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REGULATION OF HEALTH FACILITIES AND SERVICES BY "CERTIFICATE OF NEED"

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THE high and rising cost of health care, particularly the spiralling of hospital costs at a rate six percent per year above the rate of inflation generally,¹ has prompted numerous proposals to improve the economic performance of the health care system.² These proposals would take such diverse approaches to cost control as rejuvenation of the market as a mechanism for controlling the cost and utilization of health services; requiring components of the health care system, perhaps organized on a regional basis, to operate with fixed annual budgets; or direct regulation, perhaps by adapting traditional public utility regulation for hospitals. To date, the chief manifestation of regulatory cost-control techniques has been a pronounced trend toward the enactment of so-called "certificate-of-need" laws in the states.

Flowing in part from experience with community and regional health planning but also incorporating an important element of public utility regulation, certificate-of-need laws place extensive regulatory controls on entry into the health services industry and on new investments in health care facilities. These controls take the form of a requirement for a prior administrative determination that a public need for additional

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¹ M. FELDMAN, *THE RISING COST OF HOSPITAL CARE* 10-13 (1971).

² Cost inflation is one of two essential dimensions of the so-called health care "crisis." The other is the inaccessibility to some citizens of good quality medical care, due to either geographic or financial barriers. Cost inflation exacerbates the accessibility problem, however, and deters congressional action on national health insurance, the chief means of mitigating financial barriers.

facilities or services exists. Twenty states enacted some kind of certificate-of-need law in the 1971-73 legislative sessions, and, although North Carolina recently repealed its law in the wake of a court decision declaring it unconstitutional,³ twenty-three states now have such laws.⁴ Federal

³ Ch. 113 [1973] N.C. Sess. Laws, *repealing* N.C. GEN. STAT. §§ 90-289 to -291 (Supp. 1973). In *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973), the North Carolina Supreme Court ruled that the regulatory scheme violated substantive due process guarantees of N.C. CONST. art. I, § 19. Following such earlier decisions as *Roller v. Allen*, 245 N.C. 516, 96 S.E.2d 851 (1957), and *State v. Harris*, 216 N.C. 746, 6 S.E.2d 854 (1940), and such repudiated federal precedents as *New State Ice Co. v. Liebman*, 285 U.S. 262 (1932), the court found that the law's potential for public benefit did not justify the deprivation of the certificate-of-need applicant's liberty to engage in a lawful business. Although mentioning the need to spread the "overhead cost" of vacant hospital beds, the court gave no other evidence of understanding that many of the costs of excess hospital capacity are borne publicly rather than privately, as in other industries. See text accompanying notes 50-60 *infra*. Thus, the court viewed the legislation as primarily protectionist in character (see note 77 *infra*) and therefore also violative of a constitutional provision against monopolies. N.C. CONST. art. I, § 34. The court distinguished franchising of public utilities, permitted in North Carolina, on the ground that utility rate regulation protects the public against the evils of monopoly, thus suggesting that it would not be troubled by public utility regulation of hospitals which entailed entry restrictions indistinguishable from the certificate-of-need requirement.

It seems unlikely that courts in other states, even if they apply the same balancing standard, will agree with the North Carolina court on the unconstitutionality of hospital certificate-of-need laws. See *Attoma v. State Dept. of Social Welfare*, 26 App. Div. 2d 12, 18, 270 N.Y.S.2d 167, 171 (1966); Paulsen, *The Persistence of Substantive Due Process in the States*, 34 MINN. L. REV. 91 (1950); Stuve, *The Less-Restrictive-Alternative Principle and Economic Due Process*, 80 HARV. L. REV. 1463 (1967). Indeed, even this Article, which is relatively unsympathetic to such laws, makes them out to be no worse than unwise legislative attempts to deal with a substantial public problem. As to the laws' applicability to nonhospital facilities, however, the Article takes a somewhat less tolerant view, with possible constitutional implications. See note 96 *infra* and accompanying text, and compare text accompanying notes 221-32 *infra*.

Other constitutional arguments against certificate-of-need laws have focused on the delegation of legislative powers, either because of the indefiniteness of standards for the determination of "need" or because the delegation runs to nongovernmental planning agencies. As to the vagueness of the standard, local law will again govern, but such terms as "need" and the "public interest" have usually been accepted as adequate standards in regulatory statutes. See, e.g., *Federal Radio Comm'n v. Nelson Bros. Bond & Mortgage Co.*, 289 U.S. 266 (1933). This Article later advocates greater definiteness as a means of reducing the political dimension of the regulatory program, however, see text accompanying notes 125-127 *infra*, and a state court might well conclude that either the legislature or the administering agency does indeed have an obligation to declare clear policies. See *In re Application of Point Pleasant Hosp.*, No. A-64-72 (N.J. Super. Ct., App. Div. 1972). Cf. *People v. Dobbs Ferry Medical Pavillion, Inc.*, 40 App. Div. 2d 324, 340 N.Y.S.2d 108 (1973). On delegation to nongovernmental agencies, see *Simon v. Cameron*, 337 F. Supp. 1380 (C.D. Cal. 1970). See also note 109 *infra*.

⁴ ARIZ. REV. STAT. ANN. §§ 36-401 to -402, -421, -428 (Supp. 1972); CAL. HEALTH &

legislation adopted in late 1972 may foster continuation of the trend to certificate-of-need requirements by underwriting the states' administrative costs.⁵

The enacted certificate-of-need laws⁶ are far from uniform, but all except Oklahoma's, which covers only nursing homes, require need certification for new hospital construction. Most also cover construction of new nursing-care facilities⁷ and the expansion of the bed capacity⁸ and

SAFETY CODE §§ 437.7 to 438.7, 1331-32, (West, Supp. 1973); 66 COLO. REV. STAT. ANN. art. 41 (1973); No. 73-117 [1973] Conn. General Acts (1973 CONN. LEG. SERVICE 151 (1973)); FLA. STAT. ANN. §§ 381.493-.497 (Supp. 1972); KAN. STAT. ANN. §§ 65-2a01 to -2a14 (1972); KY. REV. STAT. ANN. §§ 216.405-.485 (Supp. 1973); MD. ANN. CODE art. 43, § 559 (Supp. 1972); MASS. GEN. LAWS ANN. ch. 111, §§ 25B, 25C (Supp. 1972); MICH. COMP. LAWS §§ 331.451-.462 (Supp. 1973); MINN. STAT. ANN. §§ 145.71-.83 (Supp. 1973); NEV. REV. STAT. §§ 439A.010-.100 (Supp. 1971); N.J. STAT. ANN. §§ 26:2H-1 to -26 (Supp. 1973); N.Y. PUB. HEALTH LAW §§ 2800 to 2801-a, 2801-c to 2802 (McKinney Supp. 1972); N.D. CENT. CODE §§ 23-17.2-01 to -15 (Supp. 1971); OKLA. STAT. tit. 63, §§ 1-851 to -860 (1971); ORE. REV. STAT. §§ 441.090, -.095 (1971); R.I. GEN. LAWS ANN. §§ 23-16-2, -12 (Supp. 1972); S.C. CODE ANN. §§ 32-761 to -786 (Supp. 1971); S. D. COMPILED LAWS ANN. §§ 34-7A-1 to -21 (1972); ch. 257, [1973] Tenn. Pub. Acts; 419 VA. CODE ANN. §§ 32-211.3 to -211.16 (Supp. 1973); WASH. REV. CODE §§ 70.38.010 to .900 (Supp. 1972).

⁵ Social Security Amendments of 1972, 42 U.S.C. § 1320A-1 (Supp. 1973).

⁶ The 23 statutory references appear in note 4 *supra*. Notes 7-16 *infra* refer only to the 23 states without further citation of the laws themselves. Because of ambiguities and wide variations in the laws, generalizations about a group of states may not always be equally accurate for each. Definitive regulations have not yet been available in many cases and could alter the statutes' constructions. Earlier surveys of the laws appear in Curran, *National Survey and Analysis of Certification-of-Need Laws: Health Planning and Regulation in State Legislatures, 1972*, in AMERICAN ENTERPRISE INSTITUTE, REGULATING HEALTH FACILITIES CONSTRUCTION: PROCEEDINGS OF A CONFERENCE ON HEALTH PLANNING, CERTIFICATES OF NEED, AND MARKET ENTRY (C. Havighurst ed.) (1973 forthcoming) [hereinafter cited as AEI PROCEEDINGS]. Page references to the AEI PROCEEDINGS are not yet available and will be omitted in future citations.

⁷ The only exceptions are Michigan, Oregon, and Rhode Island.

⁸ Over half the states refer to bed expansion expressly. Colorado, Minnesota, Rhode Island, and Tennessee specify a minimum capital expenditure on new beds before the certification requirement applies, and Colorado also allows up to a 10 percent increase in beds without approval. Massachusetts allows four beds or a 10 percent increase, whichever is less. The Maryland law clearly covers only new or relocated hospitals and nursing homes, but regulations purport to expand coverage to bed expansion and other things. Md. State Dep't of Health and Mental Hygiene, Regulations Governing Determination of Conformance to Comprehensive Health Plan for Hospitals and Non-Profit Related Institutions §§ 10.07.02(F)(3), (4) (1972) [hereinafter cited as Md. Regs.].

physical plant⁹ of existing hospitals and nursing-care institutions.¹⁰ Many of the laws extend as well to all substantial expansions of hospital services¹¹ and to investments of more than a specified amount in new equipment.¹² About half of the laws cover free-standing outpatient facilities as well as hospitals, with the result that ambulatory surgical facilities

⁹ Formulations include references to "capital expenditure," "construction," "expansion," "alteration," "modification," "major modernization," and "change." Colorado, Kentucky, Minnesota, Nevada, Oregon, and Tennessee add that the expansion must also have a certain purpose or effect, and several states allow at least certain types of expenditures up to a fixed amount without approval. *E.g.*, Connecticut (\$25,000, with a more elaborate procedure above \$100,000); Kansas (the lesser of \$350,000 or five percent of annual operating expenses); Massachusetts (\$100,000); South Dakota (\$50,000). New York's law distinguishes between "establishment" of a new facility and "construction" of added facilities, prescribing different procedures in the two cases. Here again, the narrow Maryland law has been interpreted expansively. *See* Md. Regs., *supra* note 8, §§ 10.07.02(F) (5), (6).

¹⁰ Again, the Michigan, Oregon, and Rhode Island laws cover hospitals but not nursing homes, and Oklahoma only covers nursing homes.

¹¹ All 23 states except Kansas, Michigan (which covers a "change in function" of facilities), New York, Oklahoma, and Washington appear to cover all substantial expansions. However, California (though mentioning "creation or expansion of new areas of service") requires certification only where a service change would change the institution's licensing category. Several states impose, by statute or regulation, a dollar minimum below which expenditures on service changes need not be approved. Only Connecticut, Massachusetts, New Jersey, Oregon, and Tennessee differentiate between the institution of a new hospital service and expansion of existing services, covering only the former. A few states set a certification requirement that combines various criteria. Thus, Colorado requires an expenditure above \$100,000 which also produces a change either in service or in licensure category, and Minnesota and Tennessee require certification where a capital expenditure exceeds a certain amount and also expands service offerings or increases the bed count. Maryland's regulations once again overreach the statute. Md. Regs., *supra* note 8, §§ 10.07.2(F) (2), (5). Florida may also have done so by asserting authority over expansions irrespective of dollar minimum, apparently in reliance on the "legislative intent" section of the law. Florida Bureau of Comprehensive Health Planning, Rules and Regulations Governing the Certificate of Need, ¶ B.1.d. (1973) [hereinafter cited as Fla. Regs.]. In Washington, although the declaration of policy in the preamble of the statute contemplates a certification requirement for new hospital services, the operative provisions do not reach services per se. In New York, service changes require approval and a change in the institution's "operating certificate," but there is no clear statutory authority for withholding such approval on the basis of the public's needs or impact on other facilities. *See* 10 N.Y.C.R.R. § 701.3 (1973).

¹² In most states, investments in new equipment would be included as service changes, *see* note 11 *supra*, or as plant improvements, *see* note 9 *supra*. Equipment is expressly mentioned in about half the statutes, and dollar minimums are frequently specified below which approval is not required. Replacement equipment is excluded, expressly or otherwise, in Colorado (if "consistent with . . . planning"), Connecticut, Kentucky, and Massachusetts (up to a \$100,000 capital expenditure in each case), and in Arizona, Michigan, South Carolina, and Tennessee.

(surgicenters) and clinics operated by group practices and health maintenance organizations (HMOs) may require approval,¹³ though no law yet extends to the individual practitioner's place of business.¹⁴ Proponents of certification of need usually argue for giving the laws maximum scope so that the health planners' authority will extend to any material alteration in available services,¹⁵ and, in this spirit, several laws require approval of major cutbacks in services as well as expansion.¹⁶ Although the laws differ widely in scope and regulatory mechanics,¹⁷ the variations do not obscure the central fact that the regulation imposed differs in kind from customary health and safety regulation in the health care system.

Despite the popularity of certificate-of-need laws, it is appropriate to inquire whether there is a realistic basis for expecting desirable results from introducing such regulatory controls in the market for health services. Moreover, certificate-of-need laws offer an opportunity for assessing generally the view held by some that comprehensive economic regulation following the public utility model can make the health care system function acceptably. An appraisal of the efficacy of certificate-of-need laws and of proposed similar regulatory efforts in health care

¹³ See notes 221-32 *infra* and accompanying text.

¹⁴ But cf. note 56 *infra*.

¹⁵ E.g., CUITAN, *supra* note 6; AMERICAN HOSPITAL ASSOCIATION, GUIDELINES FOR IMPLEMENTATION OF CERTIFICATION OF NEED FOR HEALTH CARE FACILITIES AND SERVICES (1972) [hereinafter cited as AHA GUIDELINES]; American Hospital Association, Suggested Model Legislation for Implementation of State Certification of Need, Nov. 15, 1972 (mimeo., draft) [hereinafter cited as AHA Model Legislation]. This predilection may produce regulations and practices which exceed statutory authorizations, suggesting that challenges might be successful. See notes 8, 9, and 11 *supra* and note 16 *infra*. Maryland's Comprehensive Health Planning Agency relies on an opinion of an Assistant Attorney General for its broad assertion of authority. Letter from Louis E. Schmidt to Dr. Eugene H. Guthrie, June 9, 1970.

¹⁶ Arizona, Florida, Maryland, South Carolina, and Virginia require certification before contracting the number of hospital beds, nursing-care beds, or hospital services rendered. California and Oregon require certification only when the cutback will result in a change in the institution's licensing category. The Kentucky statute reaches only reductions in bed capacity, not in services. In New York, approval of cutbacks is required as part of changing the institution's operating certificate, 10 N.Y.C.R.R. §§ 701.3(a), (e), and, although need is not explicitly a factor, it is probably considered. See also note 11 *supra*. Maryland has again acted without statutory authority, Md. Regs., *supra* note 8, §§ 10.07.02(F)(2)-(5), and the Florida law has been stretched to cover cutbacks on the debatable strength of a declaration of legislative intent regarding "scope" of services. Fla. Regs., *supra* note 11, at ¶ B.1.d. The Massachusetts provision, on the other hand, covering any "substantial change in service," has been administered to impose no certification requirement for the reduction of bed capacity or service.

¹⁷ See text accompanying notes at 98-133 *infra*.

can best proceed by considering not only the limited experience to date with need certification but also the strength and implications of the analogy between the health care industry, as regulated under certificate-of-need laws, and other regulated industries. Undertaking such an appraisal, this Article suggests that administrative certification of need is unlikely to be appreciably effective in achieving cost-control objectives because of the practically unavoidable slippage involved in translating a persuasive rationale for regulation into a workable regulatory program. Further, it warns that inflationary pressures may, like a balloon, bulge out at another place even if growth in one direction is effectively prevented. Finally, it argues that the laws' limited benefits may be obtainable only at the cost of repressing useful market forces, particularly those which call forth badly needed innovations and stimulate efficiency. Despite these basically negative conclusions, the Article offers some suggestions for drafting a certificate-of-need law which might produce net benefits in spite of my skepticism. Possibly more important, however, in view of the advanced state of the trend toward enactment of certificate-of-need laws, the discussion should also be helpful in revealing traps to be avoided in administering an existing law.¹⁸

I. THE BACKGROUND OF CERTIFICATE-OF-NEED LAWS

A. *Origins in Voluntary Health Planning*

Certificate-of-need laws have their roots in the methods and institutions of health planning, which began as community efforts to organize philanthropic priorities in the hospital sector.¹⁹ As the federal government began to contribute funds for hospital development, it was logical to adapt the planning mechanisms which had facilitated private philanthropy to the task of allocating public resources. Thus, the federal Hill-Burton legislation of 1946, providing federal subsidies for hospital con-

¹⁸ Unfortunately, space does not permit detailed examination of one important dimension of the argument over certificate-of-need laws, namely the viability of the various alternative means of dealing with the problems which the laws address. Thus, at the risk of seeming less than constructive in largely confining myself to criticism of proposed regulatory ventures, I will suggest only the nature of other measures which might be finally preferred. It may be helpful to disclose, however, that I have not yet despaired, as many purport to have done, of engineering a workable market-oriented solution to the problem of allocating resources to health care. Cf. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716 (1970).

¹⁹ See Gottlieb, *A Brief History of Health Planning in the United States*, in AEI PROCEEDINGS, *supra* note 6.

struction,²⁰ contemplated consulting planners in the affected communities, many of them working under nongovernmental auspices, in order to identify needs. Some local planners also found it possible to cooperate with local Blue Cross plans, so that only approved new facilities were deemed eligible for cost reimbursement covering depreciation and interest on capital obligations. While statistical evidence of the utility of such planning has been hard to come by,²¹ the prevailing view is that voluntary planning has occasionally succeeded very well, particularly where it was backed by sources of financing. The success achieved was insufficient, however, to forestall pressure for de-emphasizing voluntariness and adding compulsion.

In helping communities to identify their most urgent health needs and to meet them by cooperative and consensual development, health planning agencies have also served to simplify the hospitals' problems by curbing 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).²² The cartel characterization need not be read pejoratively, however, since agreements among competitors can, in some industry settings, be quite useful in preventing unnecessary duplication of facilities and other wasteful side effects of competition.²³ Even

²⁰ Hospital Survey and Construction Act of 1946, 60 STAT. 1040 (codified in scattered sections of 24, 42 U.S.C.).

