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Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System

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BEYOND HEALTH CARE REFORM:
RECONSIDERING CERTIFICATE OF NEED LAWS
IN A "MANAGED COMPETITION" SYSTEM

Patrick McGinley

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BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A “MANAGED COMPETITION” SYSTEM

PATRICK JOHN MCGINLEY*

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I. INTRODUCTION

America is spending nearly a trillion dollars annually on health care.¹ Although neither state nor national legislators can agree on the details, the focus of health care reform has been the "managed competition" model. Managed competition intends to control health care costs by encouraging price competition among health care providers.² In a typical managed competition plan, such as that recently enacted in the state of Florida, a state agency negotiates on behalf of many purchasers in order to demand lower prices from providers.³ Managed competition, therefore, attempts to lower costs by managing demand.

Supply, and not demand, was the emphasis of early health care regulation.⁴ "Certificate of need" (CON) laws were designed to keep health care costs low by requiring advance approval by state agencies for most hospital expansions and major equipment purchases.⁵ Congress required all states to pass CON laws in 1974, but quickly repealed that requirement after finding it ineffective for controlling health care costs.⁶

Today, thirty-eight states retain CON laws.⁷ Many of these same states have passed managed competition laws.⁸ This Comment will

1. Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 47 (1994) [hereinafter Havighurst, *Contract Failure in Health Care*].

2. Commentators identify a definite trend toward the adoption of the managed competition health care strategy:

Managed competition is the theory underlying not only President Clinton's health care reform proposal, but also the leading alternative plans proposed by conservative Democrats and moderate Republicans. Additionally, managed competition is being pursued in many states and by many private employers, and has been advanced as the fundamental basis for health care reform by private interest groups as diverse as hospitals, doctors, labor unions, and businesses. Therefore, it is no longer necessary to speculate whether managed competition in some form will be adopted.

Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 2 (1994); see also Dennis A. Yao et al., *Antitrust and Managed Competition for Health Care*, 39 ANTITRUST BULL. 301, 301 (1994).

3. See FLA. STAT. § 408.70(2) (1993). Florida's Agency for Health Care Administration acknowledges that Florida's version of managed competition differs significantly from Professor Enthoven's original model of managed competition. See *infra* part IV.B.

4. See Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1148-51 (1973) [hereinafter Havighurst, *Regulation by CON*].

5. See *infra* part II.B.1 and statutes cited *infra* note 14.

6. See *infra* part II.B.2 and statute cited *infra* note 45.

7. Certificate of need laws are in place in Alabama, Alaska, California, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Vermont, Virginia, the Virgin Islands, Washington, and West Virginia. See *infra* note 14.

8. See Hall, *supra* note 2, at 2. See also Janice Somerville, *States Pave Way on Managed Competition*, AM. MED. NEWS, March 15, 1993, at 1.

explore the role of CON laws in a state with a managed competition system.⁹ Part II traces the origin and intent of CON, noting that CON has historically failed to achieve its intended policy goals.¹⁰ Part III summarizes the origin and implementation of a managed competition health care strategy, illustrating that strong evidence demonstrates that managed competition can lower health care costs.¹¹ Part IV shows that managed competition invalidates the presumptions underlying the alleged need for CON.¹² Part V focuses on Florida, where the conflict between CON and managed competition is becoming reality, and urges Florida and similarly situated states either to scale back CON or accept the failure of managed competition that CON will inevitably cause.¹³

II. ORIGIN AND INTENT OF CERTIFICATE OF NEED REGULATIONS

Certificate of need is the common name for a diverse group of state health care laws attempting to control health care costs by regulating supply.¹⁴ These laws require that a permit, usually called a certificate of need, be issued by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost.¹⁵ A CON will not be issued unless

9. Hospital licensing, budgeting, physician and antitrust issues are beyond the scope of this Comment.

10. See *infra* pp. 144-61.

11. See *infra* pp. 161-67.

12. See *infra* pp. 167-75.

13. See *infra* pp. 175-88.

14. E.g., CODE OF ALABAMA §§ 22-21-260 to 278 (1994); ALASKA STAT. §§ 18.07.021-.111 (1995); CAL. HEALTH & SAFETY CODE §§ 437.10, 439.7 (1995); CAL. GOV'T CODE §§ 15438.1 (1994); CONN. GEN. STAT. §§ 19a-154 to 155 (1994) (licensing and budget review law); 16 DEL. CODE ANN. §§ 9301-11 (1994); D.C. CODE ANN. §§ 32-326 (1981); FLA. STAT. ch. 408 (1993 and Supp. 1994); GA. CODE ANN. §§ 31-6-1 to 70 (1994); HAW. REV. STAT. §§ 323D-1 to 54 (1989); IND. CODE ANN. §§ 16-29-1-1 to 16 (Burns 1994) (expiring July 1, 1996 pursuant to IND. CODE ANN. §§ 16-29-1-16); IOWA CODE §§ 135.621-.73 (1994); KAN. STAT. ANN. §§ 65-4802 to 4822 (1992); KY. REV. STAT. ANN. §§ 216B.010-.310 (Baldwin 1994); ME. REV. STAT. ANN. tit. 22, §§ 301-24 (1994); MD. CODE ANN., HEALTH-GEN., §§ 19-101 to 222 (1994); MICH. COMP. LAWS §§ 333.22201-60 (1995); MISS. CODE §§ 41-7-171 to 209 (1995); MO. REV. STAT. §§ 197.30-65 (1995); MONT. CODE ANN. §§ 50-5-301 to 316 (1994); NEB. REV. STAT. §§ 71-5801 to 70 (1994); N.H. REV. STAT. ANN. §§ 151-C:1 to 15 (1994); N.J. REV. STAT. §§ 26:2H-1 to 2I-39 (1994); N.C. GEN. STAT. §§ 131E-175 to 190 (1994); N.D. CENT. CODE §§ 23-17.2-01 to 15 (1993); OHIO REV. CODE ANN. §§ 3702.51-.60 (Anderson 1995); OKLA. STAT. tit. 63, §§ 1-850 to 858 (1995); OR. REV. STAT. §§ 442.58-.86 (1992); 35 PA. CONS. STAT. §§ 448.701-.712 (1995) (expiring 1996); S.C. CODE ANN. §§ 44-7-320 to 460 (Law. Co-op. 1976); TENN. CODE ANN. §§ 68-11-101 to 125 (1994); VT. STAT. ANN. tit. 18, §§ 9431-44 (1994); VA. CODE ANN. §§ 32.1-102.1 to 102.11 (Michie 1994); V.I. CODE ANN. tit. 19, §§ 223 (1994); WASH. REV. CODE §§ 70.38.015-.920 (1995); W. VA. CODE §§ 16-2D-1 to 15 (1995).

15. 41 C.J.S. *Hospitals* § 4 (1991).

a new facility or service is genuinely needed in a given community.¹⁶ Although determining need can be problematic,¹⁷ CON laws provide statutory and rule criteria to guide the issuing agency's discretion.¹⁸

A. State Origins

CON laws originated from local community efforts to allocate philanthropic and federal funding so that new hospitals would be built where they were most needed.¹⁹ Throughout the Great Depression and World War II, few new hospitals were built in the United States, yet many existing hospitals became obsolete.²⁰ The ensuing crisis was exacerbated by an inadequate distribution of hospitals among and within the states.²¹ In response, community fund-raising and charitable activities of the 1940's evolved into organized community plans for hospital development.²² Community planning became particularly important in 1946 with the passage of the federal Hill-Burton Act.²³ Hill-Burton provided federal subsidies for hospital construction, and promoted local planning in order to identify local needs.²⁴ The local planners in some communities worked under nongovernmental auspices, while planners in other communities worked as part of governmental health planning agencies.²⁵ For those communities without

16. *Community Hosp. of New Port Richey/Univ. Psychiatric Ctr. v. Department of HRS*, 520 So. 2d 604 (Fla. 1st DCA 1989).

17. See, e.g., Ronald A. Case, Annotation, *Validity and Construction of Statute Requiring Establishment of "Need" as Precondition to Operation of Hospital or Other Facilities for the Care of Sick People*, 61 A.L.R. 3d 278 (1994) (summarizing the various ways states have defined and interpreted the requirement of "need"). "[T]he very notion of need has been rendered systematically opaque and ambiguous . . . [T]he meaning of need has increasingly been drained of substantive meaning." Daniel Callahan, *Transforming Mortality: Technology and Resource Allocation*, 65 S. CAL. L. REV. 205 (1991). But see Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 881 n.30 (1984) ("[H]istorically, demonstrating 'need' has often been an easy task, and less than one-quarter of all proposed projects fail to win planning agency approval."). The Supreme Court has held that "need" is not an unconstitutionally vague standard in regulatory statutes. See, e.g., *Federal Radio Comm'n v. Nelson Bros. Bond & Mortgage Co.*, 289 U.S. 266 (1933).

18. E.g., FLA. STAT. ch. 408 (1993); FLA. ADMIN. CODE ANN. tit. 59C-1.001-.050 (1995).

19. See Havighurst, *Regulation by CON*, *supra* note 4, at 1148.

20. S. REP. NO. 1285, 93d Congress, 2d Sess. 39 (1974), reprinted in 1974 U.S.C.C.A.N. 7842, 7859 [hereinafter S. REP. NO. 1285].

21. *Id.*

22. See Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Progress*, 69 IOWA L. REV. 1451, 1453 (1984).

23. Hospital Survey & Constr. (Hill-Burton) Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified in sections of 24, 42 U.S.C.).

24. Havighurst, *Regulation by CON*, *supra* note 4, at 1150.

25. See *id.* at 1149.

government-enforced health planning agencies, local plans were voluntary.²⁶

Over time, voluntary planning waned, while compulsory, government-enforced planning flourished.²⁷ This was not necessarily the result of the Hill-Burton Act, because eighty-seven percent of the total funds required for voluntary hospital construction from 1946 to 1967 came from private fund-raising sources.²⁸ One explanation for why voluntary planning declined is the benefit that the hospitals received from mandatory regulation.²⁹ Mandatory regulation through health planning agencies helped identify the most urgent health needs, helped meet these needs through cooperative and consensual development, and helped curb the excessive cost increases and price decreases often caused by a competitive marketplace.³⁰

Hospitals regulated by a health planning agency can collectively determine the size of a community's hospital bed supply, and thereby engage in output restriction.³¹ Regulated hospitals can also collectively allocate areas of responsibility both geographically and by activity, and thereby engage in market division.³²

These two activities—output restriction and market division—are classic characteristics of a cartel.³³ In fact, many of the output restriction and market division activities of early health planning agencies were indistinguishable from the activities of a cartel.³⁴ Critics frequently observe that "regulatory agencies tend to adopt strategies disturbingly similar to those which an industry-wide cartel . . . would pursue if it could."³⁵ In any cartel, centralized planning and sanctions

26. *See id.*

27. *See id.* at 1150.

28. *Id.* at 1150 & n.24 (citing Kotelchuch, *How To Build a Hospital*, HEALTH-PAC BULL., May 1972, at 1).

29. *See id.* at 1149-50.

30. *Id.* at 1149.

31. *See id.* at 1149 & n.21 (citing, *inter alia*, D. Brown, *The Process of Areawide Health Planning: Model for the Future?*, 11 MED. CARE 1, 3 (1973)).

32. *See id.*

33. *Id.* at 1149.

34. [H]ealth planning agencies have also served to . . . curb competitive excesses. Indeed, many of the activities undertaken in the name of planning were indistinguishable from such typical cartel practices as output restriction (collective determination of the bed supply) and market division (allocation of areas of responsibility both geographically and by activity). The cartel characterization . . . in some industry settings [is] quite useful in preventing unnecessary duplication of facilities and other wasteful side effects of competition.

Id. For a simple and practical introduction to the use and benefits of a cartel, see AVINASH DIXIT & BARRY NALEBUFF, *THINKING STRATEGICALLY: THE COMPETITIVE EDGE IN BUSINESS, POLITICS, AND EVERYDAY LIFE* 225-27 (1991).

35. Havighurst, *Regulation by CON*, *supra* note 4, at 1183 (citing Jordan, *Producer Protection, Prior Market Structure and the Effects of Government Regulation*, 15 J.L. & ECON. 151 (1972)).

against uncooperative members are essential if the participants are to avoid the effects of a competitive market.³⁶ The early mandatory health planning agencies provided the necessary planning and sanctions, and did so with the aid and permission of local governments.³⁷

Hospitals have successfully organized to support and proliferate state CON laws. In 1964, New York became the first state to pass a statute of statewide effect³⁸ that required a governmental determination of need before any hospital or nursing home was constructed.³⁹ Just four years later, the American Hospital Association indicated its membership's acceptance of CON laws.⁴⁰ The American Hospital Association then began nationwide lobbying efforts to pass CON laws at the state level,⁴¹ and even drafted a model state law.⁴² By 1975, twenty states enacted CON laws.⁴³ By 1978, thirty-six states had enacted such laws.⁴⁴

B. Congressional Origins

After 1978, almost all states enacted CON laws, primarily because the National Health Planning and Resources Development Act of

36. *Id.* at 1150.

37. Self-enforcing cartels are difficult to arrange. Cartels are far more effective if an outsider enforces the collective agreement limiting competition. Laws often serve as the outside enforcer. DIXIT & NALEBUFF, *supra* note 34, at 227 (describing how banning cigarette advertising from television helped cigarette company cartels "avoid mutually damaging and costly advertising campaigns and thus improved their profits").

38. Metcalf-McCloskey Act of 1964 (codified in N.Y. PUB. HEALTH LAW § 730 (McKinney 1971)).

39. Havighurst, *Regulation by CON*, *supra* note 4, at 1151.

40. *Id.*

41. *See id.* (citing AMERICAN HOSPITAL ASSOCIATION, GUIDELINES FOR IMPLEMENTATION OF CERTIFICATION OF NEED FOR HEALTH CARE FACILITIES AND SERVICES (1972)). "[T]he American Hospital Association [was] a key supporter in the movement for state certificate-of-need legislation." Randall Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 88. "Before the American Hospital Association indicated its acceptance of the certificate-of-need approach in 1968, only New York had a certificate-of-need law; legislation by other states followed that acceptance." *Id.* at 88 n.22 (emphasis added).

42. Havighurst, *Regulation by CON*, *supra* note 4, at 1151 (citing American Hospital Association, Suggested Model Legislation for Implementation of State Certification of Need, Nov. 15, 1972 (mimeo., draft)).

43. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. 475, 478 (1991).

