Necessary?

Both sides approached the argument before the court of appeals on the premise that, unless a repeal or relaxation of the antitrust laws could be inferred on the basis of other legislation, *per se* violations had been successfully made out. The court of appeals did not pause to examine this assumption, stating only that "[t]he violations HBC asserts it proved in this case—[a] horizontal market allocation scheme and a concerted refusal to deal—are generally *per se* violations of the antitrust laws."¹² Careful comparison of legal doctrine with the allegations submitted to the jury raises real doubt, however, that either of the specified types of *per se* violation was present in the case, and therefore suggests that the court may have done unnecessary violence to antitrust analysis in designing its special rule of reason. Indeed, some of the conduct that formed the basis of plaintiff's allegations may not, under the rule of reason, have been a violation at all. Thus, the court may have invented an unprecedented "good faith" defense for conduct that, properly evaluated, needed no defense that is not supplied by accepted doctrine. It would not be productive to argue these points at great length, but an outline of the argument may be instructive in demonstrating that antitrust law can be intelligently applied and does not compel perverse results in specific cases.

"Horizontal market allocation" is indeed a *per se* violation of the antitrust laws. Properly understood, however, that label refers to horizontal division of market—that is, agreements among competitors not to compete across geographic or product lines.¹³ In *Rex*, the health care facilities plan drawn up by the Joint Committee with the participation of Rex and Wake would amount to a market-allocation agreement only if the hospitals had agreed to abide by the plan by providing only the services assigned to them or locating their facilities at prescribed points. More importantly, even if such an agreement eliminating or reducing competition between Rex and Wake were established, it could not have harmed HBC, which was not a party to the agreement and remained free to act independently. Similarly, if Rex and Wake had agreed to limit output, that arguable *per se* violation, far from affecting HBC adversely, would have actually expanded its market opportunities. Obviously, HBC's complaint was not about market allocation as such but about an alleged additional conspiracy by Rex and Wake to

12. *Id.* at 684.

13. See *United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972); *Timken Roller Bearing Co. v. United States*, 341 U.S. 593 (1951).

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curb HBC's growth in some illegitimate way. However, such a conspiracy would have to be proved specifically and requires some showing of anticompetitive intent—which is precisely what the court of appeals has required Rex and Wake to negate (rather than HBC to show) on retrial.

The other asserted *per se* violation, a “concerted refusal to deal,” apparently involved the discriminatory practices of Blue Cross, particularly in refusing to pay HBC's capital costs and a return on its equity investment unless the planners approved its project. As an independent business entity, Blue Cross is free within very broad limits to decide the terms upon which it will deal with others; indeed, the exercise of such business discretion is essential to operating a competitive market.¹⁴ On the other hand, a true concerted refusal to deal, or group boycott, involves the agreement of several competitors to forgo independent selection of customers or suppliers. Although the term “boycott” has frequently been misapplied to a refusal to deal by a single entity controlled by or collaborating with competitors of the ultimate victim,¹⁵ the *per se* label has generally been reserved for boycotts that represent agreed-upon refusals to deal by multiple actors in a horizontal relationship with each other.¹⁶

In *Rex*, Blue Cross did not act in concert with other insurers and was therefore not engaged in a classic boycott subject to the *per se* rule. Plaintiff claimed, however, that Blue Cross (which was not a defendant) conspired with Rex and Wake to discourage HBC's expansion by establishing burdensome terms of dealing. Although such a “vertical” conspiracy is sometimes referred to as a concerted refusal to deal and in any event would violate the law,¹⁷ it could be proved only by showing the anticompetitive motives of the conspirators.¹⁸ Thus, once again, the intent which the court of appeals wants demonstrated in a new trial under its “special rule of reason” appears to be an essential

14 See *infra* note 43 and accompanying text.

15 E.g., L. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 243-44 (1977); *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980).

16 It also appears to be essential that the boycott threaten harm to competition involving some party to the arrangement and not merely harm at some other level of the market. See *generally* *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978); *United States v. General Motors, Inc.*, 384 U.S. 127 (1966); *Radiant Burners v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656 (1961); *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Fashion Originators Guild v. FTC*, 312 U.S. 457 (1941).

17 See, e.g., *Spray-Rite Service Corp. v. Monsanto Co.*, 684 F.2d 1226, 1235 n.4 (7th Cir. 1982), *cert. granted*, 51 U.S.L.W. 3633 (U.S. Feb. 28, 1983) (No. 82-914) (“Monsanto, however, could not lawfully terminate Spray-Rite's distributorship pursuant to an agreement with its distributors because such conduct is a concerted refusal to deal which is *per se* unlawful even if not part of a scheme to fix resale prices”).

18 Although such vertical agreements to eliminate a competitor are unlawful, such a conspiracy is difficult to prove, requiring proof of motive. Thus, the *per se* label is misleading in suggesting that motive is not an element of the offense. See *infra* note 20 and cases cited.

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element of the offense under traditional doctrine. If Blue Cross acted for business reasons of its own¹⁹ and not simply as the cat's paw of Rex and Wake in an attempt to eliminate HBC, it is probable that no violation occurred.²⁰

Perhaps the best way to give effect to the court of appeal's ruling in retrying the *Rex* case would be to instruct the jury that joint participation by the competitors Rex and Wake in voluntary health planning cannot be given an adverse construction in and of itself. Ordinarily, meetings between competitors to discuss their future business plans are highly suspect and can serve as evidence of a naked conspiracy to coordinate future actions if no other purpose appears. Here, however, the extensive encouragement to voluntary health planning given by the federal government and others, including insurers and major financiers of hospital construction, amounted to a strong invitation to parley and would seem to neutralize any adverse inferences that might otherwise be drawn from participation in planning. Indeed, it seems likely that this was all that the court of appeals, in its own peculiar way, was saying.

Competitor collaboration to collect and share information on market developments and to advise governmental and nongovernmental bodies concerning the state of the market is not legally objectionable in itself,²¹ even though the obvious and substantial risks to competition presented by such collective action justify close scrutiny.²² The defendants in *Rex* should certainly be free to claim that their planning had no purpose other than its official one—namely, to advise federal and state funding agencies, private philanthropists, Blue Cross, potential lenders, and other investors of the nature and existence of unmet health care needs and to suggest efficient ways of meeting such needs. An antitrust

19. A comparable issue was presented in the *National Gerimedical* case. See *infra* note 43 and accompanying text.

20. Vertical restraints imposed on a dealer by a manufacturer at the behest of its other dealers present issues analogous to the instant situation. See *supra* note 17. In *Valley Liquors, Inc. v. Renfield Importers*, 678 F.2d 742, 743-44 (7th Cir. 1982), Judge Posner suggested that the business purposes of the seller in refusing to deal were crucial and that a conspiracy would be found only if the seller acted as his distributors' "cat's paw." Other decisions are somewhat quicker to find a vertical agreement. See, e.g., *Battle v. Lubrizol Corp.*, 712 F.2d 1238 (8th Cir. 1983); *Roesch, Inc. v. Star Cooler Corp.*, 712 F.2d 1235 (8th Cir. 1983); *Edward J. Sweeney & Sons, Inc. v. Texaco, Inc.*, 637 F.2d 105 (3d Cir. 1980), *cert. denied*, 451 U.S. 911 (1981). The Supreme Court may clarify the law on such vertical agreements in reviewing *Spray-Rite Service Corp. v. Monsanto Co.*, 684 F.2d 1226 (7th Cir. 1982), *cert. granted*, 51 U.S.L.W. 3633 (U.S. Feb. 28, 1983) (No. 82-914).