²¹ See D. BROWN, *Evaluation of Health Planning*, in CENTER FOR HEALTH ADMINISTRATION STUDIES, UNIVERSITY OF CHICAGO SELECTED PAPERS ON HEALTH PLANNING, HEALTH ADMINISTRATION PERSPECTIVES No. A8, at 29 (1969): "Although the planners pointed to many kinds of specific results to illustrate their successes, the achievement considered to be most important is an established ongoing planning process." *Id.* at 28.

²² D. BROWN, *The Process of Areawide Health Planning: Model for the Future?*, 11 MED. CARE 1, 3 (1973), describes areawide hospital planning as "a process of blended provider interests," implying its desirability. For a scathing analysis consistent with the cartel characterization, see HEALTH POLICY ADVISORY CENTER (HEALTH-PAC), *THE AMERICAN HEALTH EMPIRE: POWER, PROFITS AND POLITICS* 191-231 (1971).

²³ P. AREEDA, *ANTITRUST ANALYSIS* 186-92 (1967). The nonprofit character of most hospitals may make the cartel characterization of their concerted action seem inappropriate. Nevertheless, nonprofit enterprises probably do not differ greatly in their behavior from professionally managed for-profit firms, both seeking growth as the primary source of managerial gratification. Under conditions of reasonable prosperity, management of either type of organization is constrained only partially by the need to show an acceptable relation between costs and revenues. Compare generally W. NISKANEN, *BUREAUCRACY AND REPRESENTATIVE GOVERNMENT* (1971) (treating nonprofit organizations as "bureaus"), with R. MARRIS, *THE ECONOMIC THEORY OF MANAGERIAL CAP-*

though cartels have been outlawed in other industries, special considerations, such as the impact of third-party payment and the prevalence of nonprofit firms, might dictate dispensation for cartel-like behavior in the hospital industry.

Voluntary health planning failed to achieve its promise for the same reason that cartels usually founder—that is, the self-interest of the participants tended to take precedence whenever an opportunity for institutional aggrandizement presented itself.²⁴ Not only were the hospitals themselves given to self-serving activity despite their eleemosynary status, but certain sponsoring groups, particularly prideful communities and religious, fraternal, and labor organizations, very often chose to go their own way. Even though the Hill-Burton program controlled an important source of funds, hospitals which were denied support could often raise the needed money from other sources.²⁵ Thus, private philanthropy was often influenced more by institutional and community leadership than by the planners, and broadening health insurance coverage frequently enabled hospitals to accumulate surpluses or assured future revenues to an extent which made borrowing increasingly feasible. Logic appeared to point to the conclusion that, because neither pure voluntarism nor partial control over the various purse strings resulted in adequate effectuation of the planners' directives, "teeth" were essential to make health facilities planning effective. The pattern was similar to that in any cartel, where sanctions against uncooperative members, preferably governmentally imposed, are essential if the plan is not to break down.

TALISM (1964). Nonprofit hospitals sometimes "distribute" profits in the form of perquisites to—or lucrative business contracts with enterprises controlled by—trustees, managers, or controlling physicians. See, e.g., Kessler, *The Hospital Business*, Washington Post, Oct. 29-Nov. 3, 1972, at 1 each day, reprinted in 119 Cong. Rec. H188-H204 (daily ed. Jan. 11, 1973). See also *Sonora Community Hosp.*, 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968). Moreover, it has been shown that, under the demand conditions of a seller's market, hospitals' costs tend to rise so that their prices seem to behave not too differently from those of for-profit firms. Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECON. REV. 853 (1971). If the excess earnings of nonprofit hospitals are used to supply more or better services and are not wasted in overpayments or invested improperly, there is no reason to object to them, on distributive grounds, as monopoly profits and perhaps no reason to condemn cartel practices which produce them.

²⁴ See Gottlieb, *supra* note 19.

²⁵ On the sources of funds for hospital construction, see Kotelchuck, *How to Build a Hospital*, HEALTH-PAC BULL. 1 (May 1972). The Hill-Burton program provided only 13 percent of the total funds required for voluntary hospital construction from 1946 to 1967. *Id.* at 1.

The movement for health planning with teeth began in the late 1950s²⁶ but grew slowly. New York's Metcalf-McCloskey Act of 1964,²⁷ providing for mandatory need determinations prior to hospital and nursing home construction, was the first substantive development. The next states to adopt the certificate-of-need approach were Maryland, Rhode Island, California, and Connecticut in 1968 and 1969. In 1968, the American Hospital Association (AHA), in response to increasing public concern about rapidly rising hospital costs, first indicated its membership's acceptance of facilities planning using the certificate-of-need model. Since 1968, the AHA has come to assign a higher priority to adoption of this regulatory model,²⁸ and the recent legislative activity clearly reflects the hospital industry's increased lobbying efforts. The AHA has proposed a draft of a model state law;²⁹ and its proposal for a national health care policy, embodied in the so-called Ullman bill,³⁰ reflects its acceptance of an even higher degree of regulation.

B. The Federal Government and Health Planning

Since the Comprehensive Health Planning Act, the federal government has moved gradually toward strengthening reliance on local health planning. Most recently, the Social Security Amendments of 1972 provide that state health facilities planning can be backed up by a denial of Medicare and other federal reimbursement of the capital costs (primarily interest and depreciation) of unapproved facilities.³¹ This provision takes the form of authorizing federal contracting with cooperating states for planning services, which would be rendered through existing planning agencies with the federal government paying the full cost. Although some savings in the health care expenditures of the federal government are probably expected, Congress's chief purpose was to assure that federal financing policy was consistent with the policy of encouraging facilities planning in the states.³²

²⁶ See, e.g., R. Brown, *Let the Public Control Through Planning*, 33 HOSPITALS 34 (1959).

²⁷ Metcalf-McCloskey Act of 1964, ch. 730, [1964] N.Y. Laws 1883 (codified in scattered sections of N.Y. PUB. HEALTH LAW, McKinney 1971).

²⁸ See AHA GUIDELINES, *supra* note 15.

²⁹ AHA Model Legislation, *supra* note 15.

³⁰ H.R. 1, 93d Cong., 1st Sess. (1973).

³¹ 42 U.S.C. § 1320A-1 (Supp. 1973); Proposed Regulations, 38 Fed. Reg. 20994 (1973).

³² S. REP. NO. 92-1230, 92d Cong., 2d Sess. 185 (1972).

The 1972 legislation may provide a further impetus for enactment of certificate-of-need laws, primarily by lowering the state's cost of administration. It is quite possible, however, for states to contract to provide the federal government with the desired planning services without enacting any specific legislation or supplying sanctions other than the federal leverage.³³ Nevertheless, the federal initiative by itself will probably fail to give state or local health planning decisions sufficient impact to obviate more substantial sanctions. The penalty of withholding an interest and depreciation component from payments under Medicare, Medicaid, and maternal and child health programs is a relatively weak sanction, particularly since providers can control the number of federal beneficiaries whom they serve and can bill Medicare beneficiaries for any unpaid excess. On the other hand, if the local Blue Cross plan has also agreed to reflect the planners' decisions in its reimbursement practices, considerable control over hospital facilities will have been achieved.³⁴

Of course, the federal government could take more substantial steps.³⁵ In 1972, for example, the Nixon administration proposed legislation to deny federal payments altogether for services rendered in facilities unapproved by planners.³⁶ The more comprehensive of the various health policy proposals before Congress also bear on planning, the AHA's pro-

³³ See, e.g., Mississippi Division of Comprehensive Health Planning, Federal Certificate of Need Program Review and Recommendation Procedures (April 11, 1973). In many communities, zoning decisions necessary for hospital construction have taken need into account, supplying another form of planning sanction.

³⁴ As of November 1972, some 24 Blue Cross Plans had added conformance clauses to either their contract or brochures, stating in effect that reimbursement to member hospitals would be conditional upon evidence of compliance with appropriate local planning agencies. The various clauses . . . range from a simple statement of principle to a more detailed schedule of conditions that would mean a limitation of reimbursement.

It should also be noted that eight of these states also have an enacted certification-of-need law.

American Hospital Association, AHA Planning Bulletin, April 1973, at 10 (No. 73-1, mimeo.). Continued pressure for certificate-of-need laws in states where both federal and Blue Cross payments are effectively controlled by the planners appears to reflect primarily a desire to curb competitive developments which would substitute ambulatory for inpatient care. See text accompanying notes 221-32 *infra*.

³⁵ See Address by Elliot L. Richardson, Secretary of HEW before the Institute of Medicine, in Washington, D.C., May 10, 1972. This speech is a broad endorsement of health planning.

³⁶ HOUSE COMM. ON WAYS AND MEANS, AMENDMENTS TO THE ADMINISTRATION'S NATIONAL HEALTH INSURANCE PARTNERSHIP ACT, H. DOC. NO. 782-6, 92d Cong., 2d Sess. (1972).

gram being the most far-reaching in its endorsement of planning-cum-regulation at the state level. The Kennedy-Griffiths proposed Health Security Act would embody a requirement that all new or enlarged health facilities be certified as needed by a state or federal agency.³⁷

Enthusiasm for health planning may be waning somewhat at the federal level, however, as hospital and other costs apparently remain out of control even in areas where facilities planning has seemed reasonably effective. Pleas from many planners for increased appropriations and power—either direct decision-making responsibility or, as many planners seem to prefer, an influential advisory role³⁸—have been met merely by a one-year extension of the Comprehensive Health Planning Act through June 1974.³⁹ Although Congress may eventually enact a national health insurance program, it seems likely that such action must await a firmer judgment as to whether regulation, the market, or some combination of the two is adequate to contain the inflationary impact of a new infusion of demand.⁴⁰

C. *A Possible First Step Toward Public Utility Regulation of Hospitals*

Tracing the threads of certificate-of-need laws back through past health planning efforts may imply that they are the culmination of a movement, finally bringing reason to health facilities development by giving the planners needed "teeth." But from another point of view they seem merely a step down the much longer road to comprehensive economic regulation of the hospital industry as a public utility. The signs of a trend in this direction are unmistakable.

Certificate-of-need laws establish entry controls which are similar in intent and impact to the certificate-of-public-convenience-and-necessity device widely employed in public utility and common carrier regulation. Moreover, the utility regulation model has been explicitly adopted by some observers of the hospital scene⁴¹ and is embodied in the AHA-

³⁷ S.3, 93d Cong., 1st Sess. §§ 53, 89 (1973).

³⁸ See note 186 *infra*.

³⁹ Pub. L. No. 93-45, § 106 (June 18, 1973).

⁴⁰ At the same time inquiries concerning experience with certificate-of-need laws and comprehensive planning have recently been commissioned by the Department of Health, Education, and Welfare in anticipation of an ultimate decision on the workability of planning-cum-regulation and other variations on the planning model as mechanisms for controlling health care costs.

⁴¹ See, e.g., A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 2-6, 204-08 (1969); R. BROWN, *supra* note 26; Somers, *Toward a Rational Community Health Care System: The Hunterdon Model*, 54 HOSPITAL PROGRESS 46 (1973); Epstein, *Rele-*

backed Ullman bill.⁴² A number of states have implemented hospital rate regulation,⁴³ and the federal wage and price control program, which in "Phase III" preserved controls over the health sector while lifting most others,⁴⁴ contains the seeds of permanent price regulation. The idea of "franchising" hospitals by assigning them specific area and service responsibilities analogous to the obligations of public utilities and common carriers is also increasingly popular, particularly as the veto power supplied under certificate-of-need laws proves an insufficient tool for affirmatively influencing developments.⁴⁵ Various mechanisms for regulating the quality of service have also been proposed. The sum of these various regulatory measures, in being or proposed, would be traditional public utility regulation.⁴⁶

Restrictions on market entry are the type of economic regulation which has been most widely criticized for pernicious effects in other fields.⁴⁷ Since certificate-of-need laws prevent a new firm's entry or an existing firm's expansion except upon demonstration of a public "need" for the new service, they are similar to the laws governing admission to a wide range of regulated industries, including banking, for-hire transportation, generation and distribution of electricity, consumer credit, and communications. But in view of what is widely regarded as unsatisfactory experience with economic regulation, it becomes important to

vance of the Public Utility Concept to the Health Care Industry, HOSPITAL FORUM, Sept., 1972, at 12; Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 LAW & CONTEMP. PROB. 839 (1970).

⁴² The AHA appears to be attracted by the argument that the North Carolina statute recently ruled unconstitutional, see note 3 *supra*, would have been saved had utility-type rate regulation also been provided for. See Attachment to Memorandum from William L. Casady, Director, AHA Division of Planning, Aug. 24, 1973 [hereinafter cited as Casady Memo].

⁴³ ARIZ. REV. STAT. ANN. §§ 36-346 to -436.03 (Supp. 1973); Conn. Pub. Act No. 73-117 (1973 CONN. LEGIS. SERVICE 151); MD. ANN. CODE art. 43, §§ 568H-X (Supp. 1972); MASS. GEN. LAWS ANN. ch. 7, §§ 30K-P (1973); N.J. STAT. ANN. §§ 26:2H-1 to -26 (Supp. 1973); N. Y. PUB. HEALTH LAW § 807 (McKinney Supp. 1972); ch. 5 [1973] Wash. Laws, 43d Legis., 1st Extraord. Sess. (1973 WASH. LEGIS. SERVICE 404). The Connecticut, Maryland, New Jersey, and Washington laws come closest to embodying the public utility model. For proposals along a similar line, see Pennsylvania Senate Bill No. 863 (May 29, 1973); WISCONSIN GOVERNOR'S HEALTH PLANNING & POLICY TASK FORCE, FINAL REPORT (1972). See also ch. 837 [1973] Ore. Sess. Laws.

⁴⁴ See 6 C.F.R. §§ 130.60-.62 (1973).

⁴⁵ See, e.g., INTERNATIONAL HEALTH ADVISORY COUNCIL *et al.*, MANAGEMENT MEMORANDUM ON HOSPITAL FRANCHISING (1973) [hereinafter cited as HOSPITAL FRANCHISING].

⁴⁶ 1 A. KAHN, THE ECONOMICS OF REGULATION: PRINCIPLES AND INSTITUTIONS 3, 10 (1970).

⁴⁷ See note 49 *infra*.

inquire whether certificate-of-need proponents have carefully examined the ramifications of their proposals.⁴⁸

II. THE RATIONALE FOR CERTIFICATE-OF-NEED LAWS

The arguments offered for certificate-of-need laws are highly persuasive on their face. Indeed, they are considerably stronger in theory than the rationales offered to justify regulatory restrictions on entry and expansion in other industries.⁴⁹ They originate in demonstrable market failures attributable to the manner in which health care is paid for, the control which providers exert over demand for health care, and the incentives affecting both consumption and investment decisions. As measures to correct the very real problems of overinvestment in, and overconsumption of, health services, certificate-of-need laws have earned many adherents.

It is important to recognize at the outset, however, that, whatever their merits, certificate-of-need laws are an attempt to deal merely with symptoms rather than root causes. This may be surprising since their origin in health planning, a calling with some scientific pretensions, might suggest a "systems" approach to the total health care crisis and a

⁴⁸ The AHA did consult Professor A.J.G. Priest, a well-known expert in public utility law but one who tends to accept the fact of regulation uncritically. Compare Priest, *supra* note 41, with the approach taken in this Article and in Posner, *Natural Monopoly and Its Regulation*, 21 STAN. L. REV. 548 (1969), and other references herein.

⁴⁹ On the perceived need for entry restriction in so-called natural-monopoly industries (to protect revenues needed for internal subsidization), see note 78 *infra* and accompanying text. In potentially competitive industries, entry controls may be viewed with even greater skepticism because of their necessary effect of depriving consumers of the benefits, and sparing producers the hardships of competition. See, e.g., R. CAVES, *AIR TRANSPORT AND ITS REGULATORS* 169-76, 192-231 (1962); L. SCHWARTZ, *FREE ENTERPRISE AND ECONOMIC ORGANIZATION: ANTITRUST AND REGULATORY CONTROLS* ch. 4 (4th ed. 1972); Jordan, *Producer Protection, Prior Market Structure and the Effects of Government Regulation*, 15 J. LAW & ECON. 151 (1972); Kitch, Isaacson & Kasper, *The Regulation of Taxicabs in Chicago*, 14 J. LAW & ECON. 285 (1971); Kreps, *Modernizing Banking Regulation*, 31 LAW & CONTEMP. PROB. 648 (1968); Nelson, *The Effects of Entry Controls in Surface Transport*, in NAT'L BUREAU ECON. RESEARCH, *TRANSPORTATION ECONOMICS* 381 (1965). Even the case for controlling entry into broadcasting, which is premised on the technical problems involved in getting maximum use from the electromagnetic spectrum, has been questioned. Coase, *The Federal Communications Commission*, 2 J. LAW & ECON. 1 (1959). See also Johnson, *Towers of Babel: The Chaos in Radio Spectrum Utilization and Allocation*, 34 LAW & CONTEMP. PROB. 505 (1969). The broadcasting case aside, the case for the entry restrictions in certificate-of-need laws appears to be the strongest by far, being based on objective considerations—third-party payment and provider control of demand—which seem to negate serious hopes for satisfactory market responses.

commitment to solving it in the most fundamental and efficient way. The arguments for certificate-of-need laws—and indeed the foundations of health planning itself—imply the continued predominance of financing mechanisms which encourage inefficiency both by guaranteeing recovery of costs, no matter how great, and by externalizing the costs of doctors' and patients' consumption decisions. Such exclusive reliance on health insurance and other types of third-party payment is not inevitable, nor must its impact necessarily continue to be as pernicious as it has been under existing payment systems. 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 which create the problems to which they are addressed.

A. Third-Party Payment and Facilities Duplication

The broad consensus on the need for restraining hospital facilities construction flows in large measure from the circumstance that the health care crisis is characterized at least as much by surplus as by shortage. An oversupply of health facilities, particularly hospital beds, exists in many areas,⁵⁰ and worrisome shortages occur only where the population is too small or too poor to support the provision of adequate services and where public subsidies have been insufficient. In other industries, overcapacity usually does not qualify as a "crisis" except for the producers themselves, who are seldom able to persuade the government to assert a public interest in their plight.⁵¹ In health care, however, several institutional factors raise the problem of excess capacity to the level of legitimate public concern, by causing the costs of excess health facilities to be borne in large measure by the public rather than by the affected industry itself. Moreover, the excess capacity, rather than remaining idle, may be put

⁵⁰ As the argument is developed, oversupply does not take only the form of empty beds, although occupancy rates are declining. *MEDICAL WORLD NEWS*, June 16, 1972, at 14; *AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 1971*, 13 (1972) (showing decline from a high of 78.8 percent in 1969 to 76.7 percent in 1971 for nonfederal short-term general and other special hospitals). Excessive hospital utilization by patients who do not require such expensive care is the big problem. See notes 54-60 *infra* and accompanying text. For a recent and persuasive presentation of the oversupply problem and the conventional wisdom concerning it, see Cohn, *Our Unplanned Hospitals*, *Washington Post*, Aug. 26-31, 1973.