44. James F. Blumstein and Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 3 n.1 (citing DIVISION OF REGULATORY ACTIVITIES, BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT, DEP'T OF HEALTH, EDUCATION AND WELFARE, STATUS OF CERTIFICATE OF NEED AND SECTION 1122 PROGRAMS IN THE STATES (1978)).

1974⁴⁵ provided substantial federal funding for state and local health planning activities.⁴⁶ Under the 1974 National Health Act,⁴⁷ certain federal health care funds were conditioned on the state's enactment of CON laws.⁴⁸ By 1986, forty-two states plus the District of Columbia had responded to Congressional pressure by enacting a CON program.⁴⁹ After 1986, however, Congress turned full circle, repealing the 1974 National Health Act and its requirement for state CON laws.⁵⁰ The reason for Congress' abandonment of CON is simple: the laws are counterproductive for reforming health care.

1. *Why Congress Promoted Certificate of Need: The Legislative History*

CON laws were expected to add "teeth" to the 1974 National Health Act.⁵¹ Under the Act, Congress intended CON to achieve three health care goals. First and foremost, CON was to restrain skyrocketing health care costs.⁵² Second, CON was to prevent the unnecessary duplication of health resources.⁵³ Third and most ambitiously, CON was to achieve equal access to quality health care at a reasonable cost.⁵⁴ The legislative history of the National Health Act clearly enunciates these goals, yet does not clearly illuminate the social and economic situation which made these goals appear acceptable and necessary. The following addresses each of these legislative goals separately, supplementing each with information gathered from legal sources published at the time the Act was passed, or published after

45. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. § 300k-300n-6 (1982)), amended by Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1-129, 93 Stat. 592 (codified at 42 U.S.C. §§ 300k-300t (1976 & Supp. V 1981), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986).

46. Scott D. Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U. L. REV. 149, 150 (1991).

47. In using the term "1972 National Health Act," this Comment refers to the National Health Planning and Resources Development Act of 1974 and also to the interpretive federal regulations authorized by section 300n-1(c) of that Act. *E.g.*, 42 Fed. Reg. 4,002 (1977) (index); *id.* at 4,017-18 (explanatory comments); *id.* at 4,027 (formerly codified in 42 C.F.R. §§ 122.308-309 (1977)); *id.* at 4,031 (formerly codified in 42 C.F.R. § 123.409 (1977)).

48. Kaplan, *supra* note 43, at 478. For a discussion of the requirements under the Act, see generally Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. 39.

49. Kaplan, *supra* note 43, at 478.

50. See generally James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025 (1986).

51. Havighurst, *Regulation by CON*, *supra* note 4, at 1153.

52. S. REP. NO. 96, 96th Congress, 1st Sess. 42, reprinted in 1979 U.S.C.C.A.N. 1306, 1347.

53. *Id.* at 1310.

54. *Id.*; 42 U.S.C. § 300k(a)(1) (Supp. V 1975).

the Act with the intent of analyzing the Act's purpose. Through such an analysis, Congress's "three" reasons for CON are revealed to be just a single purpose: to reduce the aggregate cost of the nation's health care.

a. Restraining Skyrocketing Health Care Costs

The primary Congressional purpose in requiring CON laws was to save money.⁵⁵ Statistics compiled prior to the passage of the 1974 Act reveal the severity of the 1970s' health care crisis. For example, when Congress considered the National Health Act, medical care prices were rising at an annual rate of 16.6 percent,⁵⁶ hospital charges were rising at an annual rate of 18.7 percent,⁵⁷ yet the consumer price index was rising at a considerably lower annual rate of 13.7 percent.⁵⁸ The average cost of a single day in the hospital rose from nearly \$16.00 in 1950, to almost \$45.00 in 1965, and then to about \$128.00 in 1974.⁵⁹ These figures show an alarming rate of increase in health care costs. At the time of the 1974 Act, as now, health care costs were out of control.⁶⁰

b. Preventing the Unnecessary Duplication of Health Resources

The drafters of the 1974 National Health Act viewed the underutilization of health care resources as a primary cause of skyrocketing health care costs.⁶¹ The 1974 National Health Act was "premised on the theory that the current structure and incentives of the health care industry lead to overinvestment and that unneeded . . . health care resources contribute significantly to rampant inflation in health care costs."⁶²

55. See Bovbjerg, *supra* note 41, at 84.

56. S. REP. NO. 1285, *supra* note 20, at 55.

57. See Bovbjerg, *supra* note 41, at 84.

58. *Id.*

59. *Id.*

60. *Contra* Havighurst, *Contract Failure in Health Care*, *supra* note 1, at 47 (arguing that health care costs never were, and are not now, excessive). Critics of certificate of need do not contend that health care costs are not a nationwide crisis. *But see* Bovbjerg, *supra* note 41, at 84 (contending that the continually rising cost of health care is not a crisis, but an economic situation no less troubling than the continually rising cost of cellular phones). CON's critics differ from their proponents in their beliefs about the cause of the health care crisis. *E.g.*, *id.* (blaming the cost of health care on a failure of contract law); A. J. G. Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 LAW & CONTEMP. PROBS. 839 (1970) (advocating regulation such as that of natural monopolies). Congress believed that the cause of the health care crisis was largely because the health care marketplace lacked adequate incentives for cost containment. S. REP. NO. 1285, *supra* note 20.

61. Bovbjerg, *supra* note 41, at 83.

62. *Id.*

The Senate committee drafting the 1974 National Health Act found that the need for additional hospital beds⁶³ in the nation had virtually disappeared.⁶⁴ As of 1974, 20,000 beds nationwide were underutilized to the point of being labeled "surplus," and the number of surplus beds was expected to exceed 67,000 by 1975.⁶⁵ Accordingly, the Act sought to remedy the "maldistribution of health care facilities and manpower."⁶⁶

Congress adhered to the theory that the cost of excess supply was ultimately borne by third party purchasers, and then passed on to health care consumers in the form of higher premiums and cost for services.⁶⁷ According to Congress's theory, third party fee-for-service insurance agreements encourage providers to overindulge in capital investments.⁶⁸ Companies operating in a traditionally competitive market do not overindulge in capital investments because service and facility expansion benefits a company only if demand exceeds supply, or if efficiencies can be realized through economies of scale.⁶⁹ In Congress's theory, however, health care facilities do not respond to these typical pressures of a competitive market. Proponents of CON cite four reasons why health care facilities have the propensity to overinvest in capital investments: the externalization of purchase costs, the nonprice competition among providers, the physicians' effect on supply, and the "Roemer Effect" on demand.⁷⁰

i. The Externalization of Purchase Costs

In the health care climate that created the 1974 Act, third party fee-for-service insurance agreements, such as those traditionally provided by Blue Cross/Blue Shield and the federal Medicare and Medicaid health insurance programs, were the dominant means of health care

63. In order to discuss available patient services most accurately, without regard to the type and size of the health care facility, health care planners identify services by referring to the number of beds available for patient usage.

64. S. REP. NO. 1285, *supra* note 20.

65. *Id.*

66. 42 U.S.C. § 300k(a)(3)(B) (Supp. V 1975).

67. See Blumstein & Sloan, *supra* note 44, at 4-5 ("[T]hird-party payment . . . provides few incentives for either the hospital or the physician to achieve greater efficiency, and inexorably leads to higher overall consumer costs.").

68. Bovbjerg, *supra* note 41, at 85; Campbell-Eaton, *supra* note 22, at 1458.

69. See CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY—PLANNING FOR COMPETITION 54 (1982) [hereinafter HAVIGHURST, DEREGULATING FOR COMPETITION].

70. No source actually cites to all four of these reasons. The author compiled this list himself, gathering information from a variety of sources. See generally Blumstein & Sloan *supra* note 44; Bovbjerg, *supra* note 41; Campbell-Eaton, *supra* note 22; Havighurst, *Contract Failure in Health Care*, *supra* note 1; HAVIGHURST, DEREGULATION FOR COMPETITION, *supra* note 69; Kaplan, *supra* note 43; Simpson, *supra* note 50; Makar, *supra* note 46; Budetti, *supra* note 48.

financing.⁷¹ Third party fee-for-service insurance agreements, or “fee-for-service,” reimburse health care providers retrospectively for the costs of services rendered to insured patients.⁷² In other words, fee-for-service agreements do not negotiate medical fees in advance, but instead negotiate payment after services are rendered and prices are set. Fee-for-service reimbursement rates typically include “overhead,” such as the operating costs and capital expenditures of health care providers.⁷³ Congress believed that the overhead payments, although initially made by the third party insurer, are ultimately borne by the public through higher taxes due to Medicare/Medicaid⁷⁴ or through higher premiums charged by commercial insurers.⁷⁵ Health care facilities are therefore allegedly insufficiently deterred from unnecessary construction,⁷⁶ because costs are passed to the consumer in the form of higher fees. As a result, fee-for-service allegedly allows health care entities to overinvest in new facilities and equipment with diminished regard for public need or efficiency.⁷⁷

Therefore, fee-for-service allegedly reduces the financial risks of excess capacity and overinvestment because health care providers directly recoup their investment costs.⁷⁸ However, this contention overlooks the monitoring effects of section 1122 review. The 1974 National Health Act’s CON program was modeled after the earlier, and coexisting, section 1122 capital expenditure review provisions⁷⁹ of the Social Security Amendments of 1972.⁸⁰ Even after Congress mandated the passage of state CON laws, Medicare and Medicaid section 1122 reviews were allowing states to review capital expenditures and to deny reimbursement for expenditures which did not fit the state’s

71. Blumstein & Sloan, *supra* note 44, at 4-5.

72. Havighurst, *Regulation by CON*, *supra* note 4, at 1157.

73. *Id.*

74. *Id.*

75. Because neither providers nor patients directly face medical costs under the system, only the insurers have the incentive to control costs. Even this incentive is reduced, however, due to the insurer’s ability to disperse costs widely among the insured population, thereby reflecting cost increases only by increased insurance premiums.

Campbell-Eaton, *supra* note 22, at 1458. *See also*, Havighurst, *Regulation by CON*, *supra* note 4, at 1157, 1159-60.

76. Havighurst, *Regulation by CON*, *supra* note 4, at 1158; Campbell-Eaton, *supra* note 22, at 1458-59.

77. Campbell-Eaton, *supra* note 22, at 1458.

78. Havighurst, *Regulation by CON*, *supra* note 4, at 1157-58; Campbell-Eaton, *supra* note 22, at 1458; *see* HAVIGHURST, *DEREGULATING FOR COMPETITION*, *supra* note 69, at 54.

79. Havighurst, *Regulation by CON*, *supra* note 4, at 1153-55.

80. Pub. L. No. 92-603, 86 Stat. 1329 (1972) (codified as amended at 42 U.S.C. § 1320a-1 (1976 & Supp. V 1981)).

health plan.⁸¹ Section 1122 programs allow states, on a voluntary basis, to participate in reviewing capital expenditures made by health care facilities receiving federal funds under the Medicare and Medicaid subchapters⁸² of the Social Security Act.⁸³ State planning agencies perform the section 1122 reviews, and may deny federal reimbursement for amounts attributable to depreciation, interest on borrowed funds, and return on equity capital if the agency finds that a health care facility's capital expenditure does not further state health planning needs.⁸⁴ Section 1122 review programs therefore sought the same result as CON laws by empowering state agencies to curb health care facility growth and expenditures by requiring conformance with a state health care plan. Stated somewhat differently, section 1122 and CON both seek the same goals using the same methods.

With 20/20 hindsight, it appears Congress was unwise in believing that CON would succeed in adequately controlling health care costs when the section 1122 review programs did not succeed. According to the legislative history, Congress was aware that CON laws achieved a purpose nearly identical to section 1122 review, and achieved this purpose by nearly identical means.⁸⁵ Recognizing this, a House of Representatives committee recommended amending the Senate bill so that CON laws would be required only in states which did not voluntarily engage in section 1122 review programs.⁸⁶ However, in a Conference Committee, a substitute bill was drafted omitting the House Committee's recommended amendment.⁸⁷ Thus, even in states already controlling capital expenditures under section 1122 review programs, CON laws were required⁸⁸ under the 1974 National Health Act.⁸⁹

81. H.R. CONF. REP. NO. 1640, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 7971, 7985. The Senate bill creating the 1974 National Health Act "specifies that a certificate-of-need program is required if the State Agency serves as the designated planning agency under section 1122." *Id.*

82. Chapters XVIII and XIX, 42 U.S.C. § 1320a-1 (Supp. V 1981).

83. Campbell-Eaton, *supra* note 22, at 1455 n.35.

84. *Id.*

85. H.R. CONF. REP. NO. 1640, *supra* note 81, at 7985.

86. *Id.*

87. *Id.* at 7986.

88. Although termed "requirements," the CON provisions by themselves . . . create *powerful incentives* . . . by conditioning the receipt of large amounts of federal funds on . . . enter[ing] into a "designation agreement" . . . [A] state [certificate of need] program is a mandatory requirement for entering into a designation agreement . . . The designation agreement entails federal authorization of a state health planning and development agency (SHPDA). The SHPDA then may receive funds for the administration of the state CON program.

Campbell-Eaton, *supra* note 22, at 1455-56 (emphasis added, footnotes omitted). In practical effect, certificate of need programs were mandated, but the mere possibility that a state would

ii. *The Non-Price Competition Among Facilities*

Congress also believed that health care facilities were not only un-daunted from making unnecessary construction and capital expenditures, but were actually *encouraged* to construct and expend by the pressures of non-price competition.⁹⁰ Hospitals cannot compete for patients or doctors based on price, so they compete for doctors and patients based on quality.⁹¹ To most, competition based on quality would seem to be an acceptable behavior.⁹² To proponents of CON, however, competition based on quality is socially undesirable.

Health care consumers, providers, and hospitals agree that quality means having the biggest, most elaborate, most modern facilities and equipment. "While health care regulators seek to rationalize the health care system, health care consumers want to feel that when family members fall ill, they will have convenient access to the best and most technologically advanced medical care."⁹³ Patients want to be treated by hospitals using the latest and best technology and procedures, even if they do not "need" these facilities in the eyes of industry regulators.⁹⁴

Hospitals have four reasons for wanting the best facilities and equipment: a concern for patients, a desire to attract new patients, a desire to attract the best physicians, and a desire "not to be regarded as a second-class institution."⁹⁵ The concern for patients is both altruistic and advantageous.⁹⁶ The desire to attract new patients is a necessity for the profitable operation of any health care facility.⁹⁷ The

sacrifice all federal health care development funding was enough to avoid labeling certificate of need laws as compulsory. 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) (holding that the National Health Planning Resource and Development Act was not unconstitutional because the Act's requirements were optional and not compulsory).