21. E.g., *Maple Flooring Mfrs. Ass'n v. United States*, 268 U.S. 563 (1925); *McCann v. New York Stock Exch.*, 107 F.2d 908, 912 (2d Cir. 1939).

22. See, e.g., *United States v. Container Corp.*, 393 U.S. 333 (1969); *American Column & Lumber Co. v. United States*, 257 U.S. 377 (1921); *Eastern States Lumber Dealers' Ass'n v. United States*, 234 U.S. 600 (1914) (data dissemination apparently inducing anticompetitive collaborative behavior).

violation would occur only if the alleged conspirators went further and agreed either to abide by the plan (an agreement that would not harm a competitor such as HBC) or to force plaintiff to abide by it. The court of appeals must have thought that the jury had not been clearly instructed concerning the basis upon which it could find a conspiracy of the latter type.

The *Rex* court caused unnecessary trouble by the way in which it cast its holding. Its opinion is probably best understood as not creating any unprecedented exception to basic antitrust principles at all. Nevertheless, whatever the proper analysis and result on the particular facts of the case, the court's stated holding raised a central issue of statutory construction and antitrust policy. The remainder of this article addresses that issue in a different but closely related statutory and factual context.

II. AGREEMENTS TO IMPLEMENT THE GOALS OF HEALTH PLANNERS

The court of appeals in *Rex* was not called upon to decide whether the two competing hospitals, in addition to participating in health planning, could lawfully agree with each other to abide by the planners' determinations, thereby giving up their competitive independence. Nevertheless, the court's express formulation of its holding, quoted above, suggests that such anticompetitive agreements would be lawful if they were entered into in good faith and for purposes that Congress, judging from its other pronouncements, would probably regard as worthy. Because naked agreements in restraint of trade are normally per se violations, a holding to this effect would amount to a major doctrinal change. Under the court's formulation, antitrust defendants of all kinds would be free to argue that their anticompetitive agreements, normally violative of the Sherman Act, carried out in good faith some other congressional policy. Not only would statutes encouraging private "planning" invite arguments of this variety,²³ but other congressional indications of doubt about the benefits of vigorous competition could be cited to justify special antitrust treatment.²⁴ In short, the door

23 In its Petition for Writ of Certiorari at 22-23 and App. F, *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 691 F.2d 678 (4th Cir. 1982), *petition for cert. filed*, 51 U.S.L.W. 3738 (U.S. April 6, 1983) (No. 82-1633), plaintiff argued that, under the court of appeals decision, 23 cited federal statutes permitting local "planning" could be deemed to immunize antitrust violations.

24 In *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978), the Supreme Court refused to conclude that congressional lack of confidence in competition signaled an intention to relax the antitrust laws. There Congress, through the Brooks Act, 40 U.S.C. §§ 541-544 (1970), had determined not to require competitive bidding for government purchases of engineering services. The Court stated:

The Society relies heavily on the Brooks Act as evidence that its ban on competitive bidding is reasonable. The argument is without merit. The Brooks Act does not even purport to exempt engineering services from the antitrust laws, and the reasonableness of an individual

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would be open for arguments that Congress had amended the normal antitrust rules by legislation implying less than total faith in competition as a mechanism for controlling some area of economic activity.

The legality of anticompetitive agreements to implement goals established through federally sponsored health planning has received specific attention under federal legislation enacted since the *Rex* case arose. An analysis of this issue will serve to demonstrate both the operation of the implied repeal doctrine and the difficulties that would arise if an implied amendment doctrine, such as the *Rex* court seemed to announce, were also recognized. Detailed consideration of the legislation is necessary to reveal the dangers of trying to deduce Congress's policies from evidence other than clear statutory language.

A. Public Law 93-641 and the CVHSA Problem

In 1974, Congress adopted the National Health Planning and Resources Development Act.²⁵ This law clearly placed the federal government behind the movement to regulate hospital growth by requiring the states, under penalty of losing substantial federal funds, to enact certificate-of-need laws similar to the one invalidated in North Carolina.²⁶ The statute also provided for the creation of local "health systems agencies" (HSAs), most of which turned out to be private nonprofit corporations rather than public agencies and all of which were required to include provider representatives as well as consumer representatives on their governing boards. The HSAs were assigned

purchaser's decision not to seek lower prices through competition does not authorize the vendors to conspire to impose that same decision on all other purchasers.

(435 U.S. at 695, n.21)

Though the Court used only the language of implied repeal, it was clearly rejecting a request for implied amendment of the antitrust laws to permit a weighing of worthy purposes in rule-of-reason analysis.

Perhaps the most telling authority against implying amendments of the antitrust laws from congressional sentiments is the leading case of *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). That case condemned a price stabilization scheme that was very much in keeping with Congress's 1930's policy of promoting industry "codes of fair competition," attenuating competition in depressed industries. The Court stated:

The fact that the buying programs may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of respondents' activities either prior to or after [the act's expiration]. For as we have seen price-fixing combinations which lack Congressional sanction are illegal per se; they are not evaluated in terms of their purpose, aim or effects in the elimination of so-called competitive evils.

Id. at 227-28.

Had the Court not resisted the invitation to infer a weakening of antitrust policy from Congress's general faith in the efficacy of benign cartels, the Sherman Act would have become virtually impossible to administer.

25. 42 U.S.C. §§ 300k-300t (1976).

26. After North Carolina's law was found to violate the state's constitution, the state challenged Public Law 93-641 unsuccessfully on federal constitutional grounds. *See North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978).

the tasks of developing local health systems plans and advising "state health planning and resource development agencies" (SHPDAs) on the appropriateness of granting certificates of need in particular cases. This legislation and its legislative history obviously strengthened whatever argument might be made on behalf of health planners and hospitals to the effect that the antitrust laws should not be given their normal effect where planning is in the background.

In late 1978, the Antitrust Division of the Department of Justice received a request by the Central Virginia HSA (CVHSA) for a "business review letter" indicating a favorable opinion from an antitrust standpoint of certain activities, including its efforts to gain providers' voluntary compliance with its recommendations for the closing, conversion, and consolidation of services. Because these efforts involved the HSA in negotiations with competing providers and gave rise to the possibility of providers' mutual withdrawal from competition under tacit or even explicit anticompetitive agreements, a severe antitrust problem was presented. The Antitrust Division naturally addressed this problem under the doctrine of implied repeal, a settled principle of statutory construction holding that exemptions from the antitrust laws are not "lightly" attributed to Congress.²⁷ An implied repeal of the antitrust laws in a particular field will normally not be found unless there is a "clear repugnancy" between a statutory regulatory scheme and antitrust doctrine—that is, where the exemption is necessary to make the regulatory program work in accordance with Congress's declared intention.