⁵¹ Exceptions to this exist, of course, most notably in farming and in industries affected by sudden increases in foreign competition. See also 2 KAHN, *supra* note 46, at 173-76, on the "ruinous competition" argument.

to inappropriate uses, giving rise to additional, noncapital costs which the public may also bear.

By far the most important factors occasioning entry and construction controls are the frequency of "third-party" payment for medical care—that is, by government, insurers, and Blue Cross-Blue Shield service plans—and the "cost-plus" character of these payments. Government programs and Blue Cross almost invariably pay hospitals on the basis of their costs.⁵² Commercial insurers usually pay on the basis of charges rather than cost but often impose a top limit, over which the patient must pay the excess. In reality, because charges are not set under competitive conditions, they never fall below cost as fixed by Medicare and Blue Cross.

Because cost accounting under reimbursement formulas occasions much negotiation, third-party payments for some services frequently include some of the costs of other services, with the result that the public rather than the hospitals may absorb the costs of excess capacity. For example, a hospital can usually expect its revenues from inpatient care to cover its full costs at less than 100 percent occupancy, since third-party payers are willing to pay something toward the maintenance of empty beds in order that the hospital can meet peak demands. Some hypothetical occupancy rate will therefore be adopted for cost-reimbursement purposes and will be negotiable to some degree.⁵³ Furthermore, negotiations will usually result in at least some costs of unremunerative services being borne by the third-party payers, though increasing cost-consciousness has toughened bargaining in this regard in recent years. Under this payment system, the public pays the full cost of all occupied and many unoccupied hospital beds and of many unremunerative or underutilized services, either through taxation, in the case of public programs, or through health insurance premiums. The hospital, on the other hand, is partially relieved of its concern that the price for its services will fall below cost—as it would in a competitive market characterized by overcapacity. Only when the hospital's vacancy rate or the cost of its underutilized services rises above what it can persuade third-

⁵² See Sigmond, *How Should Blue Cross Reimburse Hospitals? "Costs!"*, MODERN HOSPITAL, July, 1963, at 91; TeKolste, *How Should Blue Cross Reimburse Hospitals? "Charges!"*, MODERN HOSPITAL, July, 1963, at 90 (reporting on Indiana Blue Cross).

⁵³ For example, recent changes in Medicare policy allow fixing of maximum acceptable costs for standby facilities, among other things. 42 U.S.C. § 1320a-1 (Supp. 1973). New York assumes at least a 60 percent occupancy rate for maternity units, even though many hospitals have lower rates.

party payers to incorporate in the reimbursement formula are losses from excess capacity borne by the hospital rather than the public.

Why cannot third-party payers be relied upon not to subsidize hospital beds which are truly unnecessary? Putting aside the case of Blue Cross plans, which as creatures of the hospitals in varying degrees may tend to favor provider over consumer interests, insurers and government probably could prevent excess capacity were it not for the control which hospitals can apparently exercise over their own occupancy. 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 decisions⁵⁴ and, where insurance is present, may even prefer to consume more hospitalization than is appropriate. Even making allowances for the fact that on marginal cost principles an empty bed can be filled at a relatively low additional cost⁵⁵ so that higher utilization rates are economically appropriate, the effect on the total cost of care borne by the public can be considerable. Thus, there is some validity in the widely accepted notion that overbedding breeds overutilization, though this expression overstates the point by implying that the economic decision to fill an empty bed is the same as the decision to build it. The significant point is that the cost of extra beds, including the added variable costs incurred in their use, is borne by the public, and hospitals are therefore insufficiently deterred from unnecessary construction.

Although the supply of health services, and particularly hospital beds,⁵⁶ does appear to generate new demand and thus increased utilization and

⁵⁴ But see FELDSTEIN, *supra* note 1, at 28-29 (discussing how "decisions are to an important extent made jointly"); M. Feldstein, *Econometric Studies of Health Economics*, 8-11, April, 1973 (Discussion Paper No. 291, Harvard Institute of Economic Research) [hereinafter cited as Feldstein, *Econometric Studies*].

⁵⁵ It is widely accepted that an empty stand-by bed costs about two-thirds as much as an occupied one. See, e.g., MEDICAL WORLD NEWS, June 16, 1972, at 14. This implies that a bed, *once it is in being*, should be used if the value of hospitalization to the patient is at least one-third the total cost to the hospital.

⁵⁶ Although the argument is pushed hardest with respect to hospital beds, it probably applies equally to physicians' services. See V. FUCHS & M. KRAMER, DETERMINANTS OF EXPENDITURES FOR PHYSICIANS' SERVICES IN THE UNITED STATES 1948-68 (DHEW Pub. No. (HSM) 73-3013, 1972). There is, for example, good evidence that the amount of surgery done is in large measure determined by the number of surgeons available. Bunker, *Surgical Manpower: A Comparison of Operations and Surgeons in the United States and in England and Wales*, 282 N. ENG. J. MED. 135 (1970). Moreover, 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. See Feldstein, *The Rising Price of Physicians' Services*, 52 Rev. of

higher costs—the so-called “Roemer effect”⁵⁷—the nature and strength of this effect may be debated. Some 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.”⁵⁸ Because most observers have been primarily intent on establishing the existence of the effect, they have given little attention to assessing its limitations.⁵⁹ For example, it is clear that hospitals cannot continue to fill new beds indefinitely, and it thus appears that the seriousness of the policy problem presented by the Roemer effect depends on whether it is strong or weak in fact. Although assessment of such an effect is extremely difficult, Martin Feldstein has estimated as “a reasonable first approximation” that about half of the impact of new hospital beds is felt in an outward shift of the demand curve—that is, the creation of new demand—and that the other half of the impact appears in a fall in price.⁶⁰ It is probably appropriate to conclude that the Roemer effect, although frequently exaggerated, is nevertheless real.

The foregoing paragraphs state the essence of the main argument for hospital certificate-of-need laws, and it is quite powerful. It says that the mechanism of third-party payment based on cost reimbursement,

ECON. & STATISTICS 121 (1970); Monsma, *Marginal Revenue and the Demand for Physicians' Services*, in EMPIRICAL STUDIES IN HEALTH ECONOMICS 145 (H. Klarman ed. 1970) [hereinafter cited as EMPIRICAL STUDIES]. It is striking, therefore, that the nation is embarked on a crash program to educate more doctors while seeking to control facilities development. One distinction is that facilities, unlike physicians, have a fixed location and may be easily compared to local needs. Presumably the increased supply of physicians is expected to spill over into underserved rural areas and urban ghettos, but this is likely to occur only after a great deal of new demand and costs have been generated. If the current educational programs do for physician manpower what the Hill-Burton program has helped to do for hospitals, doctors' services and offices may eventually be subjected to the equivalent of certificate-of-need requirements. Professional groups, which would like to resist expansion of the supply of physicians, are in the awkward position of not wanting to make their most persuasive argument—namely, that doctors influence the demand for their services.

⁵⁷ The responsiveness of demand to bed supply was first noted in M. ROEMER & M. SHAIN, *HOSPITAL UTILIZATION UNDER INSURANCE* (AHA Hospital Monograph Series No. 6, 1959); see also Roemer & Shain, *Hospital Costs Relate to the Supply of Beds*, MODERN HOSPITAL, April 1959, at 71. For a review of subsequent literature, see Klarman, *Approaches to Moderating the Increases in Medical Care Costs*, 7 MED. CARE 175, 177-79 (1969). See also Feldstein, *Econometric Studies*, *supra* note 54, at 19-22.

⁵⁸ G. ROSENTHAL, *HOSPITAL UTILIZATION IN THE UNITED STATES* (1964).

⁵⁹ See Klarman, *Some Technical Problems in Areawide Planning for Hospital Care*, 17 J. CHRONIC DISEASES 735, 742-43 (1964).

⁶⁰ Feldstein, *supra* note 23, at 865. One would expect that the ratio between the two impacts would vary depending on how nearly exhausted were the opportunities for demand creation.

when coupled with utilization decisions, results in externalization of much of the business risk involved in creating excess capacity. In other sectors of the economy, a firm would not construct new capacity leading to oversupply and depressed prices unless it had some confidence in its greater efficiency and its ability quickly to eliminate an inefficient competitor. A strong market deterrent to the creation of excess capacity thus appears except where efficiency gains are likely. The analogous deterrent in the hospital industry seems weaker than one would like.

Interest in certificate-of-need laws has increased recently in part because various factors have combined to reduce hospital occupancy rates⁶¹ and make overcapacity more apparent. Although physicians and patients seem to have responded to substantially higher hospital prices as classical market theory says they should—by reducing consumption⁶²—newly effective regulatory controls on utilization may better explain the development. Whatever the reason, doctors seem somewhat more aware of costs and of possibilities for reducing hospital stays. In these circumstances, the Roemer effect—and, with it, the case for certificate-of-need laws—may be weakening.

B. Decision Making in Hospitals

Incentives in Nonprofit Enterprises

Another dimension of the argument for certificate-of-need laws focuses specifically on nonprofit, including public, hospitals and their lesser responsiveness to market incentives in their investment and other decisions. Such institutions are excessively concerned with institutional size and prestige—reflected in the quantity and technical sophistication of the care rendered—and the concomitant material and other benefits accruing to their managers, trustees, or sponsors. Indeed, a reasonable behavioral premise is that managers of nonprofit firms seek to maximize the size and budgets of their organizations within the constraint that revenues must cover costs,⁶³ leading in some circumstances to output much greater than

⁶¹ See note 50 *supra*.

⁶² In spite of health insurance, demand for hospital care still responds to price changes. See Feldstein, *Econometric Studies*, *supra* note 54, at 12-19.

⁶³ See *id.* at 24-30 (emphasizing that a model of the nonprofit firm lacks the "predictive power" of a model of a profit-maximizing firm); Davis, *Economic Theories of Behavior in Nonprofit Private Hospitals*, *ECON. & BUS. BULL.* (Winter 1972), at 1; Pauly, *The Behavior of Nonprofit Hospital Monopolies: Alternative Models of the Hospital*, in *AEI PROCEEDINGS*, *supra* note 6.

is socially optimal.⁶⁴ Moreover, philanthropy and income in excess of expenses frequently flow into the voluntary hospital without regard to actual need for new investment, and yet these funds cannot be distributed or invested in other than health-related activities. Seldom does the institution demonstrate concern outside its immediate geographic area, and, even if its ostensible allegiance is to the community at large and not to a particular sponsoring religious or fraternal organization, it may be inclined nevertheless to perceive its constituency in socio-economic terms or along racial lines.⁶⁵ For these reasons, the nonprofit hospital's choice of investments will often be primarily responsive to neither profit opportunities, which may signal unmet private needs, nor the welfare of the community's neediest residents.

A further factor exacerbating the problem of overcapacity in the hospital industry has been the inability of the market, as currently organized, to induce nonprofit hospitals to close down beds or to go out of business altogether once they have been replaced by more efficient or better located facilities.⁶⁶ Those responsible for making such decisions are simply unlikely to vote themselves out of jobs or prestigious positions as long as they can meet the payroll, even at the expense of recoverable capital.⁶⁷

⁶⁴ A recent theoretical treatment of the economic behavior of nonprofit organizations uses the budget-maximizing postulate and strongly invites application to the hospital context. W. NISKANEN, *supra* note 23, at 81-86, 102-04. The hospital appears to be in some degree both a "discriminating monopolist" and a "bureau with a passive sponsor" (i.e., Blue Cross and other third-party payers) in Niskanen's terminology, and it does in fact sell its services "at a [net] price [to the user] less than the marginal cost." *Id.* at 85. Under certain assumptions, either type of organization in its pure form "will supply a higher output which, given constant marginal costs, is twice that of a competitive industry." *Id.* at 86.

⁶⁵ There is some evidence that nonprofit firms may be more inclined than owner-managed for-profit concerns to practice racial, religious, and sex discrimination even if it proves more costly, because the managers indulge their preferences at the organization's expense. See Alchian & Kessel, *Competition, Monopoly, and the Pursuit of Money*, in NATIONAL BUREAU OF ECONOMIC RESEARCH, ASPECTS OF LABOR ECONOMICS, SPECIAL CONFERENCE SERIES No. 14, at 157 (1962). Complaints about hospitals' performance in these respects are registered in HEALTH-PAC, *supra* note 22.

⁶⁶ Compare Carr, *Economic Efficiency in the Allocation of Hospital Resources: Central Planning vs. Evolutionary Development*, in EMPIRICAL STUDIES, *supra* note 56, at 195, 212 ("The . . . results support the hypothesis that the survivorship principle is operative."), with Rothenberg, *Comment*, in EMPIRICAL STUDIES, *supra* note 56, at 222.

⁶⁷ A for-profit firm will stay in business only as long as it can earn its out-of-pocket costs plus at least a market rate of return on that portion of its capital which it could recover by liquidating; its other capital investment is "lost" already and does not influence its decisions. Managers of a nonprofit firm might have no concern for capital at all, liquidating only when its cash flow was inadequate to continue. Although a hospital's liquidation value may often be small, the importance of the slow-exit phenomenon

Although some hospitals have reconstituted themselves as nursing homes or have relocated to follow population shifts, such opportunities are not always available, or attractive, to managers. The obsolete nonprofit firm, unnaturally sustained by cost reimbursement, unable either to liquidate for the benefit of its owners or managers or to direct its capital to activities unrelated to health care, and inaccessible to takeover bids,⁶⁸ imposes a costly burden on society by its relative permanence. It is far from clear, however, that entry controls which protect such obsolete facilities against new competition are the appropriate social response to this problem.⁶⁹

The Role of Doctors

Competition among hospitals for doctors also explains a great deal of duplicative investment, perhaps not in beds so much as in exotic equipment which duplicates underused facilities at nearby institutions.⁷⁰ Hospitals compete more actively for doctors than for patients, since the former have more to say than the latter about hospital use. Since doctors do not pay for the use of the hospital and usually have no reason for concern over their patients' bills, competing hospitals seek to provide services and facilities which make the doctors' practices more lucrative but which are paid for by third-party payers. The resulting equipment duplication resembles that of the airlines industry, where regulated fares have diverted competitive efforts to other areas. Competition among airlines has been vigorous in scheduling, up-to-date equipment, and amenities, but airplanes fly nearly half empty and the cost of service on busy routes is probably half again what it would be if price competition were allowed.⁷¹ Hospitals, too, have a "747" problem arising from the absence

would appear sharply when an HMO, seeking to acquire hospital facilities in a community, finds itself rebuffed by hospitals whose performance seems less than marginal by usual commercial standards. See text accompanying notes 215, 254 *infra*.

⁶⁸ See MARRIS, *supra* note 23, at 29-30.

⁶⁹ See text accompanying note 254 *infra*.

⁷⁰ For example, such competition might lead hospitals to procure such expensive items as radioisotope therapy equipment and open-heart surgery facilities.

⁷¹ W. JORDAN, AIRLINE REGULATION IN AMERICA: EFFECTS AND IMPERFECTIONS ch. 5 (1970), uses intrastate fares in California, which escape CAB regulation, to prove the effect of CAB policies. See also Keeler, *Airline Regulation and Market Performance*, 3 BELL J. ECON. & MGT. SCI. 399 (1972); Levine, *Is Regulation Necessary? California Air Transportation and National Regulatory Policy*, 74 YALE L.J. 1416 (1965). On the effect of restrictions on price competition on airline equipment purchases, see JORDAN, *supra*, at 36-49, 53-56, 230-33; Phillips, *Air Transportation in the United States*, in TECHNOLOGICAL CHANGE IN REGULATED INDUSTRIES 123, 156-60 (W. Capron ed. 1971).

of price competition—strong competitive pressure to invest excessively in the latest technology even though the market for it is thin.

Even where geographic dispersion or other factors weaken the competitive pressure to attract doctors, the organized medical staff will still exercise considerable influence over trustees' investment decisions.⁷² Too often, the doctors will select projects on the basis of convenience or potential fees, and their calculations of net benefits will not include all the institution's costs and may contemplate inappropriate utilization.

C. Quality of Care and Economies of Scale

The tendency of hospitals, under competitive pressure or pressure from their medical staffs, to acquire sophisticated treatment facilities also has an important quality dimension which certificate-of-need laws are thought to address. Where a surgical team performs an operation only rarely, its success rate may be significantly lower than it should be.⁷³ Similarly, the skills necessary to use certain modern equipment efficiently may not be available or may be maintainable in no more than a few centers. Any effort to maintain additional facilities may spread and underutilize the talent, leading to poorer medical outcomes in each location. Moreover, certain backup equipment may be helpful but too expensive unless the volume of procedures benefitting from it is substantial.

These various considerations reflect the presence of economies of scale in the delivery of certain kinds of specialized care. These economies may sometimes be unattainable by the market if consumers lack the knowledge necessary to penalize providers for poor success ratios. Of course, these problems might be addressed by malpractice suits,⁷⁴ by a "no-fault" system of provider-financed compensation for bad results,⁷⁵ or by improving the information available to consumers.⁷⁶ Nevertheless,

⁷² See Pauly & Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973).

⁷³ See AEI PROCEEDINGS, *supra* note 6 (remarks of Calabresi and Stickel).

⁷⁴ See generally REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (Dep't of HEW Pub. No. (OS) 73-88, 1973).

⁷⁵ See Havighurst & Tancredi, "Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance," 51 MILBANK MEMORIAL FUND Q./HEALTH & SOCIETY 125 (1973); Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1973).

⁷⁶ Although it would violate the medical profession's precepts, there is much to recommend disclosure of the presence and value of equipment and experienced manpower and perhaps even the mortality experience of particular providers. *But cf.* Havighurst & Tancredi, *supra* note 75, at 131.

certificate-of-need laws may also be employed to permit realization of scale economies. If consumers are unable to assess performance of a service well enough to force producers to strive for the optimal level of quality, regulation may be an appropriate means of permitting quality-related scale economies to materialize.