89. See 42 U.S.C. § 300m-2(a)(4)(B) (Supp. V 1975), *repealed by* Pub. L. No. 99-660, § 70(a), 100 Stat 3799 (1986) (prompting states to establish and operate their own certificate of need laws). States were given four years to create a program that complied with the Act. *Id.* § 300m(d).

90. See, e.g., Campbell-Eaton, *supra* note 22, at 1459; Roberta M. Roos, Comment, *Certificate of Need for Health Care Facilities: A Time for Re-examination*, 7 *PACE L. REV.* 491, 529 (1987); Kaplan, *supra* note 43, at 483.

91. Campbell-Eaton, *supra* note 22, at 1459.

92. See generally ADAM SMITH, 1 *THE WEALTH OF NATIONS* (Edwin Cannan ed., Univ. of Chicago Press 1976) (1776) (describing the benefits of the "invisible hand" of the marketplace).

93. Roos, *supra* note 90, at 529.

94. Kaplan, *supra* note 43, at 483.

95. *Id.*

96. See *infra* note 100 (discussing the concerns over medical malpractice claims).

97. Even charitable and non-profit health care institutions feel the necessity to attract new

desire to attract physicians stems from a concern for patient welfare and a concern for the hospital's bottom line.⁹⁸ The desire "not to be regarded as a second-class institution" is a product of human vice, which some characterize as "institutional ego."⁹⁹ The four factors combine to motivate hospitals to invest, invest, invest. Physicians further fuel the hospitals' quest to invest by demanding the most modern facilities and equipment.¹⁰⁰

iii. *The Physician's Effect on Supply*

A health care facility's financial risks from excess capacity and overinvestment are allegedly reduced because the primary decisions concerning health care services are made by the physician and not the ultimate health care consumer.¹⁰¹ Doctors influence the amount of "services" supplied to a hospital. For example, good evidence exists that the number of surgeries performed is largely determined by the number of physicians available—the more surgeons trained, the more surgery patients supplied.¹⁰² This phenomenon is not limited to surgeons, but extends to all medical professionals who potentially supply patients to a hospital. For example, "if his schedule is light, it is easy for Dr. Smith to tell Ms. Jones to come back every two weeks rather than once a month."¹⁰³ The health care system removes the "purchase" decisions from the "invisible hand" of the marketplace,

patients. "[A]s historian Rosemary Stevens has shown convincingly, even the nation's so-called not-for-profit hospitals have typically run their enterprises very much like businesses." Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J.L. & MED. 21, 27 (citing Rosemary Stevens, IN SICKNESS AND IN WEALTH: A HISTORY OF THE AMERICAN HOSPITAL IN THE TWENTIETH CENTURY 359-61 (1989)).

98. In the words of one commentator, "because physicians carry primary responsibility for making treatment decisions, health care providers find themselves competing directly for doctors." Campbell-Eaton, *supra* note 22, at 1459.

99. Kaplan, *supra* note 43, at 483.

100. In recent years, technology and facilities have meant more than quality to a physician. They protect physicians from medical malpractice claims. *Id.* ("Many physicians now refuse to perform certain services without such advanced technology for fear that the new technology will be deemed the legally required standard of care in a subsequent malpractice action."); see generally E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987) (discussing the proliferation of expensive technology and procedures); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985 (1986) (discussing the difficulty in containing costs of technology).

101. Havighurst, *DEREGULATING FOR COMPETITION*, *supra* note 69, at 55; Campbell-Eaton, *supra* note 22, at 1458-59.

102. Havighurst, *Regulation by CON*, *supra* note 4, at 1158 n.56; John P. Bunker, *Surgical Manpower: A Comparison of Operations and Surgeons in the United States and in England and Wales*, 282 NEW ENG. J. MED. 135 (1970).

103. Havighurst, *Regulation by CON*, *supra* note 4, at 1158 n.56 (citing Feldstein, *The Rising Price of Physicians' Services*, 52 REV. OF ECON. & STAT. 121 (1970)).

and puts those decisions into the hands of the physician.¹⁰⁴ Physicians have an economic incentive to “sell” their “product,” and therefore have a vested interest in generating supply.¹⁰⁵

iv. The “Roemer Effect” on Demand

Just as physicians can allegedly generate supply, hospitals allegedly generate demand.¹⁰⁶ Statistics show that when more hospital beds are available, more hospital beds will be filled.¹⁰⁷ Likewise, when more physicians are available, more health care services will be used.¹⁰⁸ In short, the effect of excess supply of health services is the “manufacture” of demand.¹⁰⁹ This effect—the “Roemer Effect”—is named after the individual who first noted the relationship.¹¹⁰

Hospitals widely accept the statistic that an empty bed costs the hospital about two-thirds as much as an occupied one.¹¹¹ Applying this realization, hospitals can assume that a bed should be used if the value of hospitalization to the patient is at least one-third the total cost to the hospital.¹¹² Economics and social pressures give hospitals the motive and opportunity to generate demand for services.

In sum, Congress adopted the second goal of CON—preventing unnecessary duplication of health care costs—to combat four

104. Proponents of certificate of need probably believe that decisions should not be in the hands of physicians, but in the hands of regulators. However well-meaning, regulators simply cannot efficiently manage a complex marketplace. See George J. Stigler & Claire Friedland, *What Can Regulators Regulate? The Case of Electricity*, 5 J.L. & ECON. 1, 11 (1962). Certificate of need regulators focus on incremental change based on consensual processes and bargaining rather than long-range planning. Havighurst, *Regulation by CON*, *supra* note 4, at 1215. No matter how large a bureaucracy may grow, the bureaucracy “cannot effectively control the daily detail of business operations.” Stigler & Friedland, *supra*, at 12. A regulatory agency is incapable of forcing a complex marketplace to operate at a specific combination of output, price, and control, yet this is exactly the goal of certificate of need agencies. Certificate of need agencies cannot be in possession of all the relevant and necessary information possessed by the managers of every health care facility. Cf. R. H. Coase, *The Federal Communications Commission*, 2 J.L. & ECON. 1, 18 (1959) (providing an analysis of the 1950s’ communications marketplace that seems equally applicable to the 1990s’ health care marketplace).

105. See generally Havighurst, *Regulation by CON*, *supra* note 4, at 1158 n.56.

106. See *id.* at 1158-59.

107. “By letting it be known that higher occupancy is desired, the hospital can usually cause a loosening of institutional utilization review and can encourage doctors both to opt for hospitalization in close cases and to prolong their patients’ stays. Patients have little to say about such decisions . . .” *Id.* at 1158 (footnote omitted).

108. *Id.* at 1158.

109. But see *id.* at 1159 (noting that “[s]ome have argued that the new supply may be merely a response to pre-existing but unmet demand, so that new utilization is not really ‘manufactured.’”).

110. *Id.* at 1159 n.57.

111. *Id.* at 1158 n.55 (citing MEDICAL WORLD NEWS, June 16, 1972, at 14).

112. *Id.*

undesirable factors: the externalization of purchase costs, the non-price competition between facilities, the physician's effect on supply, and the "Roemer Effect" on demand. A closer analysis reveals that each factor is undesirable because each leads to an increase in the nation's health care costs. Therefore, Congress' second goal of CON is only an extension of Congress's first goal—restraining skyrocketing health care costs.

c. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Congress's third goal—achieving equal access to quality health care at a reasonable cost—does not have a direct connection to restraining costs.¹¹³ Cost concerns were the paramount reason for the 1974 National Health Act's CON requirements, but the Act also intended CON to help achieve equal access to health care.¹¹⁴

However, CON was to be only one element in the equation creating equal access to health care; the most significant element was the anticipated passage of a national health insurance program.¹¹⁵ Medicare, Medicaid, and the expected national insurance program would ensure universal access, and the role of CON laws was to control rising costs before Congress passed a national health insurance plan.¹¹⁶ Of course, Congress never passed a national health insurance plan.¹¹⁷ As a result, Congress's third goal was not addressed with any practical application, but was instead little more than lip service to a noble ambition. Therefore, Congress's "three goals" were in fact just one: a goal of reducing the nation's aggregate health care costs.

113. Note, however, that by the Congress's own language, restraining health care costs is the top priority. The goal is not to achieve equal access to health care at any cost, but to achieve equal access at a *reasonable cost*.

114. See S. REP. NO. 93-1285, *supra* note 20, at 39 (expressing a concern over access to health care).

115. See *id.*

116. See *id.*

117. The national health insurance plan fell to political pressures:

[I]n May 1978, [a Democratic senator] proposed a system of "health security . . ." [involving] a comprehensive and uniform benefits package with each person having one health insurance card and receiving the same level of care. The government would have paid for the poor, disabled, elderly, and unemployed through a revised Medicare program. Medicaid also would have been eliminated as unnecessary. The Carter Administration rejected the [plan] because of fear that such an extensive health reform package would have been detrimental to the Carter economic recovery plan.

James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 15-16 (1994).

2. *Why Congress Abandoned Certificate of Need: The Legislative Reality*

Four years after the enactment of CON, Congress repealed its mandate.¹¹⁸ Two interrelated concerns spurred the decision—the law failed to reduce the nation's aggregate health care costs, and it was beginning to produce detrimental effects in local communities.

Shortly after CON was mandated to the states, the nation's aggregate health care costs reached an historic high. America's 1982 medical bill reached \$332 billion, or 10.5 percent of the gross national product.¹¹⁹ "This marked the first time the cost of medical services exceeded ten percent of the nation[']s total production."¹²⁰ "In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."¹²¹ In fact, national hospital care expenditures increased from \$52.4 billion when Congress enacted the 1974 National Health Act to an estimated \$230.1 billion in 1989.¹²² Today, Americans are spending nearly a trillion dollars annually on health care.¹²³ In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.¹²⁴ CON "has elicited a remarkable evaluative consensus—that it does not work."¹²⁵

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality

118. See Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986) (repealing the Health Planning and Resource Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. § 300k to 300n-6 (1982)), amended by Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1-129, 93 Stat. 592 (codified at 42 U.S.C. §§ 300k-300t (1976 & Supp. V 1981))).

119. Campbell-Eaton, *supra* note 22, at 1451 (citing DES MOINES REGISTER, July 17, 1983, at 10A, col. 1).

120. *Id.*

121. Kaplan, *supra* note 43, at 487.

122. *Id.* at 487 n.102.

123. See Havighurst, *Contract Failure in Health Care*, *supra* note 1, at 47.

124. One author contends that the proper evaluative analysis is not whether certificate of need succeeded in lowering the nation's health care costs, but whether it thwarted the rate of increase in the nation's health care costs. See Kaplan, *supra* note 43, at 487. That author concedes, however, that certificate of need is a failure even under his alternative analysis. *Id.*

125. *Id.* (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).

failed to control health care costs and was often insensitive to community needs.¹²⁶ In Representative Rowland's district:

The citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that's what they propose to maintain.

However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it—unless the hospital eliminated ten beds.¹²⁷

Putnam County protested the agency's decision.¹²⁸ The county's growth projections indicated that all fifty beds would eventually be needed, even though the hospital was not currently utilizing all of its beds.¹²⁹ Likewise, Putnam County's cost estimations indicated that the decrease in beds would have no significant effect on health care costs.¹³⁰ The decrease in beds "would, however, reduce the number of nursing students who could be enrolled in the hospital's LPN program at a time when the country has a critical shortage of nurses. And it would be much more costly when the county has to add back those 10 beds."¹³¹

Nevertheless, the state CON agency would not acknowledge the long-term increase in cost caused by having "to add back those 10 beds," nor would the agency consider the long-term impact on the nation's shortage of nurses which could be exacerbated by eliminating Putnam County's ability to train licensed practicing nurses.¹³² "Eliminating the beds would, however, enable the State health planning

126. 134 CONG. REC. H9455-01 (1988) ("At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.").

127. *Id.*

128. *See id.*

129. *Id.*

130. *Id.* ("In any event, there is no significant savings to be realized by eliminating the 10 beds. It's true Medicare helps pay for interest and depreciation on hospital construction, but a 10-bed cutback would have virtually no impact on health costs.").

131. *Id.*

132. *See id.*

agency to get the number [of beds] more in line with . . . the [regional] quota . . . [I]t's a classic case of a [bureaucracy] paying more attention to numbers on a piece of paper than to reality."¹³³ The reality, according to Representative Rowland, was "the harmful impact this would have on the community without doing anything significant to cut costs."¹³⁴ Representative Rowland did not blame the bureaucrats for these ill effects, but rather blamed the CON laws that necessitated such bureaucracy:

Although I believe the people at the State health planning agency are sincere, I also recognize they are tied to a system that is often high-handed and arrogant. Federal funding for certificate-of-need programs was ended in 1987, and 12 States have now abandoned the program altogether. It's now time to abolish it throughout the Nation. If anyone wants to know why, just ask the people of Putnam County.¹³⁵

C. *The Perseverance of Certificate of Need*

After repealing the 1974 National Health Act and its CON requirements, Congress did not "abolish [CON] throughout the Nation"¹³⁶ as Representative Rowland urged. Congress only repealed the legislation mandating state CON laws.¹³⁷ States were free to continue regulating health care facilities with CON even after Congress repealed its mandate.¹³⁸ Many states did.¹³⁹

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.¹⁴⁰ As the review of Congress's intent indicates, CON had

133. *See id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. *See* Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986) (repealing the Health Planning and Resource Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. § 300k to 300n-6 (1982)), *amended by* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1-129, 93 Stat. 592 (codified at 42 U.S.C. §§ 300k-300t (1976 & Supp. V 1981))).

138. *See id.*

139. *See, e.g.,* statutes cited *supra* note 14.