Under the implied repeal doctrine, the Antitrust Division would have been justified in refusing to give its blanket approval to the CVHSA's implementation activities. The original Public Law 93-641 provided no statutory basis for inferring an exemption from the usual antitrust rules governing agreements among competitors to limit output or divide markets. The involvement of an HSA as a quasi-public overseer of the process would obviously make the case different from a typical cartel agreement, but under the implied repeal doctrine this difference would amount to a decisive legal distinction only if Congress had adequately revealed an intention to authorize HSAs to approve or broker agreements that would otherwise violate the law. Because Public Law 93-641 included no explicit antitrust exemption, congressional intent had to be ascertained by inference.

Public Law 93-641 and its legislative history contained numerous in-

27. See, e.g., *National Gerimedical Hosp. & Gerontology Center v. Blue Cross*, 452 U.S. 378, 388-89 (1981); *Gordon v. New York Stock Exch.*, 422 U.S. 659, 682 (1975); *United States v. National Ass'n of Securities Dealers*, 422 U.S. 694, 719-20 (1975) (discussed *infra* note 46); *Silver v. New York Stock Exch.*, 373 U.S. 341, 357 (1963); *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 348, 350-51 (1963); *California v. FPC*, 369 U.S. 482, 485 (1961).

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dications that Congress wished the HSAs to do something about industry overcapacity and duplication of resources. For example, the law attached importance to planning efforts leading to "the development of multi-institutional systems for coordination or consolidation of institutional health services."²⁸ Moreover, provisions on "appropriateness" review²⁹ and the development of local and state health plans contemplated establishment of numerical objectives for the system, and several provisions of the original enactment indicated Congress's desire that these goals, once determined, be implemented by local efforts. Thus, the HSAs' basic mandate included a direction to "reduce documented inefficiencies, and implement the health plans of the agency."³⁰ Specific directions with respect to plan implementation included a mandate to "seek, to the extent practicable, to implement its [plans] with the assistance of individuals and public and private entities in its health service area."³¹

While some statutory language thus might be deemed to constitute authority to seek the cooperation of providers in closing facilities or curtailing services, the legislative history of Public Law 93-641 revealed that the conference committee specifically eliminated language that would have directed the HSA, upon finding in an appropriateness review that a service or facility was unneeded, to "work with the provider of the service or with the facility, the state agency, and other appropriate persons for . . . elimination . . . of such service or facility."³² Whether or not this clause would have made a difference, its omission and the lack of language specifically contemplating anticompetitive agreements among competitors meant that the statute was not sufficiently specific concerning the methods by which an unneeded facility could be eliminated to warrant finding an exemption under the implied repeal doctrine. The stumbling block lay ultimately in Congress's failure to give either the HSA or the SHPDA power to bless anticompetitive agreements to comply with health plans and appropriateness findings once they were duly promulgated. Even though concerted activity leading to specific health plans and to explicit recommendations for closure or consolidation were probably protected under available doctrines,³³ an HSA could not, without running antitrust risks, do more than persuade individual hospitals (or other providers) unilaterally to

28. 42 U.S.C. § 300k-2(2) (1976).

29. *Id.* §§ 300k-2(g), 300m-2(a)(6). See *infra* note 51.

30. *Id.* § 300k-2(a).

31. *Id.* § 300k-2(c).

32. H.R. Rep. No. 1640, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7983.

33. The *Noerr-Pennington* doctrine affords such protection. See *infra* note 40 and accompanying text.

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conform to its wishes. The difficulty of avoiding carrying messages between competitors and participating in exchanges of assurances among them³⁴ would have made the HSA's activities in these areas highly dangerous unless and until the antitrust issue was clarified.

B. The Effects of the 1979 Health Planning Amendments

This sharp conflict between substantial federal policies received early attention as the 96th Congress, in 1978, turned its attention to developing legislation that eventually became the National Health Planning and Resources Development Amendments of 1979.³⁵ Nevertheless, those amendments did not expressly address the antitrust issue raised by the CVHSA and made no attempt to satisfy the minimum requirements for judicially inferring a congressional intention to give the agencies the power to immunize anticompetitive transactions from antitrust attack. The House committee report, revealing some awareness of these requirements and their significance, noted that, although the agencies were required to perform certain functions, including appropriateness reviews, "agency acts which are not necessary to carry out such functions or which are outside the scope of title XV are not authorized and therefore not immune from the application of the antitrust laws."³⁶ The report also listed the specific functions of HSAs that the antitrust laws should not be construed to inhibit, conspicuously omitting the brokering of anticompetitive agreements. Because congressional staff members were specifically aware of the opportunity for resolving the CVHSA problem by widening the regulators' power to approve anticompetitive agreements,³⁷ decisive significance can be attached to the failure to grant such authority and even to allude to such agreements as a desirable way of rationalizing the system.

The House committee report also endorsed antitrust as a general policy in the health care industry. Although it also noted that "unfettered competition could further aggravate health system problems" and that "a practical and realistic analysis of the health care industry argues for exceptions to the rule," the discussion made clear that antitrust principles were set aside only to the extent that regulation was specifically substituted.³⁸ In keeping with established doctrine, the committee report did not invite the courts to consider whether competition is a desirable influence in particular circumstances or to decide the extent to

34. *Cf. Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939).

35. Public Health Service Act, 42 U.S.C. §§ 300k-300 (1979).

36. H.R. REP. NO. 190, 96th Cong., 1st Sess. 54-55 (1979).

37. See C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 131-40 (1982). The history of the 1979 amendments illuminates Congress's awareness of the antitrust issue and its intent in addressing it.

38. H.R. REP. NO. 190, 96th Cong., 1st Sess. 54-56 (1979).

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which it should be enforced in any situation where Congress had neither expressly set the antitrust laws aside nor established a regulatory scheme that could not work in the absence of an exemption. Because health planning agencies do not have the statutory power to immunize agreements among competitors, all such agreements for merger, consolidation, sharing, conversion, or elimination of competing services seemed, under traditional doctrine, to remain fully subject to the rules of antitrust following the 1979 amendments.

C. *The Justice Department's 1980 Letter to the CVHSA*

The contention has been made above that the only defensible reading of Public Law 93-641, as amended, is that Congress meant to leave the antitrust laws in place as a check on anticompetitive arrangements and activities not expressly contemplated in federal or state law. In May 1980 the Antitrust Division declared its support for this view in finally responding to the CVHSA's request for a ruling concerning its plan implementation activities.³⁹ The department's letter refused to grant a blanket clearance to HSA-sponsored agreements among competitors, even those agreements effectuating the configuration of services embodied in a state or local health plan. Although the letter did not state the full legal basis for its conclusion, its analysis was essentially that set forth above.

After stating its view of the law, the department indicated that it would exercise its prosecutorial discretion with a view to broader policy considerations. As a result, planning agencies and institutions cooperating with them in plan implementation probably run no serious risk of antitrust prosecution as long as their activities are undertaken in good faith and with recognition of competition's possible benefits. The conclusion of risklessness would not hold, however, if the actions taken should adversely affect private parties who are in a position to bring a private antitrust action; the courts do not have discretion comparable to that of government prosecutors in deciding whether to give effect to the law's requirements. The *Rex* case illustrates the risks.