D. "Cream-Skimming"

Another line of argument in support of certificate-of-need laws is not much employed by their proponents in theoretical discussions, though it appears to be commonly used in selling the idea to legislators and hospital administrators.⁷⁷ The argument takes a number of forms but usually begins by noting that many new hospitals, particularly proprietaries, are often uncommitted to offering "comprehensive" services but instead offer only those services which are profitable. Similarly, it is argued that expansion is most likely to occur in the profitable lines rather than in those services which cannot support themselves. The specific complaint, often left implicit in the notion that comprehensiveness is desirable for its own sake, is that this new competition deprives existing providers of essential revenues, thereby jeopardizing their ability to offer the arguably needed, though unremunerative, services.

This line of argument is familiar as a popular defense of entry restrictions in other regulated industries, where the so-called "cream-skimming" tendencies of new entrants are objected to because they disrupt the internal subsidization capabilities of existing providers and therefore the useful services which they provide at prices below cost.⁷⁸ Internal subsidization is discussed at another point and is found to be troublesome

⁷⁷ This assertion is based on general conversation, particularly with persons close to the laws' enactment in North Carolina and Virginia. In each case examples of cream-skimming by proprietary hospitals were cited as important in the law's enactment. In North Carolina, improvement of the borrowing capacity of the hospitals—by protecting them from competition—was an explicit purpose. *Durham Morning Herald*, June 25, 1971, at 1c, col. 1. In the State of Washington, concern was expressed about "promoters coming into the state to build health care facilities on an investment basis—facilities which were often not needed." *ABT ASSOC. INC., A CASE STUDY OF COMPREHENSIVE HEALTH PLANNING IN WASHINGTON* 34 (1972).

⁷⁸ See Posner, *Taxation by Regulation*, 2 *BELL J. ECON. & MGT. SCI.* 22 (1971) and text accompanying notes 163-77 *infra*. Restrictions on entry into most so-called "natural monopoly" markets—that is, those in which economies of scale dictate that having more than one provider would be inefficient—can be justified on practically no ground other than a desire to preserve the regulated firm's capacity for internal subsidization. The only other possible argument might be the social costs involved in a struggle "to the death." Cf. *Union Leader Corp. v. Newspapers of New England, Inc.*, 284 F.2d 582 (1st Cir. 1960), *cert. denied*, 365 U.S. 833 (1961).

not only because it necessitates protectionism but also because it is a vehicle for allocative mischief. On these grounds, this rationale for certificate-of-need laws must be counted as generally unpersuasive.

By distinguishing between the long run and the short run, a cream-skimming argument can be developed which, though couched in expediency, might justify a temporary moratorium on competitive developments. Thus, if an existing hospital is currently providing health care for a large number of poor and near-poor, it has a powerful claim to immediate protection against competition which would deprive it of the revenues necessary to continue those services.⁷⁹ The argument is of course much weaker if the subsidized service is the obstetric, pediatric, or intensive care unit or some other service which is simply underpriced⁸⁰ or if the needed revenues could be obtained from other sources, as in the case of a publicly owned hospital. In any event, the cream-skimming argument has less merit in the long run, when a national health insurance program for the poor may have obviated the social necessity for financing indigent care in this manner.⁸¹

E. The Laws' Consistency With the Rationales

Coverage in General

The scope of enacted certificate-of-need statutes is not always consistent with their supporting rationales. While the laws are primarily concerned with the hospital bed supply and the danger of excessive dup-

⁷⁹ The extent of dependence on internal subsidies to support indigent care is not clear. Medicaid leaves many near-poor uncovered and often pays providers less than the cost of the care given. The Department of HEW's "free-care" requirement for hospitals benefitting from the Hill-Burton program regards 3 percent of operating costs as a norm. 42 C.F.R. § 53.111(d) (1972).

⁸⁰ To some extent, laboratory, x-ray, and pharmacy profits are earned at everyone's expense, and many of the subsidized services are for everyone's benefit, suggesting that equity issues are not involved. Moreover, insurance tends to spread costs even further and to perpetuate the same allocative concerns which might otherwise be eliminated by doing away with non-cost-related pricing. Also, the hospital may respond to entry threats by underpricing services likely to be competitive while overpricing monopolized services. Cf. *United States v. United Shoe Mach. Corp.*, 110 F. Supp. 295, 325-29 (D. Mass. 1953), *aff'd per curiam*, 347 U.S. 521 (1954).

⁸¹ Of course, national health insurance may itself be underfinanced, perhaps reflecting a Congressional decision to continue to rely on supplementary revenues produced by the "monopolistic charity" model of the hospital. See Havighurst, *Speculations on the Market's Future in Health Care*, in AEI PROCEEDINGS, *supra* note 6. In this event, protectionist certificate-of-need laws would make some sense, but their enactment now as a remedy for what appears for the moment to be primarily a short-run problem of financing indigent care might prejudice the long-run prospects for a system permitting freer entry.

lication, a few of them stop short of confronting duplication of services and equipment and the related quality problems.⁸²

Although some of the laws bear on all substantial changes in hospital services, the stated rationales fail to explain coverage of cutbacks.⁸³ Here the explanation is apparently broader than the narrow concern with costs, duplication, and overcapacity. In general, planners sense a need not only to avoid nonessential services but also to assure that essential services are being provided. The power to compel continuation of a service previously rendered is seen as highly desirable, and it is but a short step from this power to mandating the provision of specific services. Thus, the franchising approach from public utility and common carrier regulation appears subtly but unmistakably in the certificate-of-need laws of several states.

The laws do not feature prominently a protectionist, anti-cream-skimming purpose.⁸⁴ For one thing, they make no specific issue of proprietary providers or of the hazards which competition poses for providers offering comprehensive services. Moreover, they seem not to contemplate that existing providers will appear in opposition to applications by potential competitors,⁸⁵ and decision makers seldom seem to frame the issue expressly in terms of the effect of new competition on existing providers. Nevertheless, the need criterion necessarily incorporates the anticompetitive premise that the need for an aspirant's service should not be determined in the marketplace. If the service is already being provided, the applicant will surely bear a heavy burden.

Although the laws make no distinction between for-profit and non-profit institutions,⁸⁶ somewhat different rationales apply to the two cases. Indeed, there may be a somewhat stronger case, on one level at least, for public control of nonprofit institutions. Even if one had confidence in the prevailing market incentives, nonprofit firms would still be less amenable to market discipline than profit-making firms.⁸⁷ On the other

⁸² Cf. notes 11-12 *supra*.

⁸³ Cf. note 16 *supra*.

⁸⁴ But see note 77 *supra*.

⁸⁵ See notes 114-16 and accompanying text.

⁸⁶ Maryland's law did for a time cover only nonprofit nursing homes. Law of April 10, 1968, ch. 222, [1968] Md. Laws 274.

⁸⁷ For-profit firms with professional (nonowner) managers may also be given to maximizing things other than profits, but shareholders probably provide a more dependable check than anything in the hospital manager's environment. See note 23 *supra*. See also Hetherington, *Fact and Legal Theory: Shareholders, Managers, and Corporate Social Responsibility*, 21 STAN. L. REV. 248 (1969).

hand, assuming the continuation of current market conditions, proprietaries are probably more likely to engage in cream-skimming in pursuit of short-run profits. Because the present weakness of market deterrents to overexpansion may affect both for-profit and nonprofit concerns about equally though in different ways, it is probably appropriate to lump the two for regulatory purposes.

The Weaker Arguments for Extending Certificate-of-Need Laws to Nonhospital Facilities

Although twenty of twenty-three states impose certificate-of-need requirements on nursing homes and other institutions providing less sophisticated levels of inpatient care, the argument for doing so is less persuasive than the case for regulating hospital development.⁸⁸ To be sure, expansion of the bed supply in such institutions does increase utilization, since many sick or elderly persons seek such care if it is available and if the price is subsidized by public programs or private insurance. Nevertheless, these consumption decisions are somewhat more in the patients' hands than decisions regarding hospital use. Moreover, both utilization and investment decisions are less likely to reflect doctors' judgments. In addition, the predominance of proprietary interests and the strength of competition help relate the incentives for building new capacity more closely to consumer wants. Finally, cost reimbursement is not inevitable as the basis of third-party payment.

Nor is there compelling evidence of oversupply of nursing-care facilities.⁸⁹ Although efficient utilization can be a problem because patients

⁸⁸ I have seen no careful justification of coverage of nursing homes. Thomas, one of the leading advocates of coverage for such institutions, provides no clear rationale. W. THOMAS, *NURSING HOMES AND PUBLIC POLICY: DRIFT AND DECISION IN NEW YORK STATE* (1969). Indeed, he describes an experience which suggests rather strongly the value of permitting market responses: rapid growth of the proprietary sector while the voluntary sector was unable to meet the emerging need; uneven quality during the period when demand exceeded supply; and, ultimately, improved quality and efficiency when supply finally allowed competition to be effective in eliminating poorer facilities. One can debate whether stronger quality controls would have been in the public interest during this period or would simply have slowed the supply response, depriving people of care altogether. I expect that the coverage of nursing homes in certificate-of-need legislation usually reflects, as in the State of Washington, nothing more substantive than the "nursing homes' interest in being regulated" and their "very effective legislative pressure." *ABT ASSOC. INC.*, *supra* note 77, at 39. See also text accompanying note 136 *infra*.

⁸⁹ The range is from 9.1 per 1000 in West Virginia to 74.1 per 1000 in Oklahoma, the only state with a certificate-of-need requirement for nursing homes only. NAT'L CENTER FOR HEALTH STATISTICS, *HEALTH RESOURCES STATISTICS 1971*, 325 (DHEW Pub. No. HSM 72-1509, 1972).

are often placed in institutions which offer more sophisticated care than they require,⁹⁰ limiting the number of beds is a less efficient and less fair method of dealing with this problem than utilization review by disinterested doctors. Doctors engaged in such review efforts, perhaps under the auspices of a Professional Standards Review Organization (PSRO)⁹¹ or a foundation for medical care,⁹² would probably be less tolerant of overutilization in extended and intermediate care facilities than in hospitals.⁹³ Furthermore, various other means, including voluntary planning, conditions attached to financing schemes, and licensure requirements, can be used to bring about better coordination and to facilitate patient transfers to more appropriate facilities.

Competition would serve consumers better with respect to nursing care institutions than with respect to hospitals. Most important, a wider range of choice is likely to result, and the poorer homes will readily close their doors if the market does not support them.⁹⁴ Decisions are more likely to remain in the hands of patients and their families, who are in a better position than hospital patients to evaluate the total package of services received, particularly the overall quality of life enjoyed by the residents. Given this subjective element and the impossibility of adequately allowing for it in regulation,⁹⁵ it must be concluded that one

⁹⁰ S. REP. NO. 91-1230, 92d Cong., 2d Sess. 285 (1972).

⁹¹ PSROs are physician-sponsored mechanisms for reviewing claims for payment under government programs as a means of controlling utilization of resources and quality of care. 42 U.S.C. § 249(f). See also note 234 *infra* and accompanying text.

⁹² Foundations for medical care are medical-society-sponsored groups which frequently engage in claims review. See C. STEINWALD, AN INTRODUCTION TO FOUNDATIONS FOR MEDICAL CARE (1971). See also note 234 *infra* and accompanying text.

⁹³ When patients are paying their own way, concerns about utilization are less warranted. Nevertheless social work, patient advocacy, and ombudsman programs have potential value as protections against families' disinterest and the frequent inability of aged or dependent patients to look out for themselves.

⁹⁴ See THOMAS, *supra* note 88, at 155-58, 175, 261.

⁹⁵ It is coming to be widely recognized that regulation would be more effective if it could be geared to "outcomes" rather than to "inputs" or "processes." See, e.g., *Hearings on Health Maintenance Organizations Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 92d Cong., 2d Sess. 489-531 (1972) (testimony of Dr. Patrick O'Donoghue); Williamson, *Outcomes of Health Care: Key to Health Improvement*, in *METHODOLOGY OF IDENTIFYING, MEASURING AND EVALUATING OUTCOMES OF HEALTH SERVICE PROGRAMS* 75 (C. Hopkins ed. 1970). Most nursing home regulation is concerned primarily with "inputs," however. See, e.g., 20 C.F.R. §§ 409.1120-1137 (1973). Moreover, it is difficult to identify the desired outcome of nursing home care, which frequently ends in death and not often in complete recovery. Unlike hospital care, which is generally short-term and geared to achieving a specific improvement in health, nursing homes should be much more concerned with providing a certain "quality of life" for their patients. In the absence of

nursing-care bed is not necessarily interchangeable with another and that market competition is too valuable a protection of patients' vital interests to be sacrificed for possible cost savings.⁹⁶

The appropriateness, under the rationales advanced, for regulating construction or expansion of outpatient facilities may also be questioned. Because ambulatory care is not regularly paid for on a cost-reimbursement basis, is not particularly the province of nonprofit providers, and has not been characterized by overcapacity (other than some maldistribution),⁹⁷ its coverage by these laws is not easily justified. Nevertheless, the argument may be made that substitution of cheaper ambulatory care for inpatient care will leave empty hospital beds, which, it is claimed, will attract new patients and raise health care costs over-all. This logic provides special bait for a classic regulatory trap, which is discussed in connection with the consequences of applying certificate-of-need laws to HMOs and other types of outpatient facilities.

III. THE OPERATION OF A CERTIFICATE-OF-NEED PROGRAM

An evaluation of certificate-of-need laws requires a review of the steps followed in processing an application under a typical program.⁹⁸ Individual programs differ in various respects from the general procedural model discussed here,⁹⁹ but an overview identifies areas of potential difficulty and provides background for a pragmatic appraisal of certificate-of-need laws.

opportunities for regulation geared to inmates' happiness and of suitable proxies for same, a great deal can be said for leaving as much as possible to consumer choice and working to improve opportunities for its informed exercise.

⁹⁶The arguments discussed here would be relevant on the constitutionality of certificate-of-need legislation as applied to nursing-care institutions. It would be possible, for example, to disagree with the North Carolina Supreme Court's reasoning in *In re Certificate of Need for Aston Park Hospital, Inc.*, see note 3 *supra*, and yet believe that such a holding with respect to coverage of nursing homes would be entirely defensible. *But see* *Attoma v. Dep't of Social Welfare*, 26 App. Div. 2d 12, 18, 270 N.Y.S.2d 167, 171 (1966).

⁹⁷See note 56 *supra*.

⁹⁸The best narrative description of a certificate-of-need program is *ABT Assoc. Inc.*, *supra* note 77, at 43-54.

⁹⁹Some of the assertions in this subsection are based on interviews in several states and on responses to a comprehensive questionnaire which was sent to the 21 states which enacted certificate-of-need statutes prior to 1973. Questionnaires were returned by the following 14 states: Arizona, California, Florida, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, North Dakota, South Carolina, South Dakota, and Washington. The statutes referred to in notes 100-126 *infra* are those cited in note 4 *supra* unless otherwise indicated.

The degree of procedural formality in certificate-of-need laws varies widely, but the usual administrative safeguards against arbitrary action are not always provided for.¹⁰⁰ State administrative procedure acts, seldom as demanding or as rigorously applied as the federal Administrative Procedure Act,¹⁰¹ may compensate for some deficiencies but may not apply to the areawide agencies, which are not, strictly speaking, creatures of the state.¹⁰² In some cases, superimposing regulatory powers on informal health planning may have introduced coercive powers without also imposing the usual responsibility to exercise those powers openly and to accord procedural protections. The absence of these procedural requirements, particularly those requiring the existence, disclosure, and application of objective criteria, may facilitate favoritism and increased political influence in decision making. It is therefore appropriate to suggest desirable procedural safeguards while at the same time providing the groundwork for an estimate of what can reasonably be expected of state agencies charged with certificate-of-need responsibility.

A. Applications

The certificate-of-need application is usually prepared on a prescribed form indicating the information which the agency regards as important in determining need. If not prepared by the applicant itself, the application may be prepared by an architect or a hospital planning consultant, who may also perform supporting surveys and analysis. This contrasts with other regulatory programs, where applications are usually prepared by lawyers specializing in practice before the agency involved. Indeed, the presence or absence of lawyers in the hospital regulation process provides an index of the regulated institutions' perceptions of the process, particularly their view of the friendliness and amenability of the regulators and of the likelihood that obstruction will be offered.¹⁰³ Although

¹⁰⁰ California, Florida, Kansas, Massachusetts, Minnesota, Tennessee, and South Dakota provide the most elaborate procedural protections in their certificate-of-need laws, whereas some other states, including North Dakota, Oklahoma, Virginia, and Washington, incorporate procedural requirements by reference to other laws.

¹⁰¹ 5 U.S.C. §§ 551-59, 701-06, 1305, 3344, 7521 (1970).

¹⁰² Statutes in most of the states leave procedures in the local agencies largely unspecified.

¹⁰³ Maryland and New York report that lawyers are "usually" involved where proprietary facilities are concerned, and California indicates that attorney involvement is usual in all types of cases. Most other states indicated that lawyers "rarely" participate in the application process.

planning-cum-regulation may be preferable in some respects to more adversary proceedings, the absence of lawyers in the process may lead to the adoption of procedures which are less well designed to produce a clear articulation of policies and objective standards.

Some of the most revealing cases are apt to be those involving conflicting applications occurring where two hospitals wish to expand in the same area or where several applicants apply for the privilege of building a single new hospital.¹⁰⁴ The result may be a sort of comparative hearing similar to that engaged in by the Federal Communications Commission in dealing with competing applications for a single broadcasting license or by the Civil Aeronautics Board in awarding airline routes. One would expect the action taken on competing applications to be instructive in identifying the priorities and philosophies of the deciding agency, but FCC and CAB experience has shown that criteria or the weight given them have tended to change from case to case, suggesting that the true grounds for decisions are not always the reasons revealed.¹⁰⁵ Brief investigations of the experience of particular certificate-of-need agencies indicate that procedures are generally inadequate to reveal to the parties the reasons for preferring one applicant over another.¹⁰⁶

¹⁰⁴ There would seem to be a danger that the certificate-of-need process may actually stimulate hospital construction by causing applicants to accelerate their plans in order to pre-empt others. The use of population projections facilitates granting of certificates well before the facilities are actually needed, and it is common for applicants to be turned down on the ground that needed beds are already subscribed for though not yet in being—in other words, the application is too late. In one state, a politically influential local hospital authority was given a certificate in 1972 to build a new hospital on the express condition that “first use” not occur before 1976. The effect of this forehandedness was to preclude other applications, possibly more in keeping with the circumstances at the relevant time.