140. For legislators, wisdom can sometimes fall prey to lobbyists. For example, the Texas Medical Association was instrumental in reinstating certificate of need laws after the Texas legislature repealed the regulations. *See Statelines—Texas: Certificate-of-Need Program Reinstated*, 1 AMERICAN HEALTH LINE, June 16, 1992. In New Jersey, a coalition of twenty urban and teaching hospitals demanded that certificate of need laws not be repealed, warning that deregulation could force hospitals out of business, and stating that they were "concerned there is a push to a deregulated environment." *Statelines—New Jersey: Many Hospitals Fear Deregulation*, 1

one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.¹⁴¹ All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.¹⁴² These justifications should therefore carry little weight in a proper analysis.¹⁴³

AMERICAN HEALTH LINE, NOV. 19, 1992. Likewise in Georgia, the Atlanta Health Care Alliance says it has “supported the certificate-of-need law and health-planning regulations Duplicative, unnecessary health-care services have been very costly to our members.” *Access, Quality, Cost — Cost Containment: Regulation “Back into Vogue,”* 1 AMERICAN HEALTH LINE, May 11, 1992. See also Havighurst, *Regulation by CON*, *supra* note 4, at 1216 (noting that “avoidance of ‘duplication’ is of course consistent with a cartel’s preference for minimizing competition”). Hospital lobbyists demand the protection of certificate of need, because “business coalitions . . . see planning as a way to control costs for their members.” *Access, Quality, Cost—Cost Containment: Regulation “Back into Vogue,”* 1 AMERICAN HEALTH LINE, May 11, 1992 (quoting James Kimmey, Dean of the School of Public Health at St. Louis University). Hospitals are aware that, instead of controlling costs (or “revenue” as seen from the hospital’s perspective), certificate of need had the opposite effect. See *supra* part I.B.2. “Viewed in the light of possibilities for more fundamental changes in the market for insurance and health services, certificate-of-need laws may appear as conservative measures, designed to preserve the very institutions [that] create the problems to which they are addressed.” Havighurst, *Regulation by CON*, *supra* note 4, at 1156. Hospitals therefore fight to keep certificate of need alive.

141. See generally Kaplan, *supra* note 43; Campbell-Eaton, *supra* note 22; Makar, *supra* note 46; Bruce Babbitt & Jonathan Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243 (1986); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Hall, *supra* note 2; Schramm & Renn, *supra* note 17; John A. Robertson, *Asking the “Woman Question” About Health Care Reform*, 3 TEX. J. WOMEN & L. 1 (1994); David M. Frankford, *Privatizing Health Care: Economic Magic To Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (1992). Examples of new justifications for old certificate of need laws include curbing “excessive competition,” solving a “moral hazard,” rectifying “inadequate information,” and eliminating “inefficient incentives.” See, e.g., Kaplan, *supra* note 43, at 479-84. The true reasons for retaining CON are far more pragmatic. See *supra* note 140.

142. See *supra* note 14.

143. A proper analysis of certificate of need should focus on the benefits of a regulated bed supply. After all, the purpose of certificate of need regulations is to control the size and growth of the bed supply. See discussion *supra* parts II.A, II.B. Therefore, to evaluate certificate of need laws properly, the effect of CON bed supply controls should be measured against the resulting increase or decrease in health care prices.

Regulatory restraint on the growth of bed supply will result in somewhat higher prices than an unregulated marketplace would produce no matter how well the health care industry is regulated. Havighurst, *Regulation by CON*, *supra* note 4, at 1218. Certificate of need laws monitor only certain kinds of hospital costs, and therefore “may merely divert inflationary pressures and achieve no control.” *Id.* In many instances, this diversion leads to a higher price for health care. For example, imagine two hospitals, one regulated by certificate of need, the other unregulated. Further imagine an unexpected increase in hospital wage costs. *Id.* (revealing that this type of

Even though CON perseveres, the rationale supporting CON has disappeared. The logic of CON was based on the health care marketplace as it existed in the 1950s through the early 1970s. Today's medical marketplace is significantly different. CON is predicated on a medical marketplace dominated by third party fee-for-service agreements. However, the modern medical marketplace is shifting away from fee-for-service. The institutions who are the primary purchasers of health care services are banding together with the aid of governments.¹⁴⁴

III. ORIGIN AND INTENT OF THE MANAGED COMPETITION HEALTH CARE STRATEGY

A governmental system fostering alliances between health care purchasers in order to manipulate the price of health care suppliers is called a managed competition plan.¹⁴⁵ Under managed competition, governments aid purchasers in negotiating the lowest price for health care.¹⁴⁶ However, the effectiveness of a group of purchasers is greatly lessened when they cannot negotiate against a single hospital, but rather must negotiate with a legalized cartel of hospitals, as is the result under a CON system. The following section suggests that managed competition is doomed to failure unless CON laws are repealed or dramatically scaled back.

Many states are now grappling with the dilemma of meshing the two health care strategies: managed competition and CON. Both strategies, it seems, foster the same goals, but differ in the means used

event is rather common in the health care industry by stating that increases in hospital wages and "other types of cost increases . . . are equally likely to occur"). The unregulated hospital has the opportunity to add beds and thereby allocate the increase in wage costs over a greater number of patients, resulting in a smaller increase in health care cost per patient. *See id.* The regulated hospital, however, cannot add beds because of certificate of need regulations. *See id.* (implying that, when a hospital's bed supply is fixed, then its maximum revenue is fixed, even though maximum costs are not). The regulated hospital must allocate the increased cost to a smaller number of patients, resulting in a larger increase in health care costs per patient. In that case, a hospital would face increased costs because certificate of need laws do not regulate wages, yet the hospital would experience no increase in revenue because certificate of need has capped the hospital's maximum revenue. Certificate of need, therefore, can prove rather costly to individual patients.

144. *See* Hall, *supra* note 2, at 3.

145. *See generally* Jackson Hole Group, *Managed Competition II: A Proposal*, 46 WASH. U. J. URB. & CONTEMP. L. 33 (1994) (proposing managed competition as an alternative to our modern health care system); Hall, *supra* note 2 (describing how managed competition works); FLORIDA AGENCY FOR HEALTH CARE ADMIN., THE FLORIDA HEALTH SECURITY PLAN. HEALTHY HOMES 1994, 25-47 (1993) (on file with the State of Florida, Agency for Health Care Administration, Publications Office) [hereinafter FLA. AHCA ATLAS] (describing the implementation of managed competition in Florida).

146. Hall, *supra* note 2, at 1-5.

to achieve these goals. Whereas CON attempts to control the marketplace by regulating supply, managed competition aspires to influence prices by putting purchasers on an equal playing field with their organized adversaries.

Like CON laws which evolved from philanthropic activities supported by special interest groups,¹⁴⁷ managed competition laws evolved from the ideas of academicians and were adopted by special interests.¹⁴⁸ Professor Alain Enthoven, of the Stanford University Graduate School of Business, first devised managed competition as an approach to health care reform in the late 1970s.¹⁴⁹ The Enthoven model was further refined by the Jackson Hole Group,¹⁵⁰ and has become the leading model for a managed competition health care delivery system.¹⁵¹

The managed competition strategy proposes a scheme of private insurance plans presenting individuals with a range of enrollment options offered by companies which manage the selection process and make individuals pay the difference in price among the insurance options chosen.¹⁵² Legislation dictates what kinds of health plans will be available, therefore creating uniform health care products from which to choose. A separate government entity assumes the task of aggregating health care purchasers, and negotiates on their behalf with providers to purchase the necessary health care products at the lowest possible price.¹⁵³ "Managed competition attempts to achieve universal health insurance coverage and health care cost containment via a hybrid between the opposite extremes of a completely socialized system of health insurance like Canada's, and a largely unregulated private

147. See *supra* part II.A. (describing the philanthropic origins and American Hospital Association support for certificate of need).

148. See FLA. AHCA ATLAS, *supra* note 145, at 25-47. The Jackson Hole Group describes itself as "an ad hoc and changing collection of health executives, leaders, and experts who have been meeting over the last twenty years to discuss and address the most serious deficiencies of the health care system." Jackson Hole Group, *supra* note 145, at 33. Jackson Hole has been instrumental in advancing modern health care reform. See FLA. AHCA ATLAS, *supra* note 145, at 25-26. Its 1993 president, Paul M. Ellwood, M.D., was an early advocate of pre-paid health care and "was instrumental in developing the 1973 legislation on health maintenance organizations." *Id.*

149. Alain Enthoven, *Consumer-Choice Health Plan: A National Health Insurance Proposal Based on Regulated Competition in the Private Sector*, 298 NEW ENG. J. MED. 650, 709 (1978). This article was the first articulation of a managed competition health care plan. Hall, *supra* note 2, at 1.

150. See *supra* note 148.

151. E.g., FLA. AHCA ATLAS, *supra* note 145, at 25-54 (admittedly inspired by the Jackson Hole model).

152. Hall, *supra* note 2, at 1.

153. *Id.*

insurance market such as currently exists in the United States."¹⁵⁴ This "hybrid" intends to be an enhancement of the existing market system that will "preserve and improve the benefits of competition without sacrificing the social objective[s]."¹⁵⁵

Managed competition, therefore, uses government regulators to ally health care purchasers in order to negotiate better prices from health care providers.¹⁵⁶ The classic structure of managed competition combines government action in the form of health boards¹⁵⁷ and health alliances¹⁵⁸ with private free-market activity in the form of private health plans.¹⁵⁹ The critical factor of managed competition is that market forces, and not regulatory forces, determine the cost of health care.¹⁶⁰ Government's role in the managed competition strategy is that of organizer and motivator.

A. Governmental Health Boards and Alliances

Through governmental health boards, regulators would set broad guidelines and enforcement standards¹⁶¹ and stimulate collaboration among purchasers, patients, and the government.¹⁶² Governmental health boards would achieve these goals by selecting the individual health plans offered to health care consumers.¹⁶³ In essence, the health

154. *Id.* at 2.

155. *Id.* Managed competition's ability to advance many social objectives, such as access to quality health care for the poorest Americans, is already being debated. See, e.g., Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105 (1994).

156. See Hall, *supra* note 2, at 3.

157. A health care board is defined as "a government agency that oversees the entire process and sets broad guidelines and enforcement standards." Hall, *supra* note 2, at 3. In the vernacular of the Jackson Hole Group's latest draft proposal, the health care board is called a "Health Security Commission" (HSC) and is described as "The Referee." Jackson Hole Group, *supra* note 145, at 36 (table 1).

158. Health alliances are defined as "private or governmental entities that oversee the selection process and premium collection at the local level." Hall, *supra* note 2, at 3. In the Jackson Hole Group's latest language, health alliances are given the winsome name "HelPS" (an abbreviation for "Health Plan Stores") and are described as "sponsors." Jackson Hole Group, *supra* note 145, at 36 (in Table 1). In the 1991 Jackson Hole draft, "HelPS" were called "HPPCs" (for "Health Plan Purchasing Cooperatives") or "Health Alliances." *Id.*

159. "The health plans . . . are, in essence, private insurance companies, although their actual nature may vary widely Common examples are the familiar Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) forms of insurance" Hall, *supra* note 2, at 4.

160. See Hall, *supra* note 2, at 4.

161. *Id.*

162. FLA. AHCA ATLAS, *supra* note 145, at 26.

163. See Hall, *supra* note 2, at 3; FLA. AHCA ATLAS, *supra* note 145, at 26-27.

board would set broad policy, and implement that policy by regulating the forms of health insurance available in the marketplace.¹⁶⁴

Through health alliances, the government would attempt to empower the disadvantaged to become players in the free market for health care. Alliances "would have the authority to set global budgets, exclude health plans, and negotiate rates."¹⁶⁵ Alliances function by amassing the purchasing power of a multitude of health care purchasers, and negotiating on their behalf in order to demand the lowest prices from providers.¹⁶⁶ A governmental health alliance's goal is to bring the purchasing power of larger businesses to the small business community and to individuals.¹⁶⁷

B. Private Health Plans

Under managed competition, governmental health boards would approve insurance plans that "employ financial incentives and managed care techniques to deliver a more economical and efficient package of health care benefits."¹⁶⁸ Such plans would be offered by private insurance companies.¹⁶⁹ Examples of acceptable plans are the Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) offered by the leading health care insurers.¹⁷⁰

164. See Hall, *supra* note 2, at 3; FLA. AHCA ATLAS, *supra* note 145, at 26-27. The Jackson Hole version of a governmental health board, the Health Security Commission (HSC), would have an even more limited role:

The HSC would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. HSC powers and responsibility would be explicitly limited in legislation to . . . [r]ecommending a standard benefits package . . . [r]ecommend[ing] measures to balance the health security budget . . . [c]oordinating a standardized data reporting system . . . [s]etting standards . . . [d]isseminating information and making recommendations on risk adjustment.

Jackson Hole Group, *supra* note 145, at 36 (in Table 1).

165. FLA. AHCA ATLAS, *supra* note 145, at 27. The Jackson Hole Group's 1994 managed competition proposal would require a balanced health security budget. Jackson Hole Group, *supra* note 145.

166. See Jackson Hole Group, *supra* note 145, at 36-37. In Florida, alliance membership is voluntary. See FLA. AHCA ATLAS, *supra* note 145, at 27. The Jackson Hole Group considered and rejected voluntary membership in favor of mandatory membership, because

[e]xperience has shown . . . that the small group market is easily fragmented into small, expensive groups that insurers avoid and small, low-cost groups that are easily insured. Such risk selection, and the associated cost shifts, remains the central problem which purchasing pools are intended to overcome and which will not be addressed by voluntary HelPS [Alliances].

Jackson Hole Group, *supra* note 145, at 30.

167. FLA. AHCA ATLAS, *supra* note 145, at 24-28

168. Hall, *supra* note 2, at 4.

169. *Id.* However, an alliance that finds a given group is not afforded adequate access to private insurance plans may offer Health Plan Purchasing Cooperatives (HPPCs)—government-run insurance plans—to the disadvantaged group. See FLA. AHCA ATLAS, *supra* note 145, at 26.

170. See Hall, *supra* note 2, at 4. Other possible examples include Independent Practice

An HMO is a type of managed care company that provides comprehensive health care coverage for a fixed price to a specific group.¹⁷¹ HMOs negotiate discounted charges with health care providers, and restrict members to using only that network of providers.¹⁷² HMOs typically refuse to pay for the medical bills of a member who does not use a network provider.¹⁷³ In this way, HMOs greatly reduce the consumer's cost of health care.¹⁷⁴

A PPO is another type of managed care company, similar to an HMO, providing comprehensive health care coverage to a specific group.¹⁷⁵ The primary difference between an HMO and a PPO is that a PPO will allow members to see a doctor outside of its network of physicians, but will not pay so much of the cost as it would if the member saw one of the doctors in the network.¹⁷⁶ HMOs, PPOs, and their hybrid forms¹⁷⁷ can be referred to generally as managed care companies, all of which play a managerial role under a managed competition health care plan.¹⁷⁸

Managed care and managed competition are not synonymous.¹⁷⁹ Managed competition refers to the overall market structure, including government involvement.¹⁸⁰ Managed care refers to a private

Associations (IPAs), Integrated Delivery Systems (IDSs), Exclusive Provider Organizations (EPOs), and even fee-for-service or point-of-service (POS) plans. Under the original managed competition proposal of the Jackson Hole Group, no limit was placed on the type of health care delivery organizations. See Jackson Hole Group, *supra* note 145, at 39. Under Jackson Hole's 1994 revised plan, restrictions would apply, so that consumer choice of providers could be achieved. *Id.*

171. *Confused by What This Alphabet Soup Means? Here's How To Tell the Difference Between an HMO, PPO, EPO and Everything Else*, DENVER BUS. J., Oct. 21, 1994 at 27C, *4, available in WestLaw, TRD&IND-C database [hereinafter DENVER BUS. J. HEALTH CARE GLOSSARY]. See also 42 U.S.C. § 1395mm (1993); 42 C.F.R. § 417.407(b); FLA. STAT. § 641.19(7) (1993); 1 HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURES § 18-B (1986).

172. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *4.

173. *Id.*

174. See generally Hall, *supra* note 2 (extolling the virtues of managed competition).

175. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *6.

176. *Id.*

177. Hybrid forms include "open-ended" HMOs, point-of-service (POS) plans, and Management Services Organizations (MSOs). Hall, *supra* note 2, at 4, 7.

178. Managed care companies provide cost control, marketing of network services, oversight of receipts and patient distributions, and management of finance, facility, and personnel costs. See Hall, *supra* note 2, at 7. The reader should note a dramatic difference between certificate of need and managed competition—managed competition shifts most regulatory control from the public to the private sector. Cf. discussion *supra* part II.B.

179. As my colleague Miles W. Hughes succinctly stated, health care alliances primarily distinguish managed competition from managed care.

180. See generally Jackson Hole Group, *supra* note 145 (proposing a system with a market structure indirectly regulated via government involvement in purchasing, financing, and risk al-

association of health care providers who collectively bargain for the use of their services.¹⁸¹ The collective services of such providers are referred to as integrated delivery systems.¹⁸² These systems are more than vertical integration and joint ventures—they cover a broad range of services, including a full array of hospital and physician services in both inpatient and outpatient settings.¹⁸³ They may also include long-term care facilities and specialized services such as mental health or physical therapy.¹⁸⁴ The managed care company and integrated delivery systems are a new form of provider,¹⁸⁵ created in response to the difficulty of individual providers to prosper in the new health care marketplace.

Although managed competition appears promising, no hard evidence unequivocally proves that managed competition is effective.¹⁸⁶ “Managed competition is a controversial public policy that is still being debated, even as it is taking hold of the health care delivery system.”¹⁸⁷ One United States Congressman has referred to managed competition as a “fairy tale,” while another likened it to the “Star Wars” defense initiative.¹⁸⁸ Even the Congressional Budget Office declared managed competition to be “untried.”¹⁸⁹ These concerns about the viability of managed competition are not ill-founded, considering the fact that no nation or state has yet fully implemented a managed competition system.¹⁹⁰ Even the Jackson Hole Group admits that managed competition proposals seem stymied by the inability to predict the economic consequences of their implementation.¹⁹¹

location). Managed competition has been defined as a “concept of providing a comprehensive range of services, from doctor visits to hospital care, using techniques . . . to keep a reign on health-care costs and ensure that the care rendered is appropriate and necessary.” DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *5.

181. See Hall, *supra* note 2, at 5.

182. *Id.* at 1-5.

183. *Id.*

184. *Id.* at 5.

185. *Id.*

186. See Hall, *supra* note 2, at 10-11.

187. *Id.* at 11.

188. Catherine T. Dunlay & Peter A. Pavarini, *Managed Competition Theory as a Basis for Health Care Reform*, 27 AKRON L. REV. 141, 157 (1993) (attributing the “fairy tale” comment to Representative Pete Stark, and the “Star Wars” comment to Representative Dan Rostenkowski).

189. *Id.*

190. *Id.* “[E]galitarian analysts doubt that a managed competition strategy can . . . contain costs Many factors support this view: a competitive system will involve high costs of administration and profit, risk-selection will remain the most lucrative strategy, and egalitarian values will be in permanent tension with profit-making.” Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105, 110-11 (1994).

191. See Jackson Hole Group, *supra* note 145.

States are nonetheless wagering that managed competition will succeed,¹⁹² and commentators are predicting that the proliferation of managed competition is inevitable.¹⁹³ The following question is therefore appropriate: what role should CON laws play in a managed competition state?

IV. WHY CERTIFICATE OF NEED IS NOT NEEDED UNDER MANAGED COMPETITION

Unfortunately, in states implementing CON, managed competition will fail. In the words of one commentator:

[With the proliferation of] certificate-of-need laws . . . an unexpected consequence may follow—a severe restriction of competition in the health care market. [CON laws are] cost-containing only if the excluded providers would have relied on fee-for-service, cost-based, retrospective reimbursement. Prepaid medical group practices or Health Maintenance Organizations (HMOs), however, operate under entirely different rate structures and payment mechanisms [R]educing [the HMOs'] ability to enter the market or to expand may contribute to higher health care costs. Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities, making it impossible for the HMO to develop or expand [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.¹⁹⁴

This commentator is illustrating a stark reality of managed competition—it can succeed only if health care providers are forced to negotiate lower consumer prices with health care alliances.¹⁹⁵ CON laws shelter health care providers from the price-cutting demands of health care alliances.¹⁹⁶ “Strength in numbers,”¹⁹⁷ the very reason why a managed competition health care strategy is touted to succeed, would

192. Several state laws provide variations of the managed competition strategy, including Florida's Health Care and Insurance Reform Act of 1993, the State Health Insurance Program of Hawaii, the HealthRight and Minnesota Care programs, Vermont's Health Care Act of 1992, the Washington Health Services Act of 1993, and Oregon's Rationing Plan. Jackson Hole Group, *supra* note 145, at 34.

193. See *supra* note 2 and accompanying text.

194. Budetti, *supra* note 48, at 44-45.

195. See *infra* part IV.B.

196. See *supra* part II.A.

197. “[Managed competition] aims to make health care a safer bet. And its guided by a concept any gambler could appreciate—strength in numbers.” FLA. AHCA ATLAS, *supra* note 145, at 30 (quoting Stephen Smith, The Miami Herald).

be thwarted by hospital cartels united under CON laws. If HMOs and other managed care companies can be forced from the marketplace by united hospitals, then managed competition will fail.

Instead of risking the failure of the managed competition health care strategy, states should repeal CON laws.¹⁹⁸ Managed competition serves as a "nail in the coffin" of CON by making obsolete the rationale and reasons for CON.¹⁹⁹ Below, each of Congress's reasons for promoting CON is addressed, and shown to be moot under a managed competition health care strategy.

A. Managed Competition Market Incentives Can Adequately Restrain Health Care Costs

Congress's first reason for promoting CON was to address a perceived inability of the health care marketplace to adequately restrain health care costs.²⁰⁰ However, a managed competition health care marketplace would keep a keen eye on health care spending. For example, many HMOs and managed care companies restrain health care costs by using the Health Plan Employer Data and Information Set (HEDIS).²⁰¹ HEDIS is used by HMOs as a performance measurement to give a numerical answer to questions about how well a given health plan serves its members.²⁰² Inefficient health plans are replaced by more efficient plans.²⁰³

As well as monitoring HEDIS, managed care companies also monitor "outcomes."²⁰⁴ "Outcomes" are a measurement of the effectiveness of medical treatments, judged against factors such as mortality and cost.²⁰⁵ By monitoring outcomes, managed care companies are creating a health care marketplace which seeks to restrain health care costs.

A third and vitally important feature of managed competition that makes the marketplace more responsive to health care costs is managed competition's abandonment of the third party fee-for-service system. Whereas fee-for-service involves individualized payments for each health care service,²⁰⁶ managed care companies negotiate service

198. See Havighurst, *Regulation by CON*, *supra* note 4, at 1207-15; see HAVIGHURST, *DE-REGULATING FOR COMPETITION*, *supra* note 69.

199. See *infra* part IV.C.

200. See *supra* part II.B.1.a.

201. See DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *4.

202. *Id.*

203. See *id.*; Havighurst, *Regulation by CON*, *supra* note 4, at 1221.

204. See DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *6.

205. *Id.*

206. See *supra* part II.B.1.b.i.

discounts in exchange for sending patient volume to providers.²⁰⁷ The result is the demise of traditional indemnity insurance, in which companies pay whatever rate a health care provider may ask.²⁰⁸ Instead, health care providers receive a previously arranged maximum fee for the service performed, and the health care consumer saves money.

Fourth and finally, managed competition gives government, in its role of health care board and health care alliance, the ability to stack the deck in favor of restraint on health care costs. Health care alliances will have the authority to set global budgets,²⁰⁹ and thereby impose self-restraint on providers who realize that a finite amount of resources will be allocated to their reimbursement. A health care alliance which perceives health care costs to be increasing at too great a rate can thwart that trend by "tightening the money supply"²¹⁰ and decreasing the aggregate amount of revenue available to providers. Should a given delivery system²¹¹ not respond to an alliance's global budget pressure or otherwise prove too costly, a health care board would have the authority to eliminate the delivery system from the options available to consumers.

B. Managed Competition Market Incentives Can Adequately Prevent the Unnecessary Duplication of Health Resources

Congress's second reason for promoting CON was that health care markets cannot adequately prevent the unnecessary duplication of health resources.²¹² Yet, integrated delivery systems and managed care companies like HMOs have the ability to manage health care resources. "HMO development is perhaps the most promising nonregulatory strategy for bringing the excessive use of health care resources under effective control."²¹³

Hospitals which are allied with HMOs and other managed care companies should be exempt from CON statutes.²¹⁴ Hospitals controlled by managed care companies do not face the same incentives

207. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *3.

208. *See id.* at *4 (defining "indemnity insurance").

209. *See supra* part III.A.

210. In this way, a governmental health care board would be not unlike the Federal Reserve, which imposes self-restraint on the growth of the national economy and national interest rates by restricting or loosening the money supply at strategic times.

211. For example, a fee-for-service system, a PPO system, or the like.

212. *See supra* part II.B.1.b.

213. Havighurst, *Regulation by CON*, *supra* note 4, at 1225 (citing Ellwood et al., *Health Maintenance Strategy*, 9 MED. CARE 291 (1971)). *Accord* Clark C. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716 (1970).

214. *See* Havighurst, *Regulation by CON*, *supra* note 4, at 1207.

for overexpansion that characterize fee-for-service hospitals.²¹⁵ Managed care companies pay providers in advance, rather than retrospectively on a cost-reimbursement basis, and thus have "every incentive to conserve their resources and to seek efficiency."²¹⁶ Therefore, another presumption of CON—the marketplace's failure to control the unnecessary duplication of health care resources—is not valid under managed competition.

California, Oregon, and Washington have recognized that hospitals controlled by managed care companies should be exempt from CON regulations thwarting facility construction.²¹⁷ These states have taken an important and necessary first step toward the success of managed competition. By exempting managed care companies from CON laws, these states recognize that managed competition eliminates the four presumptions underlying the conclusion that the health care marketplace allows for the unnecessary duplication of health care resources.²¹⁸ In the following discussion, the four presumptions—the externalization of purchase costs,²¹⁹ the non-price competition between facilities,²²⁰ the physician's effect on supply,²²¹ and the "Roemer Effect" on demand²²²—are demonstrated to be inapplicable in a managed competition system.

1. *No Externalization of Purchase Costs*

Proponents of CON contend that the health care marketplace results in an externalization of purchase costs because fee-for-service insurers will reimburse for any provided health service.²²³ In other words, a patient need not worry about health care costs, because "insurance will cover it."²²⁴ If this externalization of purchase costs was

215. *Id.*

216. *Id.* at 1207-08.

217. *Id.* Oregon requires that consideration be given to "the needs of members, subscribers and enrollees of institutions and health care plans which operate or support particular hospitals for the purpose of rendering health care to such members, subscribers and enrollees." OR. REV. STAT. § 441.095(k) (1994). Washington's certificate of need regulations contain a similar proviso. See WASH. REV. CODE § 70.38.140(12) (1994). Similarly, California relaxes its facility construction regulations for HMOs, "emphasizing comprehensiveness and coordination of services, the importance of innovation and alternatives, and the 'views' of groups of users on the need issue." Havighurst, *Regulation by CON*, *supra* note 4, at 1209 (discussing 17 CAL. CODE REGS. tit. 17, § 40518 (1973)).

218. For a discussion of the four elements, see *supra* part II.B.1.b.

219. See *supra* part II.B.1.b.i.

220. See *supra* part II.B.1.b.ii.

221. See *supra* part II.B.1.b.iii.

222. See *supra* part II.B.1.b.iv.

223. See *supra* part II.B.1.b.i.

224. FLA. AHCA ATLAS, *supra* note 145, at 25.

ever a reality,²²⁵ it ceases to be so under a managed competition health care plan. Managed care companies and integrated delivery systems negotiate fees well in advance of service, and often base those fees on local averages obtained using diagnostic-related group formulas.²²⁶ Diagnostic-related group formulas, or DRG formulas, are “classification[s] developed by Medicare a decade ago to determine how much the federal program will pay for inpatient care.”²²⁷ DRG formulas provide health care providers with a fixed payment for treating patients, regardless of the provider’s expense in providing the care.²²⁸ Thus, under managed competition, purchase costs are not external, but rather internal.

The latest managed care proposal from the Jackson Hole Group, as well as internalizing purchase costs via managed care companies, further effects an internalization by requiring government to maintain a balanced health care budget.²²⁹ The Jackson Hole Group notes that a managed competition state needs to achieve a predictable and acceptable level of health care spending, and proposes that the most effective method of achieving this goal is to require that health expenditures not grow faster than revenue.²³⁰ As a result, governmental health alliances would be unlikely to pay more for the same services simply so that a provider can be repaid for unnecessary facilities or equipment. The actual use of the facility or equipment would have to pay for itself by attracting new patients or otherwise generating new revenue, because an alliance constrained by a balanced budget would not likely pay increased fees without gaining increased services in return.

2. *Non-Price Competition Among Facilities Replaced by Price and Quality Competition*

Proponents of CON contend that it is absolutely necessary to prevent non-price competition between health care providers.²³¹ Under managed competition, non-price competition is nearly eliminated by the use of “gatekeepers.”²³² A gatekeeper is an entity employed by a

225. Proponents of certificate of need overestimated any “externalization of purchase costs” because procedures were already in place to prevent such externalization. See *supra* part II.B.1.b.i (discussing the section 1122 capital expenditure review provisions of the Social Security Amendments of 1974).

226. See 42 U.S.C. § 1886 (1993); 42 C.F.R. 412.60 (1995).

227. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *3.