Technical peculiarities in legal doctrine give rise to the somewhat striking anomaly that, while it may be illegal for hospitals to agree among themselves to abide by an HSA health plan once it is adopted, it is clearly permissible for them to act in concert in helping to develop the plan. This latter result flows from the judicial view (the *Noerr-Pennington* doctrine⁴⁰) that the antitrust laws were not intended to prevent collective petitioning of government such as is involved in developing a

39. Letter from Sanford M. Litvack, Assistant Attorney General, Antitrust Division, U.S. Dept. of Justice, in the matter of Central Virginia Health Systems Agency, May 6, 1980.

40. See *supra* notes 5, 6, and 33 and accompanying text.

health plan that is eventually to be approved or adopted by the state. Because there is an ultimate political check on the plan development process, there is arguably no need for antitrust courts to scrutinize private activity that precedes the promulgation of the plan. However, even though the plan may appear to derive political legitimacy from the participatory process by which it is developed, the health planning legislation fails to give it any explicit legal or other effect except in the certificate-of-need process. The courts, in deciding what effect to give the plan in light of the antitrust laws, must take their cue from Congress, and Congress has not seen fit to give the agencies any power to implement the plan directly. Indeed, Congress has been ambivalent from the beginning concerning the legal effect of health plans and the wisdom of granting plan-implementing powers. Under all the circumstances, the Justice Department's ruling seems correct.

III. THE *National Gerimedical* Case

The leading authority to date on the reconciliation of the federal health planning laws and the antitrust laws is the *National Gerimedical* case. Although the events that occasioned that litigation occurred prior to the 1979 amendments, the Supreme Court had occasion to refer to the later legislation in its opinion. Although the case required only a decision on the application of the implied repeal doctrine, the Court laid the groundwork for the Fourth Circuit's implied amendment doctrine in an ill-considered footnote, which will be discussed separately.

A. The Implied Repeal Issue

In *National Gerimedical*, the Supreme Court reversed the lower courts' inference that Public Law 93-641 created a broad antitrust exemption for the health care industry. The lower courts' rulings⁴¹ reflected agreement with dictum in *Huron Valley Hospital, Inc. v. City of Pontiac*,⁴² an earlier district court decision. Even though neither of these cases presented a good opportunity for the defendants to invoke the implied repeal doctrine, the various courts all decided the easy case before them by stating general principles that have troublesome implications for other cases, including the CVHSA problem.

The defendant in *National Gerimedical* was a Missouri Blue Cross plan that had adopted a reimbursement policy similar to that adopted by the Blue Cross plan in *Rex* following invalidation of the North Carolina certificate-of-need law. Without such a law in effect in Missouri,

41. 479 F. Supp. 1012 (W.D. Mo. 1979), *aff'd*, 682 F.2d 1050 (8th Cir. 1980), *rev'd*, 452 U.S. 378 (1981).

42. 466 F. Supp. 1301, 1312 (E.D. Mich. 1979), *vacated*, 666 F.2d 1029 (6th Cir. 1981).

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Blue Cross had refused, as a cost-containment measure, to enter into a reimbursement contract with a new hospital built without the approval of the local HSA. The hospital sued Blue Cross, claiming that the antitrust laws required it to deal with any hospital that would like to have its services offered on favorable terms as part of the Blue Cross package. Instead of addressing the validity of this claim—which, incidentally, is highly questionable⁴³—the district court held that, by virtue of Public Law 93-641, “the antitrust laws were not intended to apply to members of the health care industry, clearly acting within the scope of the Act.”⁴⁴ This conclusion, like the dictum of the *Huron Valley* district court, was based on the implicit rejection in Public Law 93-641 of competition and market forces as constructive influences in the health care industry. The court of appeals in *National Gerimedical* affirmed this reasoning of the lower court, quoting at length from its opinion.

The Supreme Court unanimously reversed the lower courts on the ground that antitrust scrutiny of Blue Cross’s conduct would not conflict with the operation of any federal or state regulatory scheme. The Court simply applied the implied repeal doctrine, which had been largely ignored by the lower courts, holding once again that the Sherman Act is to be reconciled with the specific mandates of regulatory statutes and not swept aside altogether in the presence of regulation. It thus easily rejected the claim that Congress had created “a ‘pervasive’ repeal of the antitrust laws as applied to every action taken in response to the health-care planning process.”⁴⁵ Unfortunately, in deciding the easy case before it, the Court attached weight to several factors whose absence or presence in a later, harder case might be taken as indicating that an exemption should be inferred. In general, Justice Powell’s opinion indicated a possible willingness, in a future case, to accept emanations from a statute and its legislative history as a basis for inferring an exemption and thus not to require a specific conflict between statutory regimes before setting aside antitrust law.⁴⁶ The discussion below

43. See 452 U.S. at 393 n.19. Except in unusual circumstances, antitrust law does not impose on one party a duty to deal with another party or require justifications for refusals to deal. *E.g.*, *United States v. Colgate & Co.*, 250 U.S. 300 (1919); *Official Airline Guides, Inc. v. FTC*, 630 F.2d 920 (1980), *cert. denied*, 450 U.S. 917 (1981). Indeed, the freedom to select one’s suppliers or customers is the essence of competition. Thus, the plaintiff in *National Gerimedical*, though winning on the immunity point, should not prevail on the merits unless it could establish that Blue Cross, rather than being an independent actor, was in a conspiracy with plaintiff’s hospital competitors or was controlled by them. See *supra* notes 17-20 and accompanying text. If competitors control a dominant financing entity with the power to fix prices and exclude competitors, some distinct antitrust problems are presented. See *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980); *Federal Trade Commission, Physician Agreements to Control Medical Prepayment Plans*, 46 Fed. Reg. 48982 (1981) (enforcement policy statement).

44. 479 F. Supp. at 1021.

45. 452 U.S. at 393.

46. In *United States v. National Ass’n of Securities Dealers*, 422 U.S. 694 (1975), the

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of how the problem raised by the CVHSA ruling request might be handled in light of the *National Gerimedical* decision demonstrates the need to confine that decision to its facts and the issues actually litigated.

The main source of difficulty in *National Gerimedical* is the Court's footnote 18,⁴⁷ which may be read to resolve in the health planners' favor the problem raised by the CVHSA's ruling request. Although such issues were not before the Court and were not fully explored or argued, Justice Powell may have paradoxically broadened the impact of the Court's decision when he attempted to narrow its scope by emphasizing that "our holding does not foreclose future claims of antitrust immunity in other factual contexts." By signaling the Court's possibly favorable view of a situation "where . . . an HSA has expressly advocated a form of cost-saving cooperation among providers," Justice Powell's footnote implied that he, at least, would accept the argument that the antitrust laws do not apply to HSA-inspired joint ventures and that he might even hold exempt a naked market-division agreement of the CVHSA type if ratified by an HSA.⁴⁸ Though footnote 18 is far from being definitive or binding, its implied legal conclusion is questionable; it is doubtful that the Court would make it explicit if it heard fuller argument.