¹⁰⁵ Indeed, the granting of lucrative broadcasting licenses has produced outright corruption in the FCC. See *WKAT, Inc.* 29 F.C.C. 216, *aff'd*, 296 F.2d 375 (D.C. Cir. 1960), *cert. denied*, 368 U.S. 841 (1961). CAB route awards have been largely based on nothing more solid than parcelling out favors among the airlines equally, making up in a later case for hardships imposed in an earlier one, or vice versa. See, e.g., Hilton, *The Basic Behavior of Regulatory Commissions*, 62 AM. ECON. REV. 47, 49 (1972).

¹⁰⁶ Only two of the 14 responding states (Arizona and Maryland) said that they had specific procedures for dealing with competing applications. *But see* MASS. GEN. LAWS ANN. ch. 111, § 25C (Supp. 1972), which in providing for “filing periods” recalls the comparative-hearing requirement of *Ashbacker Radio Corp. v. FCC*, 326 U.S. 327 (1945). Despite the questionnaire response, investigations in Maryland did not reveal anything like the comparative hearing procedures used in federal agencies. See, e.g., *Clinton Community Hospital Corp., Md. Comprehensive Health Planning Agency Application No. 70-16-0012* (Dec. 1970).

B. The Decision Makers

The primary decision maker in a certificate-of-need program is frequently difficult to identify. Usually a state agency, either a separate one or the department of health, appears to have final authority, but influential advice and comments are frequently provided by local planning agencies and state advisory councils. The complex advisory and review processes tend to obscure such matters as whether advice received from various planning and advisory agencies is merely window-dressing or is tantamount to being final and whether appellate review is *de novo* or accords substantial weight to the initial decision.

The relation of the certificate-of-need process to the comprehensive health planning (CHP) process fostered under federal law varies from state to state. Only seven states delegate final decision-making authority to state CHP agencies,¹⁰⁷ but areawide agencies are usually deeply involved.¹⁰⁸ Indeed two states, Arizona and Kansas, give final decision-making authority on need to the areawide agency.¹⁰⁹ Although federal law requires the CHP agencies' planning councils to draw more than half their membership from representatives of "consumers of health services," the imprecision of this requirement has left disadvantaged groups generally underrepresented.¹¹⁰ The state laws frequently supply

¹⁰⁷ California, Colorado, Nevada, Maryland, Oregon, South Carolina, and South Dakota. These are the so-called "a" agencies organized pursuant to § 314(a) of the Public Health Service Act, 42 U.S.C. § 246(a) (1970). Areawide CHP agencies are known as "b" agencies after § 314(b), 42 U.S.C. § 246(b) (1970).

¹⁰⁸ Connecticut has by-passed the CHP mechanism almost completely. New Jersey and New York utilize "b" agencies only where the "b" agency and the regional group happen to be one and the same. The Rhode Island, Oklahoma, and Virginia statutes refer to the involvement of "b" agencies in the decision-making process, but the statutory language leaves the extent of involvement largely discretionary.

¹⁰⁹ California also gives substantial decision-making (and appellate) authority to areawide agencies, which are nongovernmental in character, and this latter circumstance prompted a legal challenge on the ground of delegation of legislative power to private interests. The challenge was unsuccessful, partly because a state agency was found to exercise final authority. *Simon v. Cameron*, 337 F. Supp. 1380 (C.D. Cal. 1970). Cf. *Self-Help for the Elderly v. Richardson*, Civil No. 2016-71 (D.D.C., filed Oct. 6, 1971), *dismissed as moot*, Nov. 20, 1972. The Arizona and Kansas statutes might be subject to possible attack on delegation grounds, a further foundation for which might be found in the historical use of planning agencies to further private interests. See notes 22 and 23 *supra*. Nevertheless, the provision for a *de novo* judicial hearing would probably save the Kansas statute. KAN. STAT. ANN. § 65-2a08 (1972).

¹¹⁰ 42 U.S.C. § 246(a) (2) (B), (b) (2) (A) (1970). See B.C. French, *Who Are the Consumers on the State Health Planning Councils?*, 1970 (Institute for the Study of Health and Society mimeo.).

similar assurance against provider domination of other agencies which may be involved.¹¹¹

In most states, the areawide health planning agency for the area in which the new facility is to be constructed acts first on the application. The purpose is to provide the opportunity for community reaction and to guarantee local involvement in the decision-making process. Areawide planning councils include both provider and consumer representatives. There is generally a small professional staff, which may or may not undertake significant independent study of the factual circumstances.¹¹² Sometimes the planners' preferences are embodied in a master plan with which applications may be compared.¹¹³

C. Hearings, Appeals, and Decisions

While a hearing on the application is frequently held, it may differ in character from hearings in other regulatory settings. In Maryland, for example, the purpose of the hearing is to inform the public about the proposal rather than to afford the applicant an opportunity to make his case before the agency. While opposition to an application may arise in the form of questions and challenges presented by persons appearing at the hearing, there are normally no formal arrangements for recognizing opposition or for intervention.¹¹⁴ Although most states report that formal opposition is unlikely,¹¹⁵ a hospital or other institutional provider whose

¹¹¹ In those states where the final determination is left solely to the state department of health, the number and quality of consumer representation is dependent on the state statute regulating appointment of the commissioner, board of health, etc. Where the certification statute establishes a new agency or advisory board, it usually specifies that (1) the members shall be appointed by the governor or some other public official, (2) there shall be a majority of consumers, (3) expiration of membership should be staggered, and (4) providers should be well represented. The identity of the "providers" is often not specified at all. *Contra*, California, Connecticut, Kentucky, North Dakota, and Tennessee. The nine-member North Dakota State Health Council, the final decision maker, has seven provider representatives, none of them representing nursing homes, which the Director of the Division of Health Planning, in his questionnaire response, says are the more important problem. Kentucky also guarantees a provider majority.

¹¹² On the financial support of the "b" agencies, *see* note 150 *infra*.

¹¹³ *But see* text accompanying notes 187-90 *infra*.

¹¹⁴ California, Florida, Kansas, Minnesota, South Dakota, and Tennessee spell out detailed intervention procedures, but Colorado, Massachusetts, and North Dakota also seem to contemplate intervention prior to a ruling.

¹¹⁵ Six questionnaires reported that existing providers "often" oppose applications, though opposition may not amount to formal intervention but only appearance at the hearing. Only two states indicated that community groups often appear in opposition. Other investigations confirmed that active opposition by competitors occurs regularly

market position is being challenged would be tempted to oppose a proposal by filing a competing application¹¹⁶ or by arguing that it could meet all future needs itself. The infrequency of formal intervention appears to reflect the perception of the proceeding as nonadversary and nonregulatory in character, but the lack of formal opposition may simply widen the agency's discretion with possible consequences for the quality of decisions.

Certificate-of-need statutes vary widely both as to when a final determination may be appealed and as to who has standing to appeal.¹¹⁷ In some states the only administrative appeals permitted are those by unsuccessful applicants.¹¹⁸ Curran argues that, since overcapacity is the main concern of these laws, approvals should also be appealable.¹¹⁹ Apparently ignoring the possibility that competing institutions may be better equipped and better motivated to raise issues of public concern, Curran would limit appeals to representatives of the "public interest."¹²⁰ In other regulated industries, competitors adversely affected by proposed new entry are generally permitted to appeal approvals, not because they are entitled to specific protection but because in asserting their own in-

in Nevada and California. Cf. *Memorial Hospital of Southern California v. State Health Planning Council*, 28 Cal. App. 3d 167, 104 Cal. Rptr. 492 (1972).

¹¹⁶ In New York, a hospital applied for authority to open an ambulatory care facility in a neighboring town where a new community hospital had been proposed. At the same time, it represented publicly that it was not opposing the pending application.

¹¹⁷ Connecticut, Kentucky, New Jersey, North Dakota, Oregon, South Dakota, and Tennessee (applicants only) allow appeals only to the courts, whereas Florida contemplates mandamus proceedings, though regulations allow appeal to an advisory council as well. Fla. Regs., *supra* note 11, at ¶ G.1. California allows appeals to the consumer members of another areawide agency before appeal to the state Advisory Health Council. Kansas provides for an appeals panel drawn primarily from other "b" agencies.

¹¹⁸ Arizona (not on need, but on conformance to the "state plan"), Oklahoma, Rhode Island, and Virginia. In Minnesota, "any person aggrieved" may appeal a denial. The statutes in California, Colorado, Florida, and Michigan provide for administrative appeals from issuance as well as denial of certification, by both the applicant and the planning agencies involved. California clearly allows additional parties to be represented in appeals initiated by others. Cf. *Memorial Hospital of Southern California v. State Health Planning Council*, 28 Cal. App. 3d 167, 104 Cal. Rptr. 492 (1972). Kansas, South Carolina, and Massachusetts allow the widest latitude for initiating administrative appeals. In lieu of an appeal, several states allow a hearing after a tentative decision is reached. See note 124 *infra* and accompanying text.

¹¹⁹ Curran, *supra* note 6. See also note 118 *supra*.

¹²⁰ The only known formal challenge by a public-interest group occurred in Minnesota, where the case was dismissed for failure to post a bond. See Casady Memo, *supra* note 42.

terest, they illuminate the public's stake in the decision.¹²¹ However, formal intervention by competing providers occurs infrequently in certificate-of-need proceedings.¹²²

Typically, a decision by the areawide agency is either advisory to, or subject to automatic review by, the statewide agency. In either case the state agency reviews the record and makes the final determination. It is not always stated whether the review merely assures that the initial decision was not clearly erroneous or was supported by substantial evidence or is instead a *de novo* consideration.¹²³ Some states permit further appeals to the state department of health or to a special review board, and procedures for these appeals vary. New York and several other states allow a hearing only after the state agency has tentatively acted on the application.¹²⁴

The manner of revealing reasons for a decision also varies among the states. New York reveals the detailed grounds for a denial only in the hearing which follows a tentative denial at the state level. Although most agencies claim to make findings of fact, to provide statements of the specific reasons for their decisions, and to make these items public, decisions appear sketchy and unrevealing as to underlying facts or criteria, and files are frequently not freely available. Nor do state procedures in these regards appear to measure up to the high standards prevailing in the federal regulatory agencies.¹²⁵ For example, a number of states indicated in questionnaire responses that dissenting views in the deciding agency or advisory body were neither reduced to writing nor otherwise revealed. In other cases, the actions or recommendations of areawide

¹²¹ See *FCC v. Sanders Bros. Radio Station*, 309 U.S. 470 (1940); *Carroll Broadcasting Co. v. FCC*, 258 F.2d 440 (D.C. Cir. 1958).

¹²² See note 115 *supra*.

¹²³ The standard for administrative appellate review is seldom stipulated in the statute. Virginia provides for *de novo* review of denials with a full hearing before the State Board of Health. California (which specifies a substantial evidence standard) and Massachusetts provide primarily for review on the record, with a hearing discretionary. Colorado's appeal is described as a "hearing on the application," suggesting *de novo* consideration.

¹²⁴ Roughly similar procedures are followed in Kentucky, Maryland, Nevada, New Jersey, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, and Tennessee. Practices vary as to whether the hearing is before an examiner or the full board or agency responsible for the decision and as to whether anyone besides the applicant can initiate the further proceeding.

¹²⁵ Massachusetts is the most explicit in its requirement for written decisions with articulated reasons, and other statutes have reassuring language. Most decisions appear in minutes or memoranda prepared by staff, however, and I know of no agency which issues signed, quasi-judicial opinions of the kind typical of many federal agencies.

agencies could not be effectively contested because the grounds were not clearly specified.¹²⁶

The expectation that administrative agencies explain the basis for their decisions is premised on a belief that it avoids arbitrariness and contributes to consistency and clarity of policy. Of course, written opinions do not necessarily reveal the true reasons for the decisions reached.¹²⁷ Even so, it is better to have reasons stated than to have them obscured. The parties may then at least address the ostensible standards, and courts and legislators will have some basis for judgment about the consistency of policies both in application and with the statutory purpose.

D. Criteria for Assessing Need

Generally, the statute spells out for the agency the applicable need criteria. These are often articulated further in regulations and in an area-wide or state health plan which the agency itself develops.¹²⁸ Nevertheless, these criteria may be too numerous, conflicting, and vague to be helpful in resolving particular cases, thus allowing an agency, while ostensibly balancing conflicting values, to pick and choose among various criteria to justify any result it wants.¹²⁹ For example, the Oregon certificate-of-need statute provides thirteen paragraphs of criteria for judging need, permitting the state agency to find grounds for granting or denying any application, emphasizing one factor or another and minimizing inconvenient circumstances when they appear.¹³⁰

¹²⁶ Questionnaires from only Nevada and New York indicated that reasons for local agency action might not appear, but files from other states including Maryland indicate that this is a more common problem. Moreover, the statutes in Colorado, Connecticut, Massachusetts, Michigan, New Jersey, North Dakota, Oklahoma, South Carolina, Virginia, and Washington suggest that the areawide agency's recommendation may be seen as confidential, although probably some disclosure would occur in practice in some of these states, as indicated in the questionnaires returned by several.

¹²⁷ A famous memorandum written to President Eisenhower by Louis Hector upon his resignation as a member of the CAB noted that the agency staff cultivated the ability to write opinions to justify any result in a given case and was careful not to write in such a way as to create precedents which would make future decision writing more difficult. Hector, *Problems of the CAB and the Independent Regulatory Commissions*, 69 YALE L. J. 931, 942 (1960).

¹²⁸ Only California, Kansas, Kentucky, Maryland, and New York of the 14 responding states claimed to have master plans as criteria in decision making, and North Dakota referred to its Hill-Burton plan. Maryland was unable to produce any developed plan, however. See note 189 *infra* and accompanying text.

¹²⁹ See H. FRIENDLY, *THE FEDERAL ADMINISTRATIVE AGENCIES: THE NEED FOR BETTER DEFINITION OF STANDARDS*, ch. 4 (1962).

¹³⁰ Compare Curran, *supra* note 6, with AEI PROCEEDINGS, *supra* note 6 (remarks of Richard A. Posner).

The issue of need for health facilities is so exceedingly complex that, unless the decision maker spells out its policies in advance, the vague criteria of most state programs permit the agency to function with little effective oversight by judicial or other authorities. New York's program, which employs a detailed state plan for hospital beds and a well-defined formula for identifying needs, is an exception. California has legislation pending which would centralize decision-making authority and allow greater use of formulas and explicit plans, an approach which has proved impossible with primary authority lodged in areawide agencies.¹³¹

Because they act without clear criteria and without the need to reveal the true grounds for actions taken, the certificate-of-need agencies exercise largely discretionary power. Administrative mechanisms for structuring and confining such power should therefore be introduced.¹³² Considerable scholarship indicates that informality, dejudicialization, and efficiency in handling a large number of cases can occur without loss of basic fairness and reasonable guarantees of the rights of the parties.¹³³

E. Procedural Problems

The procedural aspects of certificate-of-need programs appear to be an inadequate guarantee of good performance. The concern is less that individual applicants have been dealt with unjustly than that the agencies' policies and practices are largely undisclosed, leaving observers to guess whether administration is sound, fraught with favoritism for special interests, or generally ineffective in controlling costs. It is dangerous simply to assume that the logical rationale offered for the laws' enactment in fact represents the policies being implemented or that the policy reflected in the statute has been properly balanced against other policies. Even

¹³¹ California Senate Bill No. 413 (March 12, 1973).

¹³² See generally K. DAVIS, *DISCRETIONARY JUSTICE: A PRELIMINARY INQUIRY*, chs. 3-4 (1969); FRIENDLY, *supra* note 129; *Symposium—Administrative Discretion*, 37 *LAW & CONTEMP. PROB.* 1 (1972). See also notes 183-84 *infra*.

¹³³ See, e.g., K. DAVIS, *ADMINISTRATIVE LAW TREATISE* §§ 4.13-.22 (Supp. 1970); Davis, *Administrative Procedure in the Regulation of Banking*, 31 *LAW & CONTEMP. PROB.* 713 (1966).

Perhaps the most important mechanism for openly and efficiently developing and articulating policy is the administrative rule-making process. This procedure normally allows interested parties to criticize proposed regulations in writing or at a special hearing. Courts may insist on rulemaking where an agency appears to be acting without stated principles. See K. DAVIS, *ADMINISTRATIVE LAW TREATISE* ch. 6, §§ 2.00 to 2.00-6 (Supp. 1970); DAVIS, *A New Approach to Delegation*, 36 *U. CHI. L. REV.* 713 (1969); Wright, *Beyond Discretionary Justice*, 81 *YALE L. J.* 575, 593 (1972).

with good administrative procedures scrupulously observed, opportunities for political influence, favoritism, and misguided policies will still exist. Indeed, no major regulatory program at the federal level, where administrative law is most fully developed, has escaped criticism that the policies pursued usually advance the interests of the regulated industry itself. Nevertheless, adherence to procedural standards seems very close to being a necessary, though it is certainly not a sufficient, condition for successful regulation.

IV. SOME BEHAVIORAL HYPOTHESES ABOUT CERTIFICATE-OF-NEED AGENCIES

Experience with economic regulation in other areas provides a basis for skepticism that regulatory programs consistently advance the broad public interest. Specific failings have been documented in each regulated industry, and some generalizations have begun to appear valid when measured against industry-by-industry experience. While apparently unexamined in the past, the validity of such generalizations as applied to the agencies charged with administering certificate-of-need laws should be helpful in assessing the efficacy of regulation in the hospital industry.¹³⁴

A. The "Producer-Protection" Hypothesis

Economic regulation is widely assumed to be the direct result of legislative concern for the interests of consumers. Those who accept this premise account for the frequent failure in the regulatory process by the regulated industry's alleged subversion—or "capture"—of the regulatory agency through politically inspired appointments, lucrative employment prospects in industry for cooperative regulators, industry's better opportunity to urge its point of view, its ability to outspend the agency, and its influence with the elected officials who control the agency's appropriations and legislative charter.¹³⁵ Solutions to the problem are thought to lie in increased political pressure by consumers, better consumer advocacy, better appointments, and increased appropriations.