228. See *id.*

229. Jackson Hole Group, *supra* note 145, at 39-40.

230. *Id.*

231. See *supra* part II.B.1.b.ii.

232. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *3.

managed care company to ensure that patients do not unnecessarily increase the cost of health care.²³³ For example, a gatekeeper may require that a patient first see a primary care physician²³⁴ before visiting a more expensive specialist²³⁵ or seeking tertiary care.²³⁶ All patients must first contact the managed care company's gatekeeper before seeking non-emergency treatment.²³⁷ A patient is thereby precluded from visiting the biggest, most elaborate, most modern facilities when such facilities are not medically necessary.

Furthermore, managed competition fosters sharp price competition between health care providers. In fact, critics of managed competition note that health care providers in a managed competition environment can compete on few terms other than price.²³⁸ The design of managed competition is singlemindedly structured to create price competition among health care providers.²³⁹

Quality competition would indirectly arise in managed competition under the guise of efficiency. Alliances and managed care companies, in measuring outcomes, would be searching for the highest return on their health care investment. Providers with poor outcomes would cause a patient to need more health care services, which in turn would increase the price paid to care for the patient. The increased price would be noticed, and the services of the provider necessarily avoided by alliances and managed care companies. As a result, although alliances and managed care companies might not specifically search for quality, their search for the best return on their health care dollar will result in a preference for quality care.

3. *Counteracting the Physician's Effect on Supply*

The physicians' effect on supply, a concern of CON proponents, is overcome in a managed competition state by the HMO's effect on supply.²⁴⁰ HMOs counteract a physician's ability to order excessive or unnecessary medical treatment by implementing utilization review

233. *Id.*

234. "Primary care" describes the system of preventing patients from becoming seriously ill. *Id.* at *7. Doctors in the fields of family practice, pediatrics, internal medicine, and general practice are considered to be primary care physicians. *Id.*

235. *See id.* at *3.

236. Tertiary care is "[t]he most specialized kind of health care, falling under the purview of sub-specialists like neurosurgeons." *Id.* at *7.

237. *See id.*

238. *E.g.*, Rosenblatt, *supra* note 155, at 110 ("Analysts have also challenged the core premise of market competition, which . . . asserts . . . [that health care] decisions must be made by an abstract 'economic man.'").

239. *See supra* part III.A.

240. *See* Havighurst, *Regulation by CON*, *supra* note 4, at 1228.

programs.²⁴¹ Utilization review requires a physician to seek prior approval from the HMO before commencing with non-emergency medical procedures, and allows a managed care company to “look back at the care rendered to check whether [the care] was appropriate.”²⁴²

Managed competition also thwarts the physician’s effect on supply via capitation. Capitation is “[a] method of reimbursement, typically used by health-maintenance organizations, in which health-care providers receive a fixed payment for every patient regardless of how much care individual patients need.”²⁴³ Capitation provides financial disincentives for doctors and providers who would order too many tests or too many patient visits.²⁴⁴ Therefore, even a doctor with a light schedule will not have the incentive to see his patients any more than medically necessary.²⁴⁵

Typically, utilization review and capitation are methods used by HMOs, but under managed competition, governmental health boards would have the authority to design and mandate the use of integrated delivery systems which incorporate utilization review and capitation.²⁴⁶ Should a given delivery system prove too costly, the health board can redesign it to include utilization review and capitation. In short, managed competition arms the health care consumer with a powerful weapon to battle effectively a spendthrift physician.

4. Elimination of the “Roemer Effect” on Demand

A final component of the perceived need to control the unnecessary duplication of health resources results from the “Roemer Effect” view that the demand for medical services can be adversely controlled and manipulated by health care providers.²⁴⁷ Under managed competition, health care providers are thwarted from generating demand for their services. Managed care companies require pre-admission certification before a physician can admit a patient to the hospital.²⁴⁸ Thus, only medically necessary admissions will be made, as the

241. See *id.*

242. DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *8 (defining “utilization review”).

243. *Id.* at *1.

244. See *id.* “Risk sharing” is the term used to describe systems which put health care providers at some financial risk when providing medical care, such as under capitation. *Id.* at *7.

245. See *supra* note 103 and accompanying text (describing “Dr. Smith’s” method of generating extra revenue).

246. See *supra* part III.A. (discussing an alliance’s authority to choose what kind of health care delivery systems will be available to consumers within the alliance’s jurisdiction).

247. See *supra* notes 106-10 and accompanying text.

248. See DENVER BUS. J. HEALTH CARE GLOSSARY, *supra* note 171, at *6 (defining “pre-admission certification”).

hospital's incentive to fill beds is counterbalanced by the managed care company's desire to avoid paying for a filled bed.²⁴⁹

In addition, under a managed competition system with a balanced health care budget requirement, such as that suggested by the Jackson Hole Group, alliances would strongly resist any unnecessary cost.²⁵⁰ If resistance is futile, governmental health boards can mandate the redesign of delivery systems to incorporate sufficient deterrents to the Roemer Effect.²⁵¹

In sum, managed competition creates a health care marketplace where adequate incentives exist to prevent the unnecessary duplication of health care costs. Purchase costs are internalized. Competition is based on price and quality. Physicians have little or no effect on supply and the "Roemer Effect" no longer affects demand.

C. Achieving Equal Access to Quality Health Care at a Reasonable Cost

Managed competition also creates a health care marketplace with an excellent chance of achieving equal access to quality health care at a reasonable cost. CON laws state an intent to achieve equal access at reasonable cost, but rarely include any action to implement that intent.²⁵² The managed competition health care model includes a clear action plan to achieve equal access at reasonable cost. Via governmental alliances, the disadvantaged can share in the purchasing power of government agencies.²⁵³ These alliances have the single goal of making private insurance more accessible and affordable to disadvantaged individuals through collective bargaining power.²⁵⁴ No hard evidence has yet proven that alliances will succeed, but even an unproven plan such as that offered by managed competition is preferable to the failed plan offered by CON.

V. A CASE STUDY: HOW FLORIDA'S CERTIFICATE OF NEED LAWS OPERATE AND CONFLICT WITH MANAGED COMPETITION HEALTH CARE REFORM

Florida provides a prime example of the conflict between CON and managed competition.²⁵⁵ In order to illustrate best the conflict, the

249. See Havighurst, *Regulation by CON*, *supra* note 4, at 1221-29.

250. See *supra* part IV.B.1.

251. See *supra* part IV.B.3. Likely deterrents include procedures to assure that treatment is medically necessary, such as pre-admission certification, utilization review, capitation, and the like.

252. See *supra* part II.B.1.c.

253. FLA. AHCA ATLAS, *supra* note 145, at 26.

254. See *supra* part III.A.

255. California provides another example. See FLA. AHCA ATLAS, *supra* note 145, at 26.

following discussion presents Florida's CON laws and Florida's interpretation of managed competition.²⁵⁶ The discussion then identifies the Legislature's acknowledgement of the conflict between CON and managed competition.²⁵⁷

The origin of CON in Florida parallels other states' similar laws, originating from local community efforts to allocate philanthropic and federal funding.²⁵⁸ Florida's first CON laws were part of the Health Facilities and Health Services Planning Act, passed just one year before the effective date of the Congressional mandate.²⁵⁹

A. *How the Certificate of Need Program Operates in Florida Today: The Statutes and Rules*

Florida's current CON statutes are known as the "Health Facility and Services Development Act."²⁶⁰ The statutes are supplemented by agency-promulgated administrative codes.²⁶¹ The structure of the statutes and rules still shows the influence of the 1974 National Health Act.²⁶²

Under Florida law, anyone operating a hospital, nursing home, or intermediate care facility without first obtaining a CON is guilty of a

256. See *infra* part V.A.

257. See *infra* part V.B.

258. See *supra* part II.A.

259. Health Facilities and Planning Act, FLA. STAT. §§ 381.493-.497 (1973); FLA. AHCA ATLAS, *supra* note 145, at 189 ("Since 1973, Florida has regulated the market entry of health facilities and services through its certificate of need (CON) program."). After Congress repealed the law mandating state implementation of CON, Florida established a nearly identical CON system. See 1982, Fla. Laws ch. 82-182; 1987, Fla. Laws ch. 87-92; 1991, Fla. Laws ch. 91-282.

260. FLA. STAT. §§ 408.031-.045 (1993).

261. FLA. ADMIN. CODE ANN. r. 59C (1994).

262. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k to 300n-6 (1982)), amended by Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1-129, 93 Stat. 592 (1979) (codified at 42 U.S.C. §§ 300k-300t (1976 & Supp. V 1981)), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986). This Act mandated certificate of need laws in the states. See *supra* part II.B. In Florida, the agency originally charged with implementing the certificate of need laws was the Bureau of Community Medical Facilities and Planning. See 29 FLA. JUR. 2D, *Hospitals and Nursing Homes* § 2 (1979); see, e.g., *Page v. Capital Med. Ctr., Inc.*, 371 So. 2d 1087 (Fla. 1st DCA 1979) (involving the Bureau of Community Medical Facilities Planning in its role as issuer of certificates of need). The Bureau was given vague guidelines with which to review certificate of need applications. See 29 FLA. JUR. 2D, *Hospitals and Nursing Homes* § 2 n.5 (1979 & 1995 pocket part) (indicating that the Bureau must follow § 381.494(6), but when that statute failed to yield a definitive determination of need, the Bureau was required to "follow applicable federal, state and departmental rules and regulations in administering the certificate-of-need program"). The Bureau did not decide which certificate of need applications would be approved, but instead made recommendations for approval or denial to the Department of Health and Rehabilitative Services. See 29 FLA. JUR. 2D, *Hospitals and Nursing Homes* § 2 at 342 (1979 & 1995 pocket part).

second degree misdemeanor.²⁶³ Additionally, anyone operating without a necessary CON can be fined up to \$5,000 for every day the facility operates without the certificate.²⁶⁴ Thus, Florida health care facilities are very aware of CON laws.

1. *Determining Whether a Given Project Requires a Certificate of Need*

Before breaking ground for construction, offering a new service, or purchasing medical equipment, a Florida health care facility should first determine whether the new project or purchase will require a CON.²⁶⁵ Certain projects are exempted from CON review.²⁶⁶ To determine whether a project or purchase is exempt, the safest and most cost-effective method is to file a request for exemption²⁶⁷ with Florida's Agency for Health Care Administration (AHCA or Agency).²⁶⁸

2. *Securing a Certificate of Need*

Projects requiring a CON in Florida include, but are not limited to, new construction,²⁶⁹ capital expenditures beyond a specified limit,²⁷⁰

263. Anyone undertaking a project subject to review under *Florida Statutes* sections 408.031 through 408.0455 without a valid certificate of need is guilty of a second-degree misdemeanor. FLA. STAT. § 408.041 (1993). The second-degree misdemeanor is punishable as provided in *Florida Statutes* section 775.082 or section 775.083. *Id.*

264. *See id.* Florida's AHCA is rather particular about who operates Florida's health care facilities. *See, e.g.,* Brookwood-Jackson City Convalescent Ctr. v. Department of HRS, 591 So. 2d 1085 (Fla. 1st DCA 1992) (denying a certificate of need to an applicant because the applicant would be leasing the facility to an unrelated provider).

265. *See* FLA. STAT. § 408.041 (1993).

266. FLA. STAT. §§ 408.036(3), 408.043(1) (1993 & Supp. 1994).

267. The request should take the form of a letter from an authorized officer or attorney for the health care facility, and should include documentation to substantiate the request. *See* FLA. STAT. § 408.036(3) (1993); FLA. ADMIN. CODE ANN. r. 59C-1.005 (1994). Within thirty days of receipt of the request, the Agency for Health Care Administration must determine whether the proposed project is exempt from certificate of need review. FLA. STAT. § 408.036(3) (1993). The Agency's decision will be mailed to the applicant and published in the *Florida Administrative Weekly*. FLA. ADMIN. CODE ANN. r. 59C-1.005 (1994).

268. *See id.* Even if the project or expenditure is found to be exempt from state certificate of need review, it is not necessarily exempt from capital expenditure review pursuant to section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1(b)(3). In *Palmetto General Hospital, Inc. v. Department of HRS*, 333 So. 2d 531 (Fla. 1st DCA 1976), a "hybrid proceeding involving both the federal and state governments under an agreement entered into between the State of Florida and the Secretary of Health, Education and Welfare of the United States," *id.* at 532, Florida's First District Court of Appeal held that "we cannot say that . . . [exemption from Florida's certificate of need laws] in any way controls the Secretary on the question of whether or not he will approve federal participation in capital expenditures on petitioner's project without need being shown for such construction." *Id.* at 533. For a discussion of the nearly identical procedures of state certificate of need laws and federal section 1122 review, *see supra* part II.B.1.

269. FLA. ADMIN. CODE ANN. r. 59C-1.004(1) (1994).

270. *Id.* at r. 59C-1.004(2).

conversion of one type of health care facility to another,²⁷¹ changes in licensed bed capacity,²⁷² establishment of a home health agency or hospice,²⁷³ establishment of inpatient institutional health services,²⁷⁴ acquisition of a facility,²⁷⁵ acquisition of major medical equipment,²⁷⁶ exceeding the approved budget when constructing a facility,²⁷⁷ establishment of tertiary health services,²⁷⁸ and a change in the number of psychiatric or rehabilitation beds.²⁷⁹ In order to obtain a CON, the applicant must follow the administrative rules promulgated by the Agency and involving local health councils.²⁸⁰

a. *Step One: Letter of Intent*

The first step to securing a necessary CON is to file a letter of intent with the Agency and with the local health council for the area in which the project will be located.²⁸¹ "The letter of intent process has become the major hurdle for an applicant to overcome" ²⁸² The

271. *Id.* at r. 59C-1.004(3).

272. *Id.* at r. 59C-1.004(4).

273. *Id.* at r. 59C-1.004(5).

274. *Id.* at r. 59C-1.004(6).

275. *Id.* at r. 59C-1.004(7).

276. *Id.* at r. 59C-1.004(8).

277. *Id.* at r. 59C-1.004(9).

278. *Id.* at r. 59C-1.004(10).

279. *Id.* at r. 59C-1.004(11).

280. See Robert S. Cohen, *Regulatory Agencies*, FLORIDA ADMINISTRATIVE PRACTICE § 7.23, at 7-18 to 7-19 (4th ed. 1993) (a publication of the Florida Bar Continuing Legal Education section). Local health councils play only a small role in certificate of need review.

The Florida Agency for Health Care Administration (AHCA) issues certificates of need. Local health councils develop district plans, advise the agency on health care issues and resource allocations, promote public awareness of community health needs, and collect data and conduct analyses and studies related to health care needs within the district . . . but they do not have the significant role in the approval of certificates of need

Id. § 7.23, at 7-19.