The Court's footnote hinting at approval of CVHSA-type agreements results from Justice Powell's misapplication of the implied repeal doctrine and from his attempt to sense Congress's intentions concern-

Supreme Court held, 5-4, that certain practices restricting the making of a secondary market in mutual fund shares were not subject to the antitrust laws because of certain provisions in the federal securities laws. Justice Powell's opinion for the majority did not identify any specific conflict necessitating the inference of a congressional intent to set aside antitrust rules but appeared instead to infer the exemption solely on the basis of a general and unexercised power of regulatory oversight. Though giving lip service to the "clear repugnancy" requirement, Justice Powell did not apply it rigorously. This case is exceptional in its application of the implied repeal doctrine, however, and need not be read as permanently altering its requirement for "clear repugnancy."

47. 452 U.S. at 393. This footnote reads in its entirety as follows:

Nevertheless, because Congress has remained convinced that competition does not operate effectively in some parts of the health care industry, e.g., 42 U.S.C. § 300k-2(b) (1976 ed., Supp. IV), we emphasize that our holding does not foreclose future claims of antitrust immunity in other factual contexts. Although favoring a reversal in this case, the United States as *amicus curiae* asserts that "there are some activities that must, by implication, be immune from antitrust attack if HSAs and State Agencies are to exercise their authorized powers." Brief for the United States as *Amicus Curiae* 16, n.11. Where, for example, an HSA has expressly advocated a form of cost-saving co-operation among providers, it may be that antitrust immunity is "necessary to make the [NHPDA] work." *Silver v. New York Stock Exchange*, 373 U.S. 341, 357 (1963). See 124 CONG. REC. H11,963 (daily ed. Oct. 10, 1978) (Rep. Rogers) ("The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented.") Such a case would differ substantially from the present one, where the conduct at issue is not cooperation among providers, but an insurer's refusal to deal with a provider that failed to heed the advice of an HSA.

48. See *infra* note 79.

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ing the implementation of planners' goals by interpolating from vaguely revealed sentiments rather than by applying the statute. Like both of the lower courts in *Gerimedical* and the district court in *Huron Valley*, Justice Powell gave particular weight to Congressman Paul Rogers' 1978 assertion on the floor of the House (apropos of no pending legislation) that, if the antitrust laws were applied to curb competitor collaboration supportive of planning, "Public Law 93-641 simply could not be implemented."⁴⁹ The courts' general acceptance of this crucial statement of fact is surprising, to say the least, since it is not supportable in any literal sense. The antitrust laws do not prohibit all collective actions that competitors might take⁵⁰ and do not apply at all to voluntary compliance with duly promulgated health plans by individual providers or to compliance that is coerced by the force of public opinion or by a felt need to curry favor with the regulators. More generally, the antitrust laws could not prevent achievement of the act's main objective, which was to induce state adoption of federally approved certificate-of-need laws governing new investment.

What Congressman Rogers apparently meant by his indefensible statement—and the idea that must have caused Justice Powell to cite that statement as the basis for suggesting a "clear repugnancy" between the planning act and the antitrust laws—was that Congress must have intended to supply some specific means of rationalizing the delivery system and of eliminating unneeded health facilities from the market. These were, after all, results that Congress certainly seemed to desire. Because it was unclear how, other than by voluntary compliance, actual rationalizations or reductions in services could occur without an antitrust exemption, Congressman Rogers wanted, and Justice Powell felt called upon to supply, such an exemption for private entities who might collaborate to further these purposes.

Judicial provision, under this analysis, of the tools necessary for implementation might make sense if Congress were always logical and consistent. But one cannot assume that Congress always intends to supply the means to achieve its stated aspirations. Indeed, the legislative history of Public Law 93-641, particularly the appropriateness review provision, reveals that Congress consciously withheld from the planner-regulators the specific powers needed to implement cutbacks in services.⁵¹ Despite all the rhetoric, the congressional committees had

49. 124 CONG. REC. H11,963 (daily ed. Oct. 10, 1978).

50. Even under the antitrust analysis favored here, planners may still broker efficiency-enhancing agreements among competitors that do not unduly threaten to undercut competition in the wider market. Thus, the planning act's support for multi-institutional arrangements and shared services in no way supports the argument that Congress must have intended an antitrust exemption.

51. See 44 Fed. Reg. 71,754 (1979) (DHEW recounts the legislative history of the appropri-

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real policy doubts about implementing such plans and political doubts about extending the regulators' power. Moreover, as noted earlier, Congress dropped language specifically contemplating informal HSA efforts to implement findings of excess capacity. Given this history, the idea that Congress must have intended an antitrust exemption does not stand scrutiny. Congress might easily have expected that its desire to reduce capacity, though expressed, would go unrealized unless and until it was implemented either in later amendments, for which currently stated aspirations might pave the way, or by the states.

In light of these observations, it is particularly significant that, in writing the 1979 amendments with specific knowledge of the CVHSA issue and of the planners' frustration, Congress was still unwilling to grant to HSAs this new implementation power and wrote legislative history expressly accepting the antitrust consequences. Instead of laying the basis for an implied antitrust exemption, which it was invited to do,⁵² Congress authorized funds for the purpose of buying out excess capacity,⁵³ thereby pursuing the goal of system reduction and rationalization by a totally different means. Thus was Congressman Rogers' minor premise also invalidated. Obviously, the 1979 amendments' explicit reintroduction of competition as a positive value in the industry⁵⁴ must also weigh in favor of leaving antitrust its accustomed role in the absence of a specific conflict.

B. *Foreshadowings of an Implied Amendment Doctrine*

Because there was no real conflict, let alone "clear repugnancy," between Public Law 93-641 and the antitrust laws, Justice Powell's apparent receptiveness in footnote 18 to an antitrust exemption for CVHSA-type agreements appears to rest on a different, seemingly unprecedented ground—specifically, the existence in a statute or its legislative history of a general congressional finding that competition does not work well in the industry in question. Indeed, Justice Powell's footnote was explicitly occasioned "because Congress has remained convinced that competition does not operate effectively in some parts of the health care industry." Whatever alterations of antitrust policies might be recognized on the basis of congressional distrust of competition, they would seldom amount to a total exemption for particular parties or for

attness review provisions in its comments on the final regulations). Appropriateness reviews, which HSAs were required to undertake periodically, involve assessment of the current need for existing facilities. Obviously, a finding that a type of facility or service was in oversupply or that a particular provider was unneeded is pregnant with termination possibilities. But Congress, having considered providing for decertification, left it at that.

52. See C. HAVIGHURST, *supra* note 37, at 137-40.

53. See Pub. L. No. 96-79, § 301 (codified in 42 U.S.C. §§ 300t-11 to -14 (Supp. V 1981)).

54. See C. HAVIGHURST, *supra* note 37, at 142-48.

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a particular class of acts or practices. Thus, where Congress, despite its reservations about competition, has provided only an incomplete regulatory regime to substitute for market forces, the courts, instead of finding an exemption, would probably impute to Congress only an intention to lessen the rigor of the normal antitrust rules. To the extent that a court finds that Congress has relaxed the rules without creating a total immunity, it is more accurate to say that it has inferred an amendment of the antitrust laws than to say that it has found an implied exemption. Though using the language of the implied repeal doctrine, footnote 18 looked toward inferring an implied amendment.