¹³⁴ For a general effort to highlight the problems of regulating in the health care industry, see Havighurst, *Government's Increasing Involvement in the Health Care Sector: The Hazards of Regulation and Less Hazardous Alternatives*, in *THE CHANGING ROLE OF THE PUBLIC AND PRIVATE SECTORS IN HEALTH CARE* 34 (Report of the 1973 Nat'l Health Forum, Nat'l Health Council, Inc., 1973).

¹³⁵ See, e.g., M. BERNSTEIN, *REGULATING BUSINESS BY INDEPENDENT COMMISSION* (1955). My introduction to regulatory performance follows Jordan, *supra* note 49, at 152-54.

Other views of regulation suggest that demonstrable departures from the public interest are so frequent as to make them the rule rather than the exception, requiring a more sophisticated hypothesis about the reasons regulatory controls were adopted in the first place. Noting the frequency with which benefits accrue to the regulated firms, some observers suggest that protection of producers is the primary object of much regulatory legislation and that industries obtain regulation, like other governmental favors, through strategic use of economic and political power.¹³⁶ To account for this success in obtaining protective legislation, the concentrated political power of an industry and its sophisticated awareness of its self-interest may be usefully contrasted both with consumers' inability to inform themselves and to aggregate their interests and with their readiness to believe the politicians' representations that regulatory legislation is for their benefit.

The truth about regulatory agencies probably lies somewhere between the notions of legislative sell-out of the public interest and industry subversion of the regulators. On the one hand, many legislators are essentially naive about how regulation works and, in any event, as busy men concerned primarily with re-election, are apt to be interested as much in appearing to act in the consumer's interest as in doing so in fact. On the other hand, while the political appointment process effectively prevents anti-industry zealots from frequently appearing on regulatory commissions, it also precludes a majority of industry stooges. But even if the balance of power in an agency belongs to reasonable men, it is natural for them to develop a belief in the services rendered by the industry and sympathy for its problems, which will usually appear as obstacles to the continued improvement and wider availability of those services. In these circumstances the compromises reached within a multi-member agency will usually be in keeping with industry interests.

A potentially more useful insight—because it stops short of unequivocally condemning all regulation and supplies a basis for predictions about regulatory behavior—is that an agency's policies are the net product of the various incentives inherent in the operation of a politically responsive bureaucracy. These incentives can to some extent be analyzed and, if necessary, restructured by purposive institutional adjustments. Understanding the incentives affecting agency performance requires not only analysis of the rewards which regulators anticipate—either larger agency

¹³⁶ Jordan, *supra* note 49; Stigler, *A Theory of Economic Regulation*, 2 BELL J. ECON. & MGT. SCI. 3 (1971).

authority and budgets or individual opportunities upon retirement from the agency—but, more importantly in a political world, an estimation of the strength of the various pressures to which the agency is subjected. Fundamentally, regulators operate on a “minimal squawk” principle,¹³⁷ and, depending on the array, attentiveness, comprehension, outspokenness, and influence of the various potential squawkers, regulation may be capable of producing results which closely serve the public interest or which significantly depart from it.¹³⁸ Appraisal of the tendencies of a particular regulatory program may be inconclusive, however, since the directions and magnitudes of the various pressures can only be estimated. Yet, while the matter may not be reducible to a simple parallelogram of forces, there will be cases where conclusions can be drawn. If the various constituencies of an agency are well balanced in awareness and influence, some confidence in regulatory performance may be justified. But if the effective pressures seem all to push in the same direction, it must be asked whether that is where the public interest lies.

Prisoner of the Hospital Industry?

Although generalization about the past performance of health planning and certificate-of-need agencies is difficult, there seems to be no basis for discounting provider domination as a problem.¹³⁹ Moreover, even if some agencies should be deemed to have surmounted this hazard, long-term predictions of independence may be unjustified, since regulatory agencies have historically been more vigorous in their youth than in their maturity.¹⁴⁰ There may, however, be some organizational structures or other arrangements which are less prone to the kind of performance which gives rise to charges of industry “capture.” Experience in the state of New York, where a virtual moratorium has been declared on new hos-

¹³⁷ Hilton, *supra* note 105, at 48, 53.

¹³⁸ Lowi criticizes the theory of “interest-group liberalism” for failing to take account of imperfections in pluralistic bargaining, much as proponents of laissez-faire economics down-play inconvenient deficiencies of the market. T. LOWI, *THE END OF LIBERALISM* 294-97 (1969). The analysis here takes a cue from Lowi’s warning against assuming that interested groups, given the proper setting for bargaining, will produce resolutions which benefit the whole society.

¹³⁹ See HEALTH-PAC, *supra* note 22, at 191-231; HOSPITAL FRANCHISING, *supra* note 45, at 22 (remarks of Lester Breslow, D. Eugene Sibery, and Steven Sieverts); P. O’DONOGHUE, A. BRYANT, & P. SHAUGHNESSY, *A DESCRIPTIVE ANALYSIS OF CHP “B” AGENCIES* 79-80 (1973); Douglass, *Effect of Provider Attitudes in Community Health Decision-making*, 11 MED. CARE 135 (1973). See also notes 216-18 *infra* and accompanying text.

¹⁴⁰ See, e.g., BERNSTEIN, *supra* note 135, at 79-91.

pital beds under the certificate-of-need law, provides an instructive example.

In New York, the certificate-of-need agency is the Department of Health, which is also directly responsible for setting politically sensitive Medicaid reimbursement rates¹⁴¹ and for advising the Insurance Department on the setting of highly visible Blue Cross premiums. Since 1970 it has also possessed direct rate-setting authority over individual hospitals,¹⁴² a power which it has exerted so strictly that most of the hospitals in the state are operating at a deficit.¹⁴³ Although one can question the fairness of giving a major buyer of care the power virtually to name its own price,¹⁴⁴ combining political responsibility for costs and regulatory power over hospital rates in the same agency does succeed in structuring the regulators' incentives to assure that the public's interest in economy is not sacrificed to the hospitals' interests.

The New York arrangement so completely avoids the imputation of industry capture of the agency that the state hospital association is arguing that New York should create an independent commission to regulate the hospitals.¹⁴⁵ The association's plan adopts the public utility model in a relatively pure form and would free the agency of all responsibility for financing care. Experience with other such "independent" commissions clearly warrants the proponents' obvious expectation that such an agency would be more responsive to industry interests.¹⁴⁶

¹⁴¹ See Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROB. 348, 386-88 (1970).

¹⁴² N.Y. PUB. HEALTH LAW § 2807 (McKinney Supp. 1972).

¹⁴³ Hospital Ass'n of New York State, Survey of Fiscal Pressures on Hospitals in New York State, Oct. 12, 1972 (mimeo.), summarized in *Reasons for Concern*, HOSPITAL FORUM, Dec. 1972, at 9.

¹⁴⁴ Constitutional protection against "confiscatory" rates is presumably available under principles similar to those which courts employ in reviewing rates allowed regulated utilities. See 1 KAHN, *supra* note 46, at 37-41. Compare *Sigety v. Ingraham*, 29 N.Y.2d 110, 272 N.E.2d 524, 324 N.Y.S.2d 10 (1971). An interesting issue would arise if certain capital investments were held not eligible for depreciation because the facilities invested were not "needed." On the so-called "prudent investment" rule, see *Missouri ex rel. Southwestern Bell Tel. Co. v. Missouri Pub. Serv. Comm'n*, 262 U.S. 276, 289, n.1 (1923) (concurring opinion). On the requirement that property in the "rate base" be "used or useful" in the public service, see F. WELCH, *CASES AND TEXT ON PUBLIC UTILITY REGULATION* ch.8 (1961).

¹⁴⁵ HOSPITAL FORUM, Dec. 1972, at 2-8.

¹⁴⁶ See also Hospital Ass'n of Pennsylvania, Circular Letter No. 593, Feb. 22, 1973, in which the association announces changing its proposal for an independent Hospital Care Commission to a plan for vesting the same regulatory authority in the state Department of Health.

Most certificate-of-need programs feature neither a measure of financing responsibility, as in the New York model, nor an independent regulatory commission. Rather, they most frequently involve a single decision maker subject to political appointment and removal. Some view this model as increasing agency responsiveness to the executive and therefore political accountability for agency performance, a quality allegedly lacking in the case of the independent commissions.¹⁴⁷ However, such accountability might not provide adequate protection for the public interest if the incumbent governor demonstrated systematic preferences only for those constituents who could influence, with either votes or money, his or his party's future success at the polls.¹⁴⁸ Thus there is a basis for preferring control of regulatory programs by the less monolithic mechanism of the legislature. The efficacy of particular arrangements will of course depend on the power relationships in particular state governments.

Several certificate-of-need programs lodge major decision-making responsibility, either advisory or actual, in nongovernmental planning agencies and advisory councils made up of part-time participants perhaps half of whom are unconnected with provider interests.¹⁴⁹ The nonprovider majorities on such bodies should feel no desire to curry favor with the regulated industry and should evince a weaker dedication than is found in more typical regulatory bodies to expanding the power and dominion of the agency as an end in itself.¹⁵⁰ The defect in this model

¹⁴⁷ PRESIDENT'S ADVISORY COUNCIL ON EXECUTIVE ORGANIZATION, A NEW REGULATORY FRAMEWORK: REPORT ON SELECTED INDEPENDENT REGULATORY AGENCIES (1971). For a critique, see R. NOLL, REFORMING REGULATION: AN EVALUATION OF THE ASH COUNCIL PROPOSALS (1971).

¹⁴⁸ How hospitals exercise political influence would be an interesting study. Although political campaign contributions by the hospitals themselves would be unseemly, boards of trustees are likely to include major contributors and persons having other kinds of influence. Moreover, as hospitals are perceived as community enterprises, no one is likely to regard even the most overt pressure as improper.

¹⁴⁹ The New York State Public Health Council and State Hospital Review and Planning Council are examples.

¹⁵⁰ Nongovernmental health planning institutions often derive a portion of their financial support directly from the hospitals or hospital trade associations, creating a dependency whereby "capture" of local planners by local hospitals could occur. A recent study reveals a strong positive correlation between involvement of areawide health planning agencies in facilities regulation and bed control and the extent of financial support drawn from the hospital industry. O'DONOGHUE, BRYANT, & SHAUGHNESSY, *supra* note 139, at 14-15, 39-40, 46-47, 63-65, 79-80 (1973). Although the average contribution by hospitals to "B" agency budgets is only six percent, *id.* at 15, the concentration of these funds in those agencies with the most power to influence industry welfare is at least a suspicious circumstance.

is that such decision makers may be unduly dependent for advice and direction on the provider representatives and the agency staff, whom they will regard as experts. Nevertheless, the agency or council members themselves will be largely free, in terms of their personal stakes and prospects, to pursue the public interest as they see it. Moreover, the staff may find it useful to have such a prestigious body, possessing credibility and independence, to shield them from the impact of politically sensitive decisions. This decision-making model has not been much used in other fields and may prove more trustworthy than traditional models.

Organizational factors aside, there remains a potential basis for a convergence of viewpoint between the regulated hospitals and the health planners, the group from which most agency staff members are recruited. Dedicated to developing a more rational and more humanitarian health care system, the planners are likely to contemplate a long list of projects which they believe would contribute to this goal. Their shopping list is apt to be expensive and to contain at least some luxuries.¹⁵¹ Because many of the desired programs could easily be hospital-based, there is at least a potential ground for agreement between the planners and the regulated industry on the desirability of a larger hospital sector. Similarly, consumer representatives on state boards and advisory councils are quite likely to share in the general enthusiasm for more and better health services so long as duplication is avoided. Although disagreements over the priorities attached to different types of services would inevitably exist, a joint-venture attitude could easily develop if financing problems could be overcome.¹⁵²

Tool of an Industry Cartel?

It is frequently observed, without reference to the theory of agency "capture" as an explanation, that regulatory agencies tend to adopt strategies disturbingly similar to those which an industry-wide cartel or monopoly would pursue if it could.¹⁵³ Thus, prices are frequently maintained well above competitive levels, and price discrimination—that is,

¹⁵¹ For a typical shopping list, see Gentry, Veney, Kaluzny, Sprague, and Coulter, *Attitudes and Perceptions of Health Service Providers: Implications for Implementation and Delivery of Community Health Services*, Oct. 13, 1971 (revised version of a paper presented to the American Public Health Ass'n, Minneapolis, Minnesota).

¹⁵² The prospects for such a development are explored in the text accompanying notes 170-77 *infra*.

¹⁵³ E.g., Jordan, *supra* note 49.

pricing which exploits consumers' varying willingness to pay—is facilitated by restrictions which prevent both industry insiders and outsiders from seizing competitive opportunities and thereby driving prices down toward marginal cost.

Does hospital industry support for certificate-of-need laws imply an expectation that the regulators, even if not subject to "capture," will see things the same way that the industry does? Certainly the industry and the regulators appear to agree that capacity must be limited. This confluence of views is explained by Martin Feldstein's demonstration that new bed supply both stimulates new demand and depresses prices¹⁵⁴ since, if the effect of new supply were pure, consensus would not occur. If new supply always generated enough new customers at the original price, the industry would be antagonistic to public intervention, and, if the only impact of new supply was to lower prices in a competitive market, the industry alone would have good reason to see it suppressed.

Although it would be hard to document, a fairly close correlation probably exists between industry attitudes toward certificate-of-need laws and the relative strengths of the two effects of new supply.¹⁵⁵ Thus, the recent decline in occupancy rates of hospital beds, which can only have accentuated the price-depressing effect of new supply, has been accompanied by increased lobbying for regulatory controls.¹⁵⁶ Parity of reasoning suggests that a slackening of industry support for supply restrictions would accompany agency success in moving the industry out of the area where the adverse price effect of new supply is strongest. The pernicious impact of third-party cost reimbursement and provider influence over demand will thus continue to be felt, not only in the eagerness of individual providers to expand but also in industry attitudes toward enforcement of certificate-of-need laws. Indeed, it seems likely that, given the continuation of third-party payment, the hospital industry's strategy will be to restrict supply only to a point considerably higher than the public interest dictates. The problem is therefore not that an agency under strong industry influence would excessively restrict

¹⁵⁴ See note 60 *supra* and accompanying text.

¹⁵⁵ For this observation, I rely on my earlier one, *supra* note 60, that the relative strength of the two effects depends upon the extent to which existing demand-creation opportunities are already being exploited. Indeed, real medical need shades gradually into provider-created demand, and neither can be understood except in relation to both marginal and total cost.

¹⁵⁶ I have been able to find no correlation between occupancy rate trends and enactment of certificate-of-need laws, however.

supply, as classical cartels have done, but that it might not restrict it enough.

If the hospital industry resists extending supply restrictions beyond its own welfare-maximizing point, who will oppose it and keep the agency attuned to true consumer interests? Consumers will probably fail to present a united front on these issues, but even the most cost-conscious will find it hard to oppose more and better services so long as the most obvious duplication and overcapacity is avoided. In these circumstances, the main constituency influencing the vigor of certificate-of-need enforcement would usually be the hospital industry itself, and its preferences would be influenced by the system's continued reliance on cost-plus pricing and by the phenomenon of supply which seems to generate its own demand. In this event, enforcement would be effective only in reducing egregious overbedding and obvious duplication of facilities.

The cartel hypothesis would not hold under the New York expedient of lodging certification of need and direct responsibility for costs in the same agency. Even in these circumstances, however, the regulators, the overseeing politicians, and most consumer groups as well would lose interest in health care costs as soon as they were brought into line with the cost of living. This would occur because political forces respond primarily to the direction and rate of change and are much less concerned with the correctness of the absolute level of cost or activity achieved by a particular program—hence, the extreme difficulty of raising taxes and the almost total lack of pressure to reduce them. Thus, even if certification of need were made the responsibility of the most cost-conscious state agency, the equilibrium point would be such that hospitals' gross revenues would not be reduced.

Friend of Industry Insiders?

Whether or not unduly responsive to industry interests in general, regulatory agencies are sometimes subject to undue political influence exerted on behalf of particular private interests by legislators and the executive branch. Although it is difficult to generalize about the vulnerability of regulatory programs to such influences, it probably varies with such factors as the agency's esprit and sense of purpose, its dependence for budgetary and other support on legislative and executive favor, the regulators' independence in terms of tenure, and the visibility of the decisions reached. The tendency of regulatory agencies to aggrandize industry insiders is frequently justified on the ground of preferring ap-

plicants with good "track records" over unknown quantities. But the result of such a policy over time is to increase the size of industry incumbents and to foreclose new participants. This tendency is most likely to be present where political influence is a significant factor and where award of new privileges is seen as compensation for past cooperation.¹⁵⁷

That certificate-of-need agencies are subject to a considerable amount of political pressure is clear. Applications to the agency are apt to be of intense local interest, and civic leaders naturally rely heavily on their political representatives in matters of this kind. Moreover, the nonprofit character and/or community identification of most hospitals lead naturally to acceptance on all sides of the propriety of resorting to political influence. Furthermore, since one precept of health planning is that it should allow community judgments to emerge, politicization is viewed as a desirable thing. Nevertheless, reliance on political influence and infighting under circumstances where the public's interest in cost control is weakly asserted is likely to produce regulatory outcomes skewed in favor of influential institutions. Lacking a constituency actively supporting it in an aggressive role, the certificate-of-need agency may be inclined to let many influentially backed projects proceed even though it would really rather stop them.¹⁵⁸

Limited investigation suggests further that established community hospitals, major medical centers, hospitals associated with religious and similar organizations, and well-entrenched proprietaries seem to be capable of receiving special attention for applications which would be rejected

¹⁵⁷ The Civil Aeronautics Board is perhaps the most notorious agency in this regard, preferring its trunkline carrier constituency over all challengers to such an extent that no new trunk carriers have been admitted to the industry in the thirty-five years since the Civil Aeronautics Act was passed. *CAVES*, *supra* note 49, at 169-76.

¹⁵⁸ The files on applications which were frequently consulted contained letters from legislators and other officials and courteous, noncommittal replies. Agency personnel generally acknowledged such contracts, though they were reluctant to admit any deleterious effects. Some applications were frankly described as being politically touchy, however, and in one agency it was clear—and it is a safe assumption generally—that action on such applications is frequently deferred to avoid disapproval and that accommodations which would permit approval are actively sought.