281. FLA. STAT. § 408.039(2)(a) (1993); *Health Care & Retirement Corp. of Am. v. Department of HRS*, 463 So. 2d 1175 (Fla. 1st DCA 1984). The Agency publishes a schedule of deadlines for each particular project category called a "batching cycle," and all letters of intent must be submitted before the batching cycle deadline and the deadline's grace period expire. See FLA. STAT. § 408.039(2) (1993) (deadline); FLA. ADMIN. CODE ANN. r. 59C-1.008(1)(g) (1994) (grace period); *Id.* at r. 59C-1.008(1)(a)1. The application will be rejected if either filing is neglected. *Id.* at r. 59C-1.008(1). The applicant must also publish a "Notice of Filing" within 14 calendar days of the batching cycle deadline. *Id.* at r. 59C-1.008(1)(i).

282. "Before preparing a letter of intent . . . meet[] with the agency, if time permits" Cohen, *supra* note 280, § 7.26, at 7-21; but see *Martin Mem. Hosp. Ass'n v. Department of HRS*, 584 So. 2d 39 (Fla. 4th DCA 1991) (failure to use the precise language mandated by the Agency in the applicant's letter of intent was not fatal). The author does not understand why the filing of a letter of intent has become a major obstacle for those seeking a CON. The statutory requirements are quite clear and the staff of the Agency can provide assistance.

letter of intent must include the legal name, mailing address, and telephone number of the applicant,²⁸³ a specific description of the project,²⁸⁴ proposed capital expenditures,²⁸⁵ the number of beds sought,²⁸⁶ services to be provided,²⁸⁷ type of equipment and method of acquiring that equipment,²⁸⁸ subdistrict location to be served,²⁸⁹ and a certified copy of a resolution of the applicant's Board of Directors authorizing the project.²⁹⁰ No CON can be issued to an applicant that does not properly file an adequate letter of intent.²⁹¹ Even if the letter of intent appears proper and passes initial scrutiny, a flawed letter of intent can cause a winning applicant to lose his CON if challenged in an administrative proceeding.

b. Step Two: Filing of the CON Application

After properly filing a letter of intent, a CON application may be submitted. The CON application must be filed with the Agency and the local health council by the batching cycle deadline and must be submitted in the proper form.²⁹² The required contents for the CON application are enumerated by statute and rule.²⁹³ The practitioner should review successful CON applications before drafting his own.²⁹⁴

283. FLA. ADMIN. CODE ANN. r. 59C-1.008(1)(c)1 (1994). The applicant must also identify entities with controlling interests in the applicant. *See id.*

284. *Id.* at r. 59C-1.008(1)(a).

285. *Id.* at r. 59C-1.008(1)(c)3.

286. *Id.* at r. 59C-1.008(1)(c)4 (if applicable to the type of project proposed).

287. *Id.* at r. 59C-1.008(1)(c)5 (if applicable to the type of project proposed).

288. *Id.* at r. 59C-1.008(1)(c)6 (if applicable to the type of project proposed).

289. *Id.* at r. 59C-1.008(1)(c)7.

290. *Id.* at r. 59C-1.008(1)(e). The resolution must be an original and must include the corporate seal. *See id.* Many other technical requirements apply. *See id.* at rr. 59C-1.008(1)(e)1-1)(e)7; *see also* Humhosco, Inc. v. Department of HRS, 561 So. 2d 388 (Fla. 1st DCA 1990) (denying a certificate of need because the applicant's letter of intent contained an audited financial statement of the applicant's subsidiary and not the applicant); *but see* South Broward Hosp. Dist. v. Department of HRS, 14 F.A.L.R. 3163 (Dep't of HRS 1992) (accepting a Board resolution as complete even though the resolution contained an error with respect to the date).

291. *See* FLA. STAT. ch. 408 (1993).

292. FLA. STAT. § 408.039(3)(a) (1993) (describing the proper format); FLA. ADMIN. CODE ANN. r. 59C-1.010(2)(b) (1994). *See also* Gulf Court Nursing Ctr. v. Department of HRS, 483 So. 2d 700 (Fla. 1st DCA 1986) (holding that after an application is "deemed complete . . . no further application information . . . will be accepted"). *But see* Health Care & Retirement Corp. v. Department of HRS, 516 So. 2d 292 (Fla. 1st DCA 1987) (emphasizing that *Gulf Court* did not address the amendment of an application upon exceptional circumstances or prohibit the presentation of updated current information). Allowing updated and amended applications would be in the public's best interest, considering the length of time needed to obtain successfully a certificate of need and the likelihood of changed circumstances during that time.

293. FLA. STAT. § 408.037 (1993); FLA. ADMIN. CODE ANN. r. 59C-1.008(5) (1994).

294. *Florida Administrative Code* rule 59C-1.024 contains specific guidelines for public access to certificate of need records:

The wise practitioner also includes "letters, testimonials, resolutions, and similar documents to bolster the presentation of [his] case."²⁹⁵

If the Agency determines that the proposed project involves issues of great public importance, then the Agency may hold a public hearing.²⁹⁶ Otherwise, the Agency has sixty days²⁹⁷ to issue a State Agency Action Report (SAAR) and Notice of Intent which will either grant the CON in its entirety, grant a CON for a specific portion of the project, or deny the CON.²⁹⁸ The Agency must publish its proposed decision in the Florida Administrative Weekly within fourteen days after issuing the SAAR and Notice of Intent.²⁹⁹ Any "substantially affected person,"³⁰⁰ within twenty-one days after publication, may request an administrative hearing by filing a petition with the Agency³⁰¹ and serving a copy of the petition on the successful applicant.³⁰² Any applicant denied a certificate of need in the same batching cycle has a right to an administrative hearing if requested within twenty-one days

All applications for certificates of need and written material pertinent to any application are on file with AHCA and are available to the public. The records librarian sets appointments for review of any certificate of need applications and materials and copying services may be arranged for a nominal charge. AHCA is very accessible and will assist members of the public in finding any materials related to letters of intent, applications, or other pertinent materials that have been filed with the agency.

Cohen, *supra* note 280, § 7.27, at 7-22. The author can attest to the accessibility of AHCA's public records and friendly, helpful assistance of the AHCA staff. Special thanks to Gloria Moreno and Todd Henry, who supervise the AHCA's CON applicants' room and file room, and who have spent countless hours helping the author research various certificates of need and other files.

295. *Id.* Choose such documentation wisely. The Agency will consider only statutory criteria in making its decision. See *Florida Med. Ctr. v. Department of HRS*, 463 So. 2d 380 (Fla. 1st DCA 1985) (permitting only evidence relevant to statutory criteria); *Department of HRS v. Johnson & Johnson Home Health Care, Inc.*, 447 So. 2d 361, 363 (Fla. 1st DCA 1984) (requiring "a balanced consideration of all the statutory criteria"); FLA. STAT. § 120.57(1)(b)(9) (Supp. 1994) (requiring the statutory criteria to be supported by competent, substantial evidence).

296. See FLA. STAT. § 408.039(3)(b) (1993) (hearings are held at the Agency's discretion). Representatives from the local health council usually conduct the public hearing in the district where the project is proposed to be located. Cohen, *supra* note 280. Dates and times for public hearings are published in the Florida Administrative Weekly.

297. The 60-day clock starts ticking after the Agency determines all applications in a batching cycle are complete or rejected. See FLA. STAT. § 408.039(4) (1993).

298. *Id.* § 408.039(4)(b).

299. *Id.* § 408.039(4)(c).

300. This term is broadly defined in *Florida Statutes* section 408.039(5)(b) to include any applicant in the same batching cycle whose application was denied so that the successful applicant's proposal could be approved. *Id.* § 408.039(5)(b).

301. *Id.* § 408.039(5)(a). See *Florida Dept. of Transp. v. J.W.C. Co.*, 396 So. 2d 778 (Fla. 1st DCA 1981) (requiring *de novo* review at administrative hearings); *accord*, *Beverly Enter.-Fla., Inc. v. Department of HRS*, 573 So. 2d 19 (Fla. 1st DCA 1990) (requiring *de novo* review at administrative hearings involving certificates of need).

302. FLA. ADMIN. CODE ANN. r. 59C-1.012 (1994).

of the Agency's publication of its decision.³⁰³ Hearings are held in Tallahassee, Florida unless a change in venue will facilitate the proceedings.³⁰⁴

B. Florida's Managed Competition Laws

As the preceding discussion illustrates, Florida's CON laws are typical of those found in most states. Florida is atypical, however, in its commitment to adopt a managed competition health care strategy. Today in Florida, managed competition is slowly becoming a reality. In 1993, Florida's legislature responded to the plight of 2.5 million uninsured Floridians³⁰⁵ by making Florida the first state to adopt a managed competition health care strategy.³⁰⁶ The enacting law is dubbed the "Health Care and Insurance Reform Act of 1993."³⁰⁷ In order to understand how certificate of need laws will conflict with Florida's managed competition plan, a summary of Florida's managed competition system is presented.³⁰⁸

1. Managed Competition As Implemented in Florida

It is the intent of the [Florida] Legislature that a structured health care competition model, known as "managed competition," be

303. FLA. STAT. § 408.039(5)(a) (1993). See also *Bio-Medical Applics. v. Department of HRS*, 370 So. 2d 19 (Fla. 2d DCA 1979) (applying the ruling of *Ashbacker Radio Corp. v. FCC*, 326 U.S. 327 (1945), that the grant of one of two mutually exclusive applications for administrative approval without a hearing on both deprives the losing applicant of due process of law); *accord*, *Sarasota Cty. Pub. Hosp. Bd. v. Department of HRS*, 553 So. 2d 189 (Fla. 2d DCA 1989). Failure properly to request the hearing within 21 days results in a waiver of the right to a hearing. FLA. STAT. § 408.039(5)(a) (1993); *Inverness Conval. Ctr. v. Department of HRS*, 541 So. 2d 677 (Fla. 1st DCA 1989).

304. See FLA. STAT. § 408.039(5)(b) (1993); TRAWICK, *FLORIDA PRACTICE & PROCEDURE* § 5-2 (1995). A hearing officer will preside over a formal administrative hearing at the Division of Administrative Hearings (DOAH) on Apalachee Parkway in Tallahassee, pursuant to section 120.57(1) of the *Florida Statutes*. See generally 1 FLA. JUR. 2D, *Administrative Law* (1979 and 1995 pocket part); cf. FLA. STAT. § 120.57(2) (Supp. 1994) (permitting an informal administrative hearing before the Agency in certain circumstances). At the administrative hearing, the applicant always bears the burden of proof. *NME Hosps. v. Department of HRS*, 492 So. 2d 379 (Fla. 1st DCA 1985). The Florida Evidence code provides guidance, but is not binding. EHRHARDT, *FLORIDA EVIDENCE* § 103 (1995). The "rules of the game" at the administrative hearing can be shockingly different from those at the courthouse, requiring the guidance of an attorney well-versed in "administrative litigation."

305. FLA. STAT. § 408.90 (1993).

306. Sandra P. Greenblatt & Michael J. Cherniga, *New Florida Health Reform Plan Is First Large-Scale Test of Clinton's Managed Competition Theory*, 10 no.6 HEALTHSPAN 7 (1993).

307. 1993, Fla. Laws ch. 93-129.

308. Few published works adequately describe Florida's statutory scheme of health care administration. For the best discussions available, see Justice Miner's dissent in *Albertson's, Inc. v. Department of Prof. Reg.*, 20 Fla. L. Weekly (D)1603 (Fla. 1st DCA July 11, 1995) and FLA. ACHA ATLAS, *supra* note 145, at 25-33.

implemented The managed competition model will promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of health inflation in health care costs.³⁰⁹

This preamble to Florida's Health Care and Insurance Reform Act of 1993 is the guiding intent for Florida's Agency for Health Care Administration, which is charged with implementing the rules and regulations to create a managed competition health care marketplace in Florida.³¹⁰ The Agency calls Florida's new health care strategy "a voluntary, market-based managed competition model."³¹¹

a. Florida's Health Boards and Alliances

In the Florida model, Accountable Health Partnerships, or AHPs,³¹² will perform the role of governmental alliances,³¹³ and Community Health Care Purchasing Alliances, or CHPAs,³¹⁴ will perform the role of governmental health boards.³¹⁵ An AHP is defined as "an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services."³¹⁶ A CHPA is defined as a "state-chartered, nonprofit organization that provides member-purchasing services and detailed information to its members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with [AHPs]."³¹⁷

A CHPA, therefore, is a group purchasing mechanism.³¹⁸ An AHP is the entity that actually delivers health services to CHPA members.³¹⁹ AHPs may be created by health care providers, HMOs, or health insurers, so long as licensing and competency requirements are

309. 1993 Florida Health Care and Insurance Reform Act, FLA. STAT. § 408.70(2) (1993).

310. See FLA. STAT. § 408.704 (1993).

311. FLA. AHCA ATLAS, *supra* note 145, at 27.

312. *Id.* at 26.

313. See *supra* part III.A.; FLA. ADMIN. CODE ANN. ch. 59D-2 (1995).

314. FLA. AHCA ATLAS, *supra* note 145, at 27; FLA. STAT. §§ 408.701-.705 (1993) (establishing CHPAs and defining their use). In Florida vernacular, this acronym is pronounced "chip-ah."

315. See *supra* part III.A.; FLA. ADMIN. CODE ANN. ch. 59D-1 (1995).

316. FLA. STAT. § 408.701(1) (1993).

317. *Id.* § 408.701(6).

318. *Accord, Albertson's*, 20 Fla. L. Weekly at (D)1604 (Miner, J., dissenting). "Each CHPA is co-terminus with one of the eleven health service planning districts" and is "designed to insure access to high quality, affordable health care for all Floridians without regard to place of residence and at the lowest possible cost." *Id.*

319. *Id.*

met.³²⁰ CHPA membership is voluntary,³²¹ but all CHPA members must purchase their health care services from an approved AHP.

Florida's AHPs are required to use managed care procedures for containing costs, including utilization management,³²² HEDIS-style monitoring,³²³ and monitoring of access,³²⁴ grievances,³²⁵ and outcomes.³²⁶ AHPs must contract in advance with providers in order to obtain health care services at the lowest price, because only the AHP with the lowest, adequate response to a CHPA's request for proposal will be awarded the right to provide health care to individuals residing in the AHP's geographical area.³²⁷

b. Florida's Managed Competition Private Health Plans

Various managed care companies will perform the role of private health plans,³²⁸ including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), and point-of-service plans.³²⁹ Florida will also offer "pure indemnity plans," which are the equivalent of third party fee-for-service insurance plans.³³⁰

c. Rough Beginnings: The Difficulty in Implementation, the Likelihood of Failure, and the Questionable Constitutionality of Florida's Managed Competition

Implementing managed competition in Florida is proving to be a slow process. During the 1994 legislative session, only one managed care bill became law.³³¹ Likewise, the 1995 regular session passed only one managed care bill, and the passage of additional managed care bills in a special session appears doubtful.