The lower courts in *National Gerimedical* and *Huron Valley Hospital* relied heavily on the finding, appearing in the 1974 Senate committee report on Public Law 93-641, that "the health services industry does not respond to classic marketplace forces."⁵⁵ Unlike those courts, however, the Supreme Court refused to base a blanket exemption on this language and the 1974 law, finding instead that the planning act "is not so incompatible with antitrust concerns as to create a 'pervasive' repeal."⁵⁶ Nevertheless, footnote 18 revealed that the Court was still troubled by Congress's doubts about health care competition, which it documented by citing the 1979 statutory finding that "the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished . . . [by] the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient . . . and other institutional health services"⁵⁷ The Court apparently read this language as calling for some relaxation of antitrust doctrine even in the absence of a specific conflict between that doctrine and the regulatory scheme. This intimation of a willingness to infer an implied amendment based on other statutes appears to have led the *Rex* court into attempting to find in the pre-1974 legislation a basis for framing a milder antitrust rule to cover the defendants' participation in health planning.

IV. AN ASSESSMENT OF THE IMPLIED AMENDMENT DOCTRINE IN THE HEALTH PLANNING CONTEXT

In *National Society of Professional Engineers v. United States*⁵⁸ the Supreme Court reaffirmed the long-standing antitrust principle that the possible social benefits of an anticompetitive practice cannot be invoked to justify harm to competition. That decision indicated that,

55. S. REP. NO. 1285, 93d Cong., 2d Sess. 39, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7878.

56. 452 U.S. at 393.

57. 42 U.S.C. § 300k-2(b)(1) (Supp. V 1981).

58. 435 U.S. 679 (1978).

under the rule of reason, competitors may collaborate on a scale dangerous to competition only if the result of their collaboration is procompetitive—either in making the market more effectively competitive overall or in integrating resources to create a new product or service, or to achieve production efficiency, that could not be produced or achieved by collaboration on a lesser scale. Most recently, in *Arizona v. Maricopa County Medical Society*, a 4-3 majority ruled that a powerful physician organization could not defend its members' practice of agreeing on maximum fees payable by insurance carriers on the ground that, even though the practice removed a vast number of price determinations from the competitive arena, it benefitted consumers.⁵⁹ In both of these cases, the Court stressed that Congress should be looked to for whatever exceptions should be made on policy grounds to the general principle that competition should not be impaired by private agreements.⁶⁰

The implied amendment doctrine implicit in the *National Gerimedical* footnote and explicit in the *Rex* holding is true, on its face at least, to the principle that Congress, not the courts, makes the nation's antitrust policy. It raises, however, serious questions about how congressional policy is determined. On one level, the issue is one of statutory construction and the proper allocation of tasks and responsibilities between courts and legislature. On another level, there are questions specific to the making of a sound national health policy. An evaluation of the putative implied amendment doctrine under these headings leads to the conclusion that the implied repeal doctrine, which demands that Congress be clear and specific in setting aside the antitrust laws, is the superior technique for ascertaining congressional intent.

59 457 U.S. 332 (1982). The decision can be criticized for not making the power of the sponsoring organization an explicit element of the per se offense. Without power as a factor, arguably efficient arrangements would be absolutely foreclosed even though the percentage of competitors involved was not unnecessarily large or was not so large as to alter the probability of net procompetitive effects. The Court also relied unnecessarily and with apparent approval on three troublesome cases that should have been either ignored or cited in terms casting doubt on their continuing validity: *United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972) (joint venture of modest size held guilty of the per se offense of market division despite a strong claim of efficiency), *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) (vertical imposition of maximum resale price equated with fixing of minimum price despite benefit to consumers), *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951) (similar). See Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 1982 SUP. CT. REV. 319. Despite these deficiencies in the opinion, the *Maricopa* result is defensible on the ground that the defendant joint ventures embraced substantial proportions of the physicians in the market, were sponsored by the organized medical profession, threatened to preclude or inhibit competitive innovation, and offered no obvious efficiencies not obtainable by organizing on a lesser scale. Cf. Havighurst & Hackbarth, *Enforcing the Rules of Free Enterprise in an Imperfect Market: The Case of Individual Practice Associations*, in *A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE* 375 (M. Olson ed. 1981).

60 435 U.S. at 689-90, 457 U.S. at 354-55.

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A. *Deducing Antitrust Policies through Emanations*

The history of federal health planning legislation demonstrates the impossibility of determining at any given moment Congress's precise policy toward competition in particular sectors of the economy. The pre-1974 statutory situation, which concerned the court in *Rex*, defied any assessment of Congress's specific antitrust policy toward hospitals. At that time, the antitrust laws had never been enforced to an appreciable degree in the hospital industry; and Congress might reasonably have believed, until the Supreme Court's 1976 decision in *Rex*, that hospitals were largely outside its antitrust jurisdiction. In that event, of course, Congress would have had no occasion to have any antitrust policy at all with respect to hospitals⁶¹ and might have turned to health planning only as a second-best alternative. Under such circumstances, any judicial divination of a specific congressional intention to immunize Sherman Act violations would seem disingenuous. Without real guidance from Congress, the court can be accused of making statutory law, not finding it.

The adoption of Public Law 93-641 in 1974 provided more evidence of congressional support for health planning, but Congress still took no position directly conflicting with antitrust law. Nevertheless, Justice Powell appeared ready, in footnote 18, to relax the usual requirement of "clear repugnancy" and to supply such relief from antitrust strictures as health planners would need in order to achieve Congress's stated aspirations. In thus deducing congressional intentions, however, he failed to appreciate the possibility, so strikingly illustrated in the foregoing discussion of this legislation, of inconsistencies between Congress's declared ends and legislated means. Precisely because Congress frequently obfuscates when it can settle on no corporate intent, it must be concluded that considerable wisdom underlies the customary rule under which a congressional intention to create an antitrust exemption is not "lightly" inferred. Without an up-or-down vote on antitrust immunity or on a mandate directly incompatible with antitrust doctrine, judicial imputation of a purpose to alter antitrust rules runs a serious risk of misreading congressional purposes, perhaps to suit the predilections of the judges.

The reliance placed by several courts on the 1974 Senate committee's finding that "the health services industry does not respond to classic

61. It is clear that a congressional belief that a particular area is beyond its jurisdiction does not warrant a finding that it did not intend the antitrust laws to apply to that area. *United States v. South Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). But see *Flood v. Kuhn*, 407 U.S. 258 (1972) (explicit judicial holding, plus congressional inaction, justify adherence to rule of stare decisis).