In another state a file was found to contain the following handwritten note by a subordinate made preparatory to a decision on a particular application to build a new proprietary hospital, which was competing with two other applications:

Environment: [State] Senator [X] pressure; Dr. [Applicant]'s bad mouthing and pressure on [Agency Director]: [Deputy Director] "very impressed" with [Applicant], thinks it politically wise to act soon—immediately—in [Applicant's] favor; [Director] marching orders—"decision by Monday morning"; generally: pressure from all sides to accept [areawide agency's] recom and give [Applicant] go ahead.

out of hand if submitted by less well-connected interests.¹⁵⁹ The long-run consequence of such systematic preferences is that larger hospitals grow while new facilities are discouraged; incumbents enjoy an unwritten presumption in proposing to replace their outmoded facilities; "satellites" of existing hospitals are favored over new entrants; and "chains" and other proprietaries are excluded in favor of existing facilities or community-sponsored organizations. Perhaps economies of scale and quality considerations could in some measure justify these tendencies,¹⁶⁰ but the end result is less consumer choice and more concentrated control in local markets.

The inability of new entrants to obtain certificates of need is not attributable solely to political factors, for the mechanics of this form of regulation alone make displacement of an established provider difficult. Once bed needs have been filled, new facilities can be built only if old beds are shut down, and the agency generally lacks the power to close down existing facilities.¹⁶¹ Thus, an existing provider, which can offer to replace old facilities even at a different location, has almost a license in perpetuity. Moreover, the lack of incentives for nonprofit firms to sell out even when operating failing enterprises increases the would-be entrant's difficulties in buying up "operating rights."¹⁶²

Many observers will find the entrenchment and aggrandizement of existing providers, whether due to political influence or to the nature of the regulatory scheme adopted largely at the insiders' behest, to be an unattractive feature of certificate-of-need laws. However, the more destructive consequence of a regulatory system in which established providers exercise extensive influence is likely to be the exclusion of desirable innovations which threaten the industry's financial structure. Because this type of producer protection is very nearly the "clincher" in the argument against certificate-of-need laws, its discussion is deferred.

¹⁵⁹ See, e.g., text accompanying notes 217-18 *infra*.

¹⁶⁰ The extent of economies of scale in hospitals is the subject of debate. See Lave & Lave, *Hospital Cost Functions*, 60 AM. ECON. REV. 379, 394 (1970). See Pauly, *supra* note 63. Regulators may be inclined to exaggerate their importance, however, and hence to underestimate opportunities for competition. It is important to distinguish the numerous different services supplied by hospitals in assessing scale economies. See text accompanying notes 73-76 *supra*.

¹⁶¹ Interviews in New York indicated that this situation prevails there.

¹⁶² Although frequently employed in other regulated industries, this term is unlikely, for obvious reasons, to be employed in health care. A few states expressly declare certificates of need to be nontransferable, and only Tennessee expressly permits transfers.

Facilitator of the Industry's Good Works?

Producer protection by regulatory agencies may be more rational and less sinister than the foregoing discussion suggests. Indeed, producers frequently have a strong claim to protection since numerous useful services which are supplied at a loss by the regulated firms would be discontinued if the regulatory agency permitted the firms' revenues to be eroded by competition. The more conspiratorial interpretations of agency behavior may therefore miss the point. One does not have to be corrupt or an industry mouthpiece to endorse the provision of transportation services, electric power, communications services, or other products of the regulated industry which otherwise might not be provided. The next section of the Article, examining the "internal subsidization" phenomenon by which such good works are fostered, leads to some insights about regulation which have considerable bearing on regulatory initiatives in health care. In short, even without the hospital industry's political domination of the regulatory process, regulatory policies are likely to be unduly protective and to foster both inflation and an excessive allocation of resources to the hospital sector. It is simply ironic that such results are the precise opposite of what certificate-of-need proponents promise.

*B. The "Taxation-by-Regulation" Hypothesis**Internal Subsidization and Resource Allocation*

Programs of economic regulation nearly always require the regulated firm to render various unremunerative services.¹⁶³ These services receive financial support from the revenues earned by other services, which are priced well above cost. This "internal subsidization," which could not occur systematically in a competitive market and would not be tolerated by a profit-maximizing monopolist, has been incorporated by Richard Posner into a theory of regulation. He treats regulation as a hitherto unrecognized mechanism of public finance whereby a franchised firm is permitted in effect to impose an excise tax on some of its services on the condition that it apply the excess revenues to providing certain other services, thought to be needed by the public, at less than their cost.¹⁶⁴ Rather than appropriate tax monies, the legislature in effect delegates

¹⁶³ For some examples, see note 166 *infra* and references cited in note 164 *infra*.

¹⁶⁴ Posner, *supra* note 78. See also Comanor & Mitchell, *The Costs of Planning: The FCC and Cable Television*, 15 J. LAW & ECON. 177 (1972), identifying the same phenomenon as "planning by regulation" and emphasizing the regulators' pursuit of positive goals conceived as being in the public interest. These two articles provide an excellent

the power to tax and spend for public purposes to the regulatory agency and tolerates the agency's redelegation of these powers to private interests. The title of Posner's article provides a good descriptive name for this phenomenon—"taxation by regulation."

Internal subsidization can be criticized because it necessitates much of the protectionism which characterizes all regulation. Market entry and the expansion of existing firms must be controlled to prevent the high monopoly price on certain services from inducing new supply of those services, perhaps offered by firms which, in spite of their lower prices, are less efficient than the incumbent. In the eyes of the regulators, preservation of the regulated firm and its ability to earn monopoly returns on some services becomes an essential means of carrying out purposes they conceive to be desirable. Once this frame of reference is established, there is practically no room left for using competition as a check on performance or for relying on market signals to guide investment.

Another objection to this mechanism for subsidizing public services is that the usual governmental process of taxation, authorization, appropriation, and expenditure is bypassed.¹⁶⁵ As a result of their low visibility, internal subsidies may support unneeded services or may redistribute income from the more affluent to the less affluent.¹⁶⁶ Assessment of the insight into an essential characteristic of regulation, which is described by Hilton, *supra* note 105, at 50, as a tendency "to generate monopoly gain in one activity, either through administering a cartel or maintaining a monopoly, and then to dissipate it in uneconomic activity."

¹⁶⁵ See note 172 *infra*.

¹⁶⁶ It is impossible to determine whether subsidies accomplished by this method are more or less progressive in their net effect than other government programs. The identification of gainers and losers in the following examples is instructive: Freight carriers are required to serve outlying areas and small shippers at rates which are below cost for the particular service; similarly, airlines are expected to use profits from heavily traveled routes to provide service to smaller towns. Products of particular favored industries are required to be hauled at discriminatorily low rates, while tariffs on other goods are kept well above cost to make up the difference. Before Amtrak, passenger trains were compelled to run at losses which the railroads had to make up on freight traffic, with substantial benefits to suburban commuters. The FCC expects broadcasters to plow back some portion of their advertising revenues into "public interest" programming, a category which includes mostly things which appeal only to intellectual and cultural elites. Utility rates do not return the cost of service in all cases, an example being Comsat, which must price its Atlantic and Pacific satellite services at the same level in order to promote the latter at the expense of users of the former. Many transportation and communication services are compelled because, though presently unremunerative, they are potentially valuable for "national defense" purposes, though their cost does not appear in the defense (or any other) budget. See generally Breyer, *The Ash Council's Report on the Independent Regulatory Agencies*, 2 *BELL J. ECON. & MGT. SCI.* 628, 633-35 (1971); Posner, *supra* note 78, at 23-24, 29-34.

total impact of such subsidies is impossible,¹⁶⁷ but the public has little opportunity to judge the cost or merits of particular subsidies fostered by the regulators. Although reliance on internal subsidies could sometimes be a rational and efficient approach to income redistribution and the provision of public services, it would be unfortunate if policy makers were to favor such secret financing precisely because of its attendant nonaccountability.

Another hazard of internal subsidization is the considerable risk that an excessive amount of society's resources will be allocated to the regulated industry. The agency's power to tax some users and to use the proceeds for what it perceives to be good works is limited only by its ingenuity in finding worthy projects within the industry's competence. The regulators will be supported in their judgments both by the beneficiaries of the subsidies, who may be politically influential, and by the regulated firms themselves, who, assured of a "fair rate of return" on their total investment, will be happy to expand their scope. Believing in the service and being glad to broaden their own authority and influence, the regulators will have no occasion to question whether the money might find better uses elsewhere in the economy. The result, according to Roger G. Noll, is that "regulatory policy might accurately be characterized as maximizing the size of the regulated industry" ¹⁶⁸

¹⁶⁷ See, e.g., Rottenberg, *Misplaced Emphases in Wars on Poverty*, 31 LAW & CONTEMP. PROB. 64 (1966); Stigler, *Director's Law of Public Income Redistribution*, 13 J. LAW & ECON. 1 (1970). Subsidies of this kind are apt to be inefficient, entailing sacrifice of potential welfare gains (consumer surplus) without yielding an equivalent amount of dollars to be used as subsidies. Direct taxation would therefore be preferable. See Comanor & Mitchell, *supra* note 164, at 197-98, 204, 206. These authors attempt to calculate the welfare losses imposed by the FCC on would-be cable television subscribers in order to provide other broadcasting services. Internal subsidization seems not to be as inefficient in health care as in other fields, however, because of health insurance. Indeed, if insurance coverage were complete and demand were therefore perfectly price-inelastic—that is, unrelated to price—excess charges on some services would cause no welfare loss from services forgone. Nevertheless, health insurance is itself inefficient, since the internal subsidies which it provides (from one insured to another) induce overconsumption of health resources.

¹⁶⁸ NOLL, *supra* note 147, at 16. See also Comanor & Mitchell, *supra* note 164, at 184.

This concern with television revenues is characteristic of FCC policies and indeed of regulatory commissions generally. Factors which restrict revenues, and thereby the scale of the regulated industries, are immediately suspect, while factors which increase the revenues and size of the sector are to be encouraged. Given a sector-by-sector approach to economic planning, this is to be expected. A larger sector gives rise to greater prospects for regulatory "good works" while a smaller sector does not. Few regulatory authorities would wish to be concerned primarily with a declining sector of the economy, and the view that this might possibly represent a desired reallocation of resources is likely to be anathema to them. *Planning*

Internal Subsidies and Hospitals

Internal subsidization is already an important phenomenon in the hospital industry. Laboratory, x-ray and pharmacy services, and basic per diem charges are ordinarily profitable, while obstetric care, the emergency room, and the intensive care unit are usually subsidized in some degree. Where hospitals have underutilized facilities, revenues from other services usually support them. Perhaps the most defensible use of internal subsidies in hospitals, that which supports care for indigent patients, was recently underscored by the "free-care" requirement imposed by the federal government on all hospitals which have benefitted from the Hill-Burton program.¹⁶⁹ Although pressures from third-party payment programs have begun to narrow the hospitals' freedom to engage in internal subsidization, it is still an important mechanism for financing health care and is tolerated as such by most of the financing programs.

Although the "cream-skimming" issue lurks constantly in the background, certificate-of-need laws are not conceived solely as protectionist measures or to perpetuate internal subsidization. Nevertheless, as long as a need requirement is enforced, discriminatory pricing cannot be eliminated by competition which drives prices down to cost. Moreover, by requiring approval of service cutbacks some states have adopted the franchising model with its dependence on internal subsidies to support obligatory but unremunerative services. In short, some continued dependence on internal subsidies is a necessary by-product of certificate-of-need legislation.

Because certificate-of-need agencies usually lack control over hospital rates and third-party cost-reimbursement formulas, they are unable to impose the "tax" which may be necessary to make certain "needed" services or facilities feasible. If hospitals therefore propose only potentially self-supporting services, the internal subsidization possibilities in hospitals seem unlikely to expand under certificate-of-need requirements. Rather, the prevalence of subsidized services would be largely in the hands of

by regulation leads directly to actions which generally distort the allocation of resources between the regulated and the unregulated sectors of the economy.

¹⁶⁹ 42 C.F.R. § 53.111 (1972). It was clear from the vigorous industry opposition to that requirement that many institutions were not dedicating substantial resources to indigent care, but this did not mean that services of other kinds were not being subsidized. The original proposal would have required 5 percent of operating costs to be dedicated to free or below-cost care, 37 Fed. Reg. 7632 (1972); this was reduced three percent in the final regulation. See *Hill-Burton 5 Per Cent: Who Will Pay When Those Who Do Pay Won't Pay Any More?*, MODERN HOSPITAL, June 1972, at 21.

those with ultimate authority over hospital charges—the rate regulators, where they exist, and the third-party payers—either of whom might be unimpressed by an agency's determination of the need for a service which was a candidate for subsidy through the cost-reimbursement formula. Thus, although certificate-of-need laws involve a clear rejection of competition as a force corrective of internal subsidization, they do not necessarily foster internal subsidization in other ways.

To the extent that an agency determination of need for a service effectively guarantees its financial support by third-party payers, the case is analogous to public utility regulation. Under public utility principles, the regulated firm is entitled to a rate schedule which promises recovery of its total costs, plus a fair return on investment, even though some obligatory services must be offered at a loss.¹⁷⁰ Although certificate-of-need laws separate need determinations from financial support, some hospitals and some planners urge more unified control. With many unremunerative services legally mandated or regarded as a duty, the hospitals can legitimately complain when the financing is not forthcoming or, indeed, is eroded by controls imposed by government or other third-party payers who, in the hospitals' view, should share the responsibility.¹⁷¹ The health planners, on the other hand, sense many unmet needs and desire the power to compel the provision of certain unremunerative services through the franchising of hospitals. But franchising alone would not assure third-party payers' support for services other than those received by their beneficiaries. In these circumstances, the pressure—and indeed the apparent logical case—for public utility regulation is quite strong. Under such regulation, the rates to be paid would be fixed by the same regulators who authorized the services to be rendered.¹⁷²

The case against the public utility model rests fundamentally on considerations of resource allocation, although concerns about inefficiency,

¹⁷⁰ *Baltimore & O.R.R. v. United States*, 345 U.S. 146 (1953); *United Rys. v. West*, 280 U.S. 234 (1930).

¹⁷¹ The proposal by New York hospitals for an independent hospital regulatory commission arises from precisely this set of concerns. See text and accompanying notes 141-46 *supra*.

¹⁷² An alternative means of obtaining needed services with greater accountability would be by contract between local governments and providers. See Havighurst, *Franchising Experience From Other Industries and Its Relevance for the Health Field*, in *HOSPITAL FRANCHISING*, *supra* note 45, at 11, 14. Emergency medical services are sometimes provided in this manner. For a thoughtful endorsement of direct subsidies and rejection of internal subsidies in providing health services to rural residents, see Billings & Paul, *Commercial Airlines Industry: Some Lessons for Health Services Planners*, 11 *MED. CARE* 145, 151 (1973).

special privileges, repression of innovation, and monopoly also warrant reservations.¹⁷³ With 7.6 percent of the gross national product now dedicated to health care and with per capita expenditures on health five times what they were in 1950 and doubling between 1965 and 1972,¹⁷⁴ the adoption of a regulatory system which has uniformly dedicated itself in other settings to, in Noll's words, "maximizing the size of the regulated industry" seems at best a dubious policy. Although all regulated industries have demonstrated allocative inefficiencies, particularly with respect to industry size vis-à-vis the rest of the economy, none of them has offered a potential for growth approaching that of the health care industry. Even without internal subsidies protected by regulatory restrictions, belief in health care as an end in itself, the unlimited commitment to ever-improving quality and accessibility, the continuing scientific and technological explosion, and the further weakening of cost constraints through expanded third-party payment together add up to a considerable potential bill.¹⁷⁵ But when this sum is multiplied by the hidden and virtually inexhaustible revenue source, the planners' enthusiasm for many hospital-based services,¹⁷⁶ and the ever-present necessity for log-rolling in response to numerous clamoring interest groups, the prospect for further inflation in health care costs is staggering.

¹⁷³ See Havighurst, *supra* note 172.

¹⁷⁴ Cooper & Worthington, *National Health Expenditures 1929-1972*, Soc. Sec. BULL., Jan. 1973, at 3, 12, 13. Sweden spends a greater proportion of GNP on health care, England very much less. See generally O. ANDERSON, *HEALTH CARE: CAN THERE BE EQUITY?* (1972).

¹⁷⁵ It can be argued that people exaggerate the benefits which can be derived from health care and fail to get value for money. See A. COCHRANE, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1972); Neuhauser, *The Future of Proprietaries in the Health Care System*, in AEI PROCEEDINGS, *supra* note 6. As society assumes responsibility for health care, grave ethical difficulties accompany efforts to limit expenditures, and high costs may be incurred in order to avoid facing these choices. See generally NAT'L HEART AND LUNG INSTITUTE, *REPORT OF THE ARTIFICIAL HEART ASSESSMENT PANEL* (1973); Fried, *The Value of Life*, 82 HARV. L. REV. 1415 (1969); Schelling, *The Life You Save May Be Your Own*, in *PROBLEMS IN PUBLIC EXPENDITURE ANALYSIS* 127 (S. Chase ed. 1968); Zeckhauser, *Coverage for Catastrophic Illness*, 1972 (Harvard University, Kennedy School of Government, Public Policy Program Discussion Paper No. 12); Calabresi, "Toward a Theory of Tragic Choices," April, 1973 (lectures delivered at the University of Pennsylvania Law School).

¹⁷⁶ Lest it be thought that the hospital sector is already so large as to be incapable of further growth, recall that many of those exerting pressure for franchising and utility-type regulation view it as a means of carrying out an agenda of "needed" projects which hospitals, lacking financial assurances, have heretofore been reluctant to undertake. See text accompanying notes 151-52 *supra*.

The political environment offers little ground for reassurance. The regulators' small successes in preventing duplication and in vetoing occasional projects would merely obscure their contribution to inflation and, together with the vested interests spawned by the expanded subsidies, make legislative adjustments difficult to accomplish. On the other hand, the regulators might ultimately face political risks if health care costs continue their rapid rise. With this as the only check on the regulators' ability to foster expansion, however, there would be only a slowdown in the rate of inflation and certainly no substantial opportunity to reduce costs below the level eventually attained; as noted previously, political forces are concerned with costs only in proportion to their rate of increase.

In summary, the mechanisms of public utility regulation must seem on balance a distinctly unpromising means of imposing control on the health care system and its already remarkable ability to absorb resources. Indeed, it is a cause for wonder that a mechanism which has been widely criticized precisely because it misallocates resources is today being offered by sincere individuals as a means of obtaining more efficient allocative results in the health care system.