Some predict that Florida's managed competition, as currently being implemented, is doomed to failure.³³² The characteristic cited by

320. See FLA. STAT. § 408.706(2) (Supp. 1994).

321. *Id.* § 408.702(6) (1993).

322. *Id.* § 408.706(2)(d) (Supp. 1994).

323. *Id.* § 408.706(2)(e).

324. *Id.* § 408.706(2)(g).

325. *Id.* § 408.706(2)(h).

326. *Id.* § 408.706(2)(i).

327. FLA. AHCA ATLAS, *supra* note 145, at 32-33.

328. See *supra* part III.A.

329. FLA. AHCA ATLAS, *supra* note 145, at 27.

330. See *id.*; See also discussion *supra* part II.B.1.b.i (defining fee-for-service and identifying associated problems).

331. 1994, Fla. Laws ch. 94-96.

332. See FLA. AHCA ATLAS, *supra* note 145, at 28-30. AHCA identifies "the theorists" at the Jackson Hole Group as among those predicting failure. *Id.* at 29; see also *supra* note 145 and accompanying text (identifying the Jackson Hole Group).

those who predict failure is that Florida will not require small employers to purchase coverage through the CHPAs and will not require that employers or individuals purchase health insurance.³³³ Due to this characteristic, Florida's CHPAs "cannot bear any risk or make adjustments to compensate for risk between plans."³³⁴

The Legislature, as well as finding difficulty in passing managed competition laws, may also encounter difficulty in drafting managed competition laws that withstand constitutional attack. In *Albertson's, Inc. v. Department of Professional Regulation*,³³⁵ the District Court of Appeal affirmed the trial court's determination that part of the Florida Health Care and Insurance Reform Act of 1993 violates the Commerce Clause of the United States Constitution.³³⁶ The unconstitutional provision³³⁷ of the Act involved the legislation's attempt to allow Florida small business pharmacies, or "independent" pharmacies, to sell prescriptions to CHPA members even though the "independent" pharmacies were not affiliated with an approved AHP.³³⁸ This "independent" exception was intended to benefit only the smallest of small businesses, and therefore did not apply to businesses owning more than twelve Florida pharmacies or owning any non-Florida pharmacies.³³⁹ The exclusion of non-Florida pharmacies was found on its face to place an impermissible burden on interstate commerce, but the exclusion of businesses owning more than twelve Florida pharmacies was facially upheld.³⁴⁰

Albertson's illustrates the difficulty of implementing managed competition on a state rather than national level. Managed competition attempts to lower health care costs by affecting who enters the marketplace and on what terms.³⁴¹ State managed competition laws will

333. FLA. AHCA ATLAS, *supra* note 145, at 27-28.

334. *Id.* at 29.

335. 20 Fla. L. Weekly (D)1603 (Fla. 1st DCA July 11, 1995).

336. *Id.*

337. FLA. STAT. § 408.706(10) (1993).

338. *Albertson's*, 20 Fla. L. Weekly at (D)1603.

339. *Id.* The "independent" exception was limited by defining "independent pharmacy" to mean

a pharmacy facility which is not part of a group of affiliated pharmacy facilities which are under common ownership directly or indirectly in which the group has greater than 12 pharmacy facilities in the state or has directly or indirectly any interest in any facilities licensed under another state's laws for the purpose of providing prescribed medicine services

FLA. STAT. § 408.706(10) (1993) (emphasis added). The emphasized portion was stricken as violative of the federal Commerce Clause.

340. 20 Fla. L. Weekly at (D)1603. "Plaintiffs present a facial attack . . . only. Plaintiffs do not allege that section 408.706(10) is unconstitutional as applied" *Id.*

341. *See supra* part IV.

therefore inevitably have a substantial effect on interstate commerce. *Albertson's* is an elementary case foreshadowing more difficult cases in which state-managed competition laws will be alleged to be unconstitutional as applied to a given plaintiff. In those future cases, a state's managed competition law will survive only if the law is narrowly drawn to cause only an incidental effect on interstate commerce.³⁴² The theory of managed competition, however, is not narrowly drawn. The more areas of commerce that managed competition can affect, the more effective managed competition becomes. *Albertson's* suggests that, although state legislatures can proceed far down the path toward managed competition, federal legislation may ultimately be needed in order to enact completely the managed competition system.

2. *Florida's Certificate of Need Statutes Cannot Co-Exist with Managed Competition*

The Florida Legislature faces delays and problems in implementing managed competition, but has nevertheless succeeded in implementing more managed competition reform than any other state legislature.³⁴³ However, gravely looming on Florida's horizon is the problem of managed competition's conflict with Florida's CON laws. As Florida's Agency for Health Care Administration grudgingly acknowledges, the goals of managed competition in Florida are indistinguishable from the goals of CON:

It was not until 1993, however, when the Legislature passed the Health Care and Insurance Reform Act that a major issue about the continuation of the CON program emerged. The managed competition model adopted by the 1993 Legislature is intended to accomplish many of the same objectives as the CON program.³⁴⁴

The Agency is correct in stating that Florida's managed competition model is intended to accomplish the same goals as CON. For example, managed competition is designed to "control the rate of inflation in health care costs,"³⁴⁵ while CON is designed to "[e]valuate the availability of more cost-effective service alternatives" and "[p]revent

342. See 20 Fla. L. Weekly at (D)1604 (citing *Lewis v. BT Inv. Managers, Inc.*, 447 U.S. 27, 37 (1980) and *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970)).

343. See generally Greenblatt & Cherniga, *supra* note 306 (describing how Florida leads the nation in managed competition reform); FLA. AHCA ATLAS, *supra* note 145 (indicating how few states have implemented managed competition).

344. FLA. AHCA ATLAS, *supra* note 145, at 189.

345. FLA. STAT. § 408.70(2) (1993).

unnecessary hospital capital expenditures.”³⁴⁶ Managed competition will “reward providers for high-quality, economical care,”³⁴⁷ while CON will “[s]elect providers with a proven quality of care record.”³⁴⁸ Managed competition should “increase access to care for uninsured persons,”³⁴⁹ while CON should “[p]rovide access by predicated CON approval on serving indigent and other underserved persons.”³⁵⁰ Florida’s managed competition laws, therefore, will be designed to achieve the same goals as Florida’s CON laws. The only difference will be in the means to the end,³⁵¹ and, as history has proven, the means chosen by CON laws are ineffective.³⁵²

a. Florida Has No Need for Certificates of Need Under Managed Competition

The Florida Legislature must do more than merely note the Agency’s acknowledgment that CON and managed competition have the same goals. The Legislature must recognize that CON is unnecessary under managed competition, and that the reasons and rationale justifying CON no longer exist.³⁵³

CHPAs create market incentives to restrain health care costs adequately by acting as powerful purchasers who have the market clout to demand lower prices. CHPAs can achieve this effect by choosing AHPs via requests for proposals.³⁵⁴ The request for proposal is a formal method for soliciting bids from AHPs which contain detailed financial and service statements and allow CHPAs to evaluate AHPs on equal terms.³⁵⁵ To win a bid, an AHP must cut costs at every possible level, while still proving its ability to provide the necessary care to CHPA members.³⁵⁶ The CHPA therefore creates the incentive to restrain health care costs.

346. FLA. AHCA ATLAS, *supra* note 145, at 189 (identifying “Certificate of Need Program Objectives”).

347. FLA. STAT. § 408.70(2) (1993).

348. FLA. AHCA ATLAS, *supra* note 145, at 189.

349. FLA. STAT. § 408.70(2) (1993).

350. FLA. AHCA ATLAS, *supra* note 145, at 189.

351. Managed competition laws will act by means of “promot[ing] the pooling of purchaser and consumer buying power [and ensuring] informed cost conscious consumer choice of managed care plans.” FLA. STAT. § 408.70(2) (1993). Certificate of need laws act by means of “[e]valuat[ing] the impact of new providers on existing providers” and “[a]void[ing] duplication of expensive health care services.” FLA. AHCA ATLAS, *supra* note 145, at 189.

352. See *supra* part II.B.2.

353. See *supra* part IV.

354. See FLA. AHCA ATLAS, *supra* note 145, at 33-34 (discussing requests for proposals).

355. *Id.* at 33; see also FLA. ADMIN. CODE ANN. ch. 59C (1994).

356. See generally FLA. ADMIN. CODE ANN. r. 59D (1994) (awarding the bid to the best bidder).

AHPs also restrain health care costs. By statute, the AHP is required to use HEDIS-style monitoring, utilization management, and other cost-containment methods prevalent in the managed care companies.³⁵⁷ By necessity, the AHP will seek to use prospective payment plans, so that a given service will cost only a maximum amount.³⁵⁸ The AHP will use the best characteristics of managed care companies to obtain the lowest-priced health care.

b. Florida's Certificate of Need Laws Threaten the Success of Managed Competition

CON is therefore unnecessary under managed competition as implemented in Florida. More importantly, the perpetuation of CON threatens the success of managed competition.³⁵⁹ One essential element of managed competition is *competition*. CON thwarts competition by legally excluding competitors.³⁶⁰

Another essential element of Florida's managed competition system is the CHPA.³⁶¹ CON laws shelter the owners of a CON from the price-cutting demands of a CHPA. The CHPA must provide all necessary health care to CHPA members in its geographic area³⁶² and, if a CON allows only a select few health care facilities to serve that geographic area, then the CHPA will have to contract with those CON owners regardless of the price. Without CON, new providers could emerge to serve the CHPA's target population at a lower price than established providers.³⁶³ With CON, no new providers can emerge, leaving the CHPA forced to purchase from the established providers.³⁶⁴ A CHPA's purpose—to negotiate for the lowest-priced health care services—is impossible when CON laws are allowed to restrict the entry of providers into the marketplace.

Yet another essential element of Florida's managed competition system is the AHP.³⁶⁵ CON laws limit the options available when creating an AHP. The AHP which wins the right to provide service to CHPA members is the cheapest AHP able to perform the task adequately and competently.³⁶⁶ In order to perform adequately and competently, the

357. See *supra* notes 322-26.

358. See *supra* part III.

359. See *supra* part IV.

360. See Budetti, *supra* note 48, at 44.

361. See *supra* part V.B.1.a.

362. See *supra* part V.B.1.a.

363. See *supra* part IV.

364. See *supra* part IV.

365. See *supra* part V.B.1.a.

366. See *supra* part V.B.1.a.

AHP must provide facilities and services for every possible health care need.³⁶⁷ Therefore, the AHP will inevitably find itself negotiating for services which are regulated by CON. In those service areas, freedom of choice is gone: a bureaucratic system has already selected which provider will be permitted to serve a given area. The AHP does not get to select among many providers and therefore demand the lowest price. The role of the AHP—to select the most able and cost-effective health care provider—has been usurped by the bureaucratic CON process.

Florida's managed competition system is threatened by CON. Competition is the antithesis of a CON marketplace. A CHPA's role as negotiator is impossible if CON limits the number of market entrants with which to negotiate. An AHP's role of selecting the most able and cost-effective provider is commandeered by the CON process. The Florida Legislature must repeal CON to ensure the success of the managed competition reforms.

3. *The Difficult Task of Repealing Florida's Certificate of Need Laws*

Repealing CON in Florida is more easily said than done.³⁶⁸ This year's attempt to repeal CON evidences that fact.

During the Florida Legislature's 1995 regular session, the Senate Committee on Health Care sponsored a bill to repeal CON.³⁶⁹ The Committee's goal in eliminating all CON regulation was to hear from all affected groups and to keep only the CON regulations found to be absolutely essential.³⁷⁰ Apparently the affected groups did not like the idea of repealing CON, because the Committee's bill was replaced by a committee substitute³⁷¹ which only "removes certain health care projects from the certificate-of-need review requirements . . ."³⁷² Even this bill was replaced by a second committee substitute³⁷³ that only "modifies certain licensure requirements applicable to hospitals and

367. See *supra* part V.B.1.a.

368. The author thanks Wanda Carter, Legislative Analyst for the Florida Senate Committee on Health Care, for providing valuable research assistance regarding the 1995 attempt to repeal CON.

369. Fla. S. Comm. on Health Care, PCB 1780 (filed March 9, 1995); see also Fla. S. Comm. on Health Care, PCB 1780 (1995) Staff Analysis 1 (March 9, 1995) (on file with comm.).

370. Interview with Wanda Carter, Legislative Analyst for the Fla. S. Comm. on Health Care, in Tallahassee, Fla. (July 28, 1995).

371. Fla. S. Comm. on Health Care, PCS/SB 1780 (filed March 27, 1995).

372. Fla. S. Comm. on Health Care, PCS/SB 1780 (1995) Staff Analysis 1 (March 27, 1995) (on file with comm.).

373. Fla. S. Comm. on Health Care, Revised PCS/SB 1780 (filed April 24, 1995).

ambulatory surgical centers”³⁷⁴ The final bill that passed the Committee made no mention of repealing CON.³⁷⁵ On May 11, 1995, the bill died in the Ways and Means Committee.

The Senator or Representative who next proposes to repeal CON will evidently face an uphill battle. However, as CON begins to affect managed competition reforms adversely, the uphill battle may eventually be won.

VI. CONCLUSION

CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation’s health care costs. Nevertheless, CON persists in thirty-eight states, including Florida. These states are finding that the reasons and rationale justifying CON no longer exist under a managed competition health care strategy. Managed competition creates market incentives to restrain health care costs adequately by promoting a managerial role for managed care companies. Managed competition creates adequate incentives to prevent the unnecessary duplication of health care costs because purchase costs are internalized, competition is based on price and quality, physicians have little or no effect on supply, and the “Roemer Effect” no longer affects demand. Managed competition even fosters equal access to health care at a reasonable cost by providing governmental alliances with the power to negotiate on behalf of the disadvantaged.

CON has historically failed to control health care costs, yet the new managed competition model is likely to succeed. However, the perpetuation of CON threatens the success of managed competition. States should therefore repeal their outdated CON laws when implementing the managed competition health care strategy. Out with the old health care reforms; in with the new.

374. Fla. S. Comm. on Health Care, Revised PCS/SB 1780 (1995) Staff Analysis 1 (April 24, 1995) (on file with comm.).

375. See Fla. SB 1780 (1995).