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marketplace forces"⁶² provides another illustration of the difficulty of divining Congress's intentions concerning important policy issues when it has not spoken definitively. In its report on the 1979 amendments, the same committee restated the quoted proposition almost *in haec verba* but with a crucial amendment: "In the view of the committee the health care industry *has not responded* to classic marketplace forces."⁶³ Underscoring its new perception, the committee immediately repeated and amplified that thought:

Despite the fact that the health care industry has not *to date* responded to classic marketplace forces, the committee believes that the planning process—at the Federal, State, and local level—should encourage competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance and cost effectiveness.⁶⁴

By amending its earlier overgeneralization and affirming its faith in competition in at least some circumstances, the Senate committee upset any antitrust policy conclusions that might have been drawn on the basis of the report and legislation adopted just five years earlier. This episode reveals perfectly why it is dangerous for courts to impute to Congress an intention to set aside the antitrust laws when such an intention has been neither declared nor revealed by specific action. Similarly, the House committee report on the 1979 legislation showed that Congress was, after all, quite comfortable with the idea that the antitrust laws would be given their normal effect except where its action had created a specific conflict requiring an exemption.⁶⁵

For yet another powerful illustration of the dangers of trying to read major policy significance into Congress's reservations concerning the functioning of a particular market, it is only necessary to turn to the language from the 1979 amendments⁶⁶ that was cited by the Supreme Court in its *National Gerimedical* footnote to illustrate Congress's belief "that competition does not operate effectively in some parts of the health care industry." That language, which was part of a lengthy instruction to health system planners and regulators concerning the weight that they should give to competition in carrying out their assigned duties, expressed doubt—perhaps even more than doubt⁶⁷—about the value of competition in the provision of "inpatient . . . and other institutional health services."⁶⁸ As a guide to antitrust policy,

62 See *supra* note 55 and accompanying text.

63 S. REP. NO. 96, 96th Cong., 1st Sess. 52 (1979) (emphasis added).

64 *Id.* at 53 (emphasis added).

65 See *supra* notes 36-38 and accompanying text.

66 42 U.S.C. § 300k-2(b) (quoted in text *supra* note 57).

67 See 45 Fed. Reg. 69,771 (1980) (DHHS states that "Congress has stated that market forces do not or will not appropriately allocate supply for inpatient services").

68 *National Gerimedical*, 452 U.S. at 388 n.13.

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however, that statutory finding is dangerously unreliable and imprecise.⁶⁹ For one thing, some services falling easily within the statutory definition of "institutional health services" are entirely amenable to competition.⁷⁰ More importantly, the possibility existed even then that changes in "the prevailing methods of paying for health services" would in due course improve the feasibility of competition in the provision of inpatient care; indeed, the legislative history specifically anticipated such changes.⁷¹ Given the rapidly changing character of the marketplace, one may ask how Justice Powell or anyone else could know at any given point whether Congress still "remained convinced that competition does not operate effectively"⁷²

It might be suggested, in view of this latter problem, that the courts themselves should appraise the benefits of competition in a given market for a given health care service at a given moment.⁷³ Nevertheless, because such an inquiry would be so complex that only a regulatory agency could reasonably be expected to undertake it, it seems unlikely that Congress intended antitrust courts to make such judgments.⁷⁴ Moreover, the courts have heretofore resisted the adoption of legal rules that would place on the government in enforcing the Sherman Act the burden of ascertaining from day to day whether powerful combinations of competitors have abused their powers or whether previously reasonable practices have "become unreasonable through the mere variation of economic conditions."⁷⁵ Not only would evolution in private financing methods raise continual questions concerning the appropriateness of the prevailing antitrust rule, but changes in federal reimbursement policies would have to be appraised for evidence of changes in Congress's policy toward competition. For example, one can ask whether Justice Powell would consider that the 1979 finding upon which he relied is weakened or rendered obsolete by recent Medi-

69. See C. HAVIGHURST, *supra* note 37, at 267-71 (arguing that the presumption against the workability of competition is rebuttable, not conclusive).

70. *Id.* at 270.

71. H.R. REP. NO. 190, *supra* note 36, at 53-54.

72. *National Gerimedical*, 452 U.S. at 393 n.18.

73. Although it is hard to tell, this may be the view advanced in Comment, *Antitrust Implications of Health Planning: National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 8 AM. J.L. & MED. 321 (1982). On the other hand, the student commentator turned for analytical help only to scholarship aimed at clarifying mainstream antitrust doctrine. *E.g.*, Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1523 (1982). Thus, she may not have been advocating a special, relaxed antitrust standard after all.

74. In the 1960's, Congress and the Supreme Court went back and forth over the question whether "banking factors" other than competition should be given weight in the evaluation of bank mergers. Although Congress finally expressly required the courts to consider more than effects on competition in such cases, the courts have never been comfortable with the balancing task assigned to them. See generally P. AREEDA, *ANTITRUST ANALYSIS* 949-52 (3d ed. 1981).

75. *United States v. Trenton Pottery Co.*, 273 U.S. 392, 397-98 (1927).

care amendments⁷⁶ substituting prospectively determined rates of payment to hospitals for retrospective cost reimbursement, which was "the prevailing method of paying for health services" in 1979.

Although the Court in *National Gerimedical* spoke only of implied exemptions, its rejection of blanket immunity suggested the need for new substantive antitrust rules that would distinguish permissible from impermissible anticompetitive action in response to health planners' initiatives. The most obvious problem that the Court would face in applying this novel doctrine of implied amendment would be in knowing how and where to relax the law. For example, would an HSA's approval of an anticompetitive agreement between hospitals be sufficient to exempt it even in the absence of judicial or state agency review of that approval? (The Court implied elsewhere in its opinion that the HSA in Missouri, as a private rather than a governmental body, could not have conferred immunity on Blue Cross even if it had instructed Blue Cross to act as it did.⁷⁷) Would a possibly unreviewable⁷⁸ finding in a state health plan of competition's inappropriateness with respect to all hospital care confer immunity on a hospital monopolist or a hospital merger?

Another question illustrating the confusion into which an implied amendment theory would lead is whether an HSA could insulate all or only certain types of anticompetitive agreements among hospitals. In suggesting that exemptions might cover some but not all otherwise questionable conduct, footnote 18 stated that "cooperation among providers" (query whether this includes a naked CVHSA-type market-division agreement⁷⁹) differs substantially from the refusal to deal by Blue Cross at issue in *National Gerimedical*. Antitrust law provides no doctrinal basis, however, for tolerating one of these forms of conduct and not the other. Indeed, contrary to the Court's implication, competitor agreements are usually regarded with greater suspicion than unilateral refusals to deal, which are probably not unlawful at all.⁸⁰

In view of the impossibility of knowing what specific implications to draw from congressionally expressed doubt about competition's current value in a particular setting, the courts should adhere to their traditional insistence that Congress alone must declare those implications.

76. Social Security Amendments of 1983, Pub. L. No. 98-21, 1983 U.S. CODE CONG. & AD. NEWS (97 Stat.) 149.

77. 452 U.S. at 390.

78. The importance of reviewability by a government agency or a court is suggested by *Silver v. New York Stock Exch.*, 373 U.S. 341, 357-61 (1963). On reviewability of HSA determinations and health plans, see C. HAVIGHURST, *supra* note 37, at 274-77.

79. Although Justice Powell might have been willing to exempt even such a naked restraint, see *supra* note 46, the term he used, "cost-saving cooperation," might not apply to such market division. See *supra* text and accompanying note 48.

80. See *supra* note 43.

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If the courts instead undertake to make their own judgments about when an exemption or relaxation of substantive rules is or is not appropriate, they will have "set sail on a sea of doubt"⁸¹ which ninety years of antitrust jurisprudence should have taught them to avoid.⁸² The wisdom of the "clear repugnancy" test, rigorously applied, is revealed by the difficulty and subjective artificiality of trying first to guess what was in the back of Congress's collective mind and then to fashion a different, milder antitrust regime to fit a situation where competition has been declared a mixed blessing. Thus, an implied amendment doctrine has no place in antitrust law.