C. The "Brushfire-Wars" Hypothesis

The historical roots of certificate-of-need laws in health planning and the present involvement of CHP agencies in the certificate-of-need process may prompt an expectation that certificate-of-need programs will feature a strong planning orientation and be thereby distinguishable from other regulatory efforts. But if agencies exhaust their energies on problems of the moment—fighting "brushfire wars"¹⁷⁷—and if health

¹⁷⁷ Time has corrected one dearly held illusion. It was thought in the heyday of the New Deal that an operating administrative agency, because of its continuous exposure to the problems of an area, was ideally fitted for progressive planning and programming. We have found that such is not the case. The agency is so deeply, so anxiously involved in solving the problems of the moment that most of its effort goes out in keeping astride of its operating agenda. Furthermore, buffeted by strong, opposing forces it looks for compromise, expediency, and short-term solutions. After its first strenuous years of conflict with those whom it must regulate, it may arrive at a modus vivendi which it looks upon and pronounces to be good. Radical planning under such conditions is not impossible, but it is unlikely.

L. JAFFE, JUDICIAL CONTROL OF ADMINISTRATIVE ACTION 51 (1965). See also BERNSTEIN, *supra* note 135, at 176-79; NOLL, *supra* note 147, at 93-94; E. WILLIAMS, THE REGULATION OF RAIL-MOTOR RATE COMPETITION 201-15 (1958). Specific planning failures are documented in CAVES, *supra* note 49 ("The timing and substance of policies on such important

planning therefore turns out to be largely a euphemism for a political bargaining-out of differences among interest groups, it will be fair to conclude that certificate-of-need programs will probably be plagued by the same weaknesses which similar regulatory schemes have consistently revealed.

Planning and Regulation

The adoption of comprehensive regulatory programs for particular industries has usually been accompanied by an expectation that planning and coordination would be facilitated by the use of administrative mechanisms.¹⁷⁸ These hopes have been regularly disappointed, however, as the agencies strive to keep up with immediate problems. Absorbed in deciding inconsequential issues of equity such as which of several applicants shall provide a given service, the agencies are unable to perform the socially more important job of prescribing the industry's structure, determining which services should be offered, and deciding how needed change can be promoted.¹⁷⁹ In many cases, the equitable distribution of the burdens and benefits of regulation and the strengthening of the weaker firms have become primary regulatory goals.¹⁸⁰

The reason most frequently offered for the inadequacy of regulatory planning efforts is the scarcity of agency resources. Although arguably agencies are funded only at the level necessary to permit them to perform their most pressing functions, it is possible that some kind of Parkinson's

things as the irregular airlines, passenger fares, and the treatment of the local-service carriers are explainable only with reference to the political environment . . ." *Id.* at 298); Johnson, *supra* note 49. Comanor & Mitchell, *supra* note 164, point out that the "planning" functions most favored by regulators are those which involve the sponsoring of "good works" by internal subsidization.

¹⁷⁸ See, e.g., National Transportation Policy, 49 U.S.C. § 1 (1970) (Note preceding § 1, originally enacted as Act of Sept. 18, 1940, ch. 722, tit. I, 54 Stat. 899).

¹⁷⁹ Cramton, *The Effectiveness of Economic Regulation: A Legal View*, 54 AM. ECON. REV. 182 (1964). See also 2 KAHN, *supra* note 46, at 86-92.

¹⁸⁰ The ICC, charged with regulating several modes of surface transport, has adopted policies which are

consistent with a point of view which concerns itself primarily with what must be done in fairness to the carriers which have actually been competing for the particular traffic in issue. It is consistent with keeping everyone in the business. It does not, however, contribute to the development of a more economic division of the traffic, to coordination of the services, or to the development of economy in the handling of the available business.

WILLIAMS, *supra* note 177, at 214. See also Hilton, *supra* note 105, at 48-49.

law operates to absorb added agency resources in new brushfire wars, perhaps triggering an expansion of the regulatory domain rather than an increase in planning activities.¹⁸¹ The commission members themselves may not value planning highly, due to the limited term of their appointments, the lack of pressure to examine and justify policies, and the necessity for tackling the agenda at hand before going on to grander designs. Often the problems which need to be dealt with through planning are so difficult and controversial as to be totally intractable. Even when substantial planning efforts have occurred,¹⁸² they are often short-lived, and their benefit is often dissipated by the press of events and politics, the changing membership of the agency, and the difficulties of implementing major changes.

The difficulty may go much deeper than these explanations suggest. Planning and regulation can be said to differ in that on occasion the former requires major policy decisions which are harmful to the regulated interests.¹⁸³ The political environment and the view that the public interest inheres in compromise and accommodation among competing interests have made such decisions impossible under regulation. True to their political orientation, the regulators have defined their function as that of mediating among interest groups rather than defining the public interest objectively and forcing the regulated firms to accept it. As a result, the equilibria achieved are guaranteed to give even an articulate and well represented public only part of a loaf and to be even more biased in favor of the regulated group when, as usually happens, it takes the greatest interest in the matter. Theodore J. Lowi's diagnosis of the shortcomings of "interest-group liberalism" seems well sustained by the performance of the regulatory agencies: "Liberal governments can-

¹⁸¹ See NOLL, *supra* note 147, at 82.

¹⁸² The few substantial planning efforts which have been undertaken from time to time by administrative agencies have been generally applauded. *E.g.*, FPC, NATIONAL POWER SURVEY (1964); SEC, SPECIAL STUDY OF THE SECURITIES MARKETS (1963). See generally 2 KAHN, *supra* note 46, at 64-86, emphasizing the gaps in agency power to promote coordination.

¹⁸³ Charles Reich faults regulation for being too narrowly conceived and focused and for being dedicated to compromise:

As the agencies have sought a meaning for the public interest, they have come to this: the public interest is served by agency policies which harmonize as many as possible of the competing interests present in a given situation . . . In all of these cases it is thought that the public interest requires some recognition of the claims of each interest that can be identified.

Reich, *The Law of the Planned Society*, 75 YALE L.J. 1227, 1234 (1966).

not plan. Planning requires the authoritative use of authority. Planning requires law, choice, priorities, moralities. Liberalism replaces planning with bargaining."¹⁸⁴

Because politicized regulation permits at best only incremental change, it is less appropriate where there is substantial discontent with the status quo. Thus, certificate-of-need laws are favored by those who see them merely as fixing a small defect in an industry which is otherwise performing acceptably. The regulatory approach should be less appealing to those who wish to preserve and expand opportunities for major change in the health care system.¹⁸⁵

Planning-cum-Regulation in the Certificate-of-Need and Planning Agencies

In spite of their origins in health planning, certificate-of-need laws are essentially regulatory in character. Indeed, some observers perceive a danger that by converting the traditional planning agencies into politicized, quasi-regulatory bodies, certificate-of-need laws will debase health

¹⁸⁴ Lowi, *supra* note 138, at 101. Although Reich observes the same tendency to compromise, *see* note 183 *supra*, he and Lowi part company on the remedies. Reich pleads for broader interest-group representation and administrative responsibility to encompass a broader range of interests. Lowi, on the other hand, wants more specific legislative mandates and more administrative rule making, believing that administrators can carry out specific directives but succumb to compromises when told merely to pursue the public interest. The two models probably fit different circumstances, Reich's being possibly appropriate as a means of protecting against "spillover" effects on environmental and "consciousness-III" interests. *See, e.g.,* National Environmental Policy Act, 42 U.S.C. §§ 4321 *et seq.* (1971); C. REICH, *THE GREENING OF AMERICA* (1970); Breyer, *supra* note 166, at 635-37, and Lowi's being better suited to cases where regulation is directed to a specific market failure. The problems addressed by certificate-of-need laws seem to fit the latter category and Lowi's prescription.

¹⁸⁵ Another helpful characterization of the difference between planning and regulation is Charles Lindblom's distinction between "rational-comprehensive analysis" and "muddling through." Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79 (1959). A study by George Maddox of the handling of the hospital bed supply and other items on the planning agenda of the British National Health Service found that "disjointed incrementalism"—that is, "muddling through"—has been the prevalent means of policy formation and that the regionalized structure of the NHS "maximizes the probability that partisans can and will effectively contest and politicize all decisions of consequence." Maddox, *Muddling Through: Planning for Health Care in England,* 9 MED. CARE 439, 446 (1971). Characterizing incrementalism as "conservative," Maddox attributes to Lindblom the view that "incrementalism is the strategy of choice particularly in stable systems characterized by generally adequate performance vis-à-vis announced objectives." *Id.*

planning.¹⁸⁶ It is difficult to make a reliable assessment of how planning and regulation differ in this context and how they can be expected to interact in practice.

The degree of true health facility planning is suggested by the extent to which actual facility needs have been analyzed and reduced to objective criteria permitting proposals to be evaluated rather than merely bargained over. In one survey of 128 health planning agencies of all kinds, only twenty percent indicated that they were able to project, on the basis of any kind of master plan, a matter so elementary as the facility needs in their area.¹⁸⁷ Other evidence confirms the absence of hard planning.¹⁸⁸ Indeed, the Maryland certificate-of-need agency, operating under a statute which limits it to certifying projects' conformance to a "state plan," carries on even though no master plan exists.¹⁸⁹ This general record of nonplanning follows many years of federally supported

¹⁸⁶ Compare Sieverts, Book Review, 3 HEALTH SERVICES RESEARCH 251 (1968), with May, *Planning: Mainstreams and Eddies*, 3 HEALTH SERVICES RESEARCH at 327. See also J. MAY, HEALTH PLANNING: ITS PAST AND POTENTIAL (1967); *Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. pt. 2, at 714-26 (1970) (testimony of Symond R. Gottlieb); D. Brown, *supra* note 22; Curran, *Health Planning Agencies: A Legal Crisis?*, 60 AM. J. PUB. HEALTH 359 (1970). Proponents of preserving a nonregulatory, advisory role for planners stress the agencies' value in education, in increasing contact among groups, in encouraging institutional planning efforts, and in persuading providers to assume more community responsibilities. Although "planning" may be a misnomer for most of the activities engaged in, such agencies have performed useful services in many communities. Their ability to carry on as facilitators of change by persuasion and advice would be harmed, it is said, by giving them regulatory responsibilities which undercut trust, increase political exposure, and reduce the need to maintain credibility and cultivate influence. Whether these strengths could coexist with even an influential advisory role may not be clear.

¹⁸⁷ COMPTROLLER GENERAL OF THE UNITED STATES, REPORT OF THE STUDY OF HEALTH FACILITIES CONSTRUCTION COSTS 880 (Joint Comm. Print 1972) [hereinafter cited as GAO Study].

¹⁸⁸ Less than fifty percent of 163 agencies responding to the GAO survey could state that they knew the bed needs in their area for the current year. *Id.* at 878. See also McCrossin & Simmons, *Survey of Planning Agencies Shows Inadequacy of Existing Programs*, 50 HOSPITAL TOPICS 21 (1972). Many planners would deny that absence of such master plans is a basis for criticism, however, because in their view planning is a dynamic, political process rather than a numbers game. See note 186 *supra*.

¹⁸⁹ MD. ANN. CODE art. 43, § 559(a-1) (Repl. Vol. 1971), contemplates certification of conformance to "the comprehensive health plan developed and applicable for the particular area." The statute goes on to say, "Where no comprehensive health plan has been developed for a particular area, the State's comprehensive planning agency shall make the determinations required." No standards whatsoever are provided for indicating the nature of, or making, such "determinations."

planning for Hill-Burton and other purposes, suggesting that the problem extends beyond the newness of the certificate-of-need programs.¹⁹⁰

The universal emphasis on "consumer representation" on health planning bodies suggests that policy makers see community health planning as an exercise in "interest-group liberalism" rather than as an attempt to introduce real planning on the public's behalf.^{190a} Moreover, the health planners themselves do not strongly subscribe to master plans and objective criteria but instead see planning primarily as a consensual process. One description, based on a 1967 survey of voluntary planning agencies, reports that

Areawide hospital planning was fundamentally a process—a process of human involvement and reciprocity. The process was flexible, open to negotiation, and incremental—a rather untidy process that accommodated to the realities of community life. As such, it was based mainly on interpersonal relations and community organization rather than on technical procedures and refined data. Indeed, the essence of the endeavor was not plans or programs but nourishment of the process itself.¹⁹¹

This mushy statement reads like a caricature of all that Lowi reprehends. Yet it is these agencies which are being built into the decision-making process under certificates-of-need laws. These various signs establish that most certificate-of-need agencies will act not as planners in any meaningful sense but as mediators and facilitators of the bargaining out of interest-group conflicts. The pro-provider outcomes of the "process" will have been legitimized. Because the public will have had a chance to bargain for its own protection, it must pay the bill, regardless of its size.

¹⁹⁰ The existence of a master plan is not conclusive evidence that the hard decisions essential to real planning have been taken. One would have to evaluate the methodology employed and the results actually produced before a judgment could be made. The ensuing discussion reviews some suggestive evidence on whether health planning methodology is developed to the point of being useful.

^{190a} E.g., MINN. STAT. ANN. § 145.71 (Supp. 1973): "It is the policy of sections 145.71 to 145.84 that decisions regarding the construction or modification of health care facilities should be based on the maximum possible participation on the local level by consumers of health care and elected officials, as well as the providers directly concerned."

¹⁹¹ D. BROWN, *supra* note 22, at 9. See also Hall, *The Political Aspects of Health Planning*, in *HEALTH PLANNING: QUALITATIVE ASPECTS AND QUANTITATIVE TECHNIQUES* 73 (W. Reinke ed. 1972) (including an extensive bibliography).

It may not be inevitable that certificate-of-need agencies will succumb completely to a nonplanning, highly political approach.¹⁹² Health planning does have a methodology for predicting health facility needs and for evaluating arrangements for meeting them.¹⁹³ Employed to produce master plans and objective criteria, this methodology could perhaps lend credibility to hard decisions and reduce the impact of political pressures and the equitable claims of established providers. The prospects for real planning would probably be enhanced if the certificate-of-need law included a clear mandate to engage in detailed specification of the bed supply.¹⁹⁴ Further, federal financial support for the planning agencies might allow substantial planning efforts, and indeed the federal bureaucracy might insist upon a minimum level of substantive planning.

Although both the hospitals and the public would profit from lower bed-to-population ratios and more "rational" allocation of specialized services, the apparent coincidence of interests is deceiving. The public would prefer strict controls which would lower the level and distribution of output to approximately that point of optimality which would be found in a hypothetical market featuring, among other ideal conditions, consumers possessing both reasonable ability to pay for hospital services from their own pockets and good information about such services' value.¹⁹⁵ Such severe restrictions would be adverse to provider interests,

¹⁹² See, e.g., ABT ASSOC. INC., *supra* note 77, at 47, reporting how one Washington State "B-agency is currently swamped with the demanding task of review but is making headway and will soon have more staff time to concentrate on an overall plan."

¹⁹³ See, e.g., C. Hopkins *et al.*, *Methods of Estimating Hospital Bed Needs*, Oct. 1967 (UCLA School of Public Health mimeo.); Klarman, *supra* note 59; Shonick, *Understanding the Nature of the Random Fluctuation of the Hospital Daily Census*, 10 MED. CARE 118 (1972) [hereinafter cited as Shonick, *Random Fluctuation*]; Shonick, *Areawide Planning for Hospital Inpatient Resources: A Critical Overview of the Development of Methodology and Concepts* (1973) [hereinafter cited as Shonick, *Overview*].

¹⁹⁴ But see note 189 *supra* and accompanying text.

¹⁹⁵ See AEI PROCEEDINGS, *supra* note 6 (remarks of Mark V. Pauly). It is interesting to compare this concept of optimality with that of an expert in health planning methodology:

Conceptually, proper service volume is that number of patient days which would be incurred if the level of health care available and being delivered to the entire population conformed with standards of good health care presently established by the professional leaders and publications in the various health specialty fields . . . and being taught in the health professional training schools.

Shonick, *Overview*, *supra* note 193, at 3-4. The absence of any reference to cost reveals an important shortcoming of the planner's perspective and one reason why planning-cum-regulation will probably not control inflation effectively. Shonick does observe, however, that his stated objective ignores "the question as to what degree 'good' health care, as defined by professional leaders, actually improves health status." *Id.* at 4. The

however, and it is doubtful whether a law could pass which mandated such rigorous planning. Rather, one is likely to find either vague delegations to the agencies or specification of multiple contradictory criteria of the type found in the existing laws. Such laws merely invite the agency to preside over a bargaining process which, as in other industries, can benefit no one so much as the regulated interests.

Truly efficient use of hospitals would require a drastic reduction in the supply of inpatient services rather than merely a levelling off of growth, the most which might be achieved under a well-administered certificate-of-need law. For example, HMOs have demonstrated an ability to reduce utilization of hospitals dramatically without sacrificing quality of care.¹⁹⁶ Moreover, studies applying the standards of conscientious fee-for-service practitioners have shown that a substantial percentage of all hospitalized persons (the mean seems to be around twenty percent) could be cared for adequately outside the hospital.¹⁹⁷ On the basis of these observations, it is reasonably clear that the public would profit from a major reduction in the supply of hospital beds¹⁹⁸ and (in the absence of changed incentives) the installation of a sound system of bed

formula stated in the text leaves room for second-guessing both providers' judgments and consumers' actual preferences but recognizes the "question" which Shonick by-passes by asserting the relevance of hypothetical choices between consuming either more health services or other "goods." With a supply of beds and services sufficient to produce only the output dictated by either formulation of the objective, it would be necessary—given the predominance of third-party payment—to ration services on the basis of medical "need," which differs fundamentally from "demand." *Id.* at 3-4. Rate regulation would probably also be required, since bed rationing could never be effective enough to eliminate the upward pressure on prices from the excess demand created by insurance.

¹⁹⁶ On the relevance of this experience, see Shonick, *Overview*, *supra* note 193, at 84-86. Roemer's recent data show that the per capita hospital utilization rates in HMOs—which, incidentally, appeared to cover somewhat higher-risk populations—was less than half the rate for persons covered under Blue Cross plans and also considerably less than the rate for persons covered by commercial insurance. M. ROEMER, *et al.*, *HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLAN 21* (1972). The Kaiser Foundation Health Plan has over a long period maintained a supply of hospital beds equal to less than half the number of beds per capita in the nation as a whole.

¹⁹⁷ These are collected in Bureau of Facility Planning, N.Y. State Dep't of Health, *Methodology for Determining Inpatient Need Estimates*, March 1, 1970 (mimeo.).

¹⁹⁸ A twenty percent reduction would probably not affect health adversely in most places. The supply of general medical and