B. *Health Planning and Health Policy*

The wisdom of softening the requirements of antitrust law for health care providers subject to congressionally sponsored health planning may be considered separately from the legal issue of whether the law does in fact soften such requirements. Obviously, courts are not immune to letting their policy judgments guide their thinking on such legal questions. Although the court of appeals in *Rex* was probably more influenced by the seeming harshness of the treble-damage penalty should a violation be found, Justice Powell, who is not known as an antitrust enthusiast, seemed to respond to policy considerations in writing footnote 18. Some thoughts on the policy issue may therefore be worth recording in order that other courts will not accept too quickly the common argument that applying antitrust law rigorously to health planning activities has necessarily perverse effects on the public interest.

Local health planning has always had some of the earmarks of a cartel. Planning agencies developed originally at the local level to serve a variety of functions, including both the establishment of priorities for using philanthropic and governmental (Hill-Burton) funds and the allocation of service and geographic markets among hospitals anxious to minimize competition.⁸³ Eventually, with the growth of health insurance and public financing, the agencies were no longer greatly concerned about curbing competition for limited funds and for price-sensitive customers. Increasingly, the public expected the agencies to limit the system's exploitation of open-ended financing sources and to curb emerging nonprice competition, which was driving the system to incur unjustified costs. Reducing competition, originally undertaken

81. *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 284 (6th Cir. 1898). This opinion by Judge (later Chief Justice) William Howard Taft is the classic expression in antitrust law of the need to focus on competition alone and not to balance it against other supposed values.

82. *See National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978).

83. *See Havighurst, Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA L. REV. 1143, 1148-50 (1973).

voluntarily by providers for their own benefit, thus became a goal of public policy.

As regulatory powers were increasingly conferred on the health planning agencies, nonprovider interests, some of them antagonistic to providers, were given a voice in the planning process. Introducing consumer interests in this way can be viewed as an attempt to democratize the cartel. Nevertheless, Congress did not see fit to extend full regulatory (plan implementation) powers to the local agencies, even with their new participatory processes and the political accountability supplied by state agency oversight. Thus, in its reluctance to embrace finally and completely the idea that a provider cartel could be made democratic and accountable enough to define and serve the public interest, Congress revealed the same distrust of private power in which the antitrust tradition is rooted. Moreover, the emerging national distrust of economic regulation, which has so often served private rather than public interests, was also evident in Congress's hesitancy to embrace centralized decisionmaking. Courts should be careful to respect Congress's feelings on these matters.

In addition to being consistent with broad policy traditions and trends, maintaining an antitrust check on the health planners serves the salutary purpose of calling attention to the broad implications of relying too heavily on cartel-like private cooperation to allocate health resources. Thus, the Justice Department's legal position put Congress squarely in the position in 1979 of having to face head-on the hard policy questions on which it had been less than explicit in the past: Did it really want to invest the planning agencies, with their cartel-like features, with plenary powers? What additional safeguards in the nature of regulatory oversight and procedural openness and due process should be introduced before granting these agencies the power to confer antitrust immunity on private arrangements? Is there an alternative to relying on regulation and on "benign" cartels to allocate resources in this industry? Should competition have an active role? Should competition be placed wholly at the mercy of the planners and regulators and allowed to function only with their concurrence? As demonstrated above, Congress was not prepared to go along with the planners' view on these matters. Better health policy is likely to result if the courts force Congress to face issues squarely by requiring that it speak clearly.

Even though a policy of relying on competition in health care sometimes produces perverse short-term effects, the state of affairs that gives rise to this problem is not inevitable and can change, making more services amenable to effective discipline by market forces in the consumer interest. Antitrust enforcement based solely on the perception that the financing system is currently dysfunctional may serve strongly

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to confirm and reinforce the system's dysfunctional features. For example, acceptance of even a modified cartel form of organization may discourage third-party payers from attempting to get providers to compete among themselves. Even if third parties should undertake such efforts, the market's cartel characteristics might reduce the prospects for their success. Thus, if health planners are permitted to foster cartel behavior, the emergence of effective competition could easily be frustrated.⁸⁴ Judicial softening of antitrust rules could therefore directly and significantly interfere with the realization of attainable goals of antitrust policy.

Perhaps the best reason for not relaxing the antitrust laws to make way for health planning is the need for a sharp break with the health care industry's tradition of relying on cooperation rather than competition to solve any problem identified by providers or by an aroused public. The antitrust laws are now being invoked to break down the traditional power of organized providers, and the procompetition provisions in the 1979 amendments represented another challenge to the health planning tradition of centralized decisionmaking and cooperation. These and other developments have begun to cause a widespread reexamination of established practices and assumptions, but there are still many signs that the message has not gotten through. Thus, it is desirable for the courts to direct the planners' efforts away from fostering noncompetitive behavior. Given the deep-seated tradition of suppressing competition in the name of planning, the agencies require a very clear directive to place their emphasis elsewhere. The *Rex* decision, even though it relates to ancient history, sends a particularly disappointing signal in this regard.

V. CONCLUSION

The court of appeals decision in *Rex* can be read as unimportant insofar as it concerns application of the Sherman Act to the involvement of private parties in voluntary health planning. The result appears generally consistent with antitrust doctrine in requiring the jury to base any finding of the hospitals' anticompetitive intent on evidence other than their participation in the development of local health plans. Even if the court's holding is taken at face value as a relaxation of normal antitrust rules in order to accommodate Congress's support for voluntary health planning, today's legislation is so different that the rule of the case is unlikely to have any effect on the legality of current activities of a comparable nature.

84. For discussion of another situation involving a temptation to relax antitrust requirements in pursuit of short-run cost savings, see Havighurst & Hackbarth, *supra* note 59.

On another level, however, the *Rex* decision has significant implications for the substance of antitrust law in industries that have been explicitly or implicitly identified by Congress, perhaps in legislation providing for limited public or private regulation or voluntary "planning," as being inadequately or inappropriately disciplined by market forces. The thesis of this article has been that both the *Rex* decision and the Supreme Court's footnote dictum in *National Gerimedical*, which foreshadowed the *Rex* court's theory of statutory construction, were mistaken in suggesting that modifications of antitrust doctrine should or can sensibly be devised to accommodate congressional misgivings about the value of competition in particular circumstances. As an illustration of the confusion and error into which the Fourth Circuit's implied amendment doctrine can lead, the experience of courts and others in trying to reconcile federal health planning legislation with the antitrust laws is unsurpassed. From the misreadings of congressional purpose and the bad health policy that resulted from attributing to Congress policies toward the health care industry that it had not definitively declared, one can learn the dangers of departing from the traditional implied repeal doctrine, with its insistence that the antitrust laws be enforced in accordance with precedent unless Congress has unambiguously revealed a contrary intent.

From this review of the courts' attempts to divine congressional policy from between the lines of statutes and legislative history also come some useful lessons about how policymaking responsibility should be allocated between Congress and courts sitting in antitrust cases. Because special interests are constantly probing for soft spots in Congress's basic policy of enforcing competition, there are good reasons for the courts to hold Congress to a high standard of clarity and to refuse to supply antitrust dispensations that have not been expressly granted. If Congress wants to confer an exemption or to change an antitrust rule, it is always free to do so. The implied repeal doctrine puts Congress on notice that it must face issues, not evade them in the hope that the courts will do its legislative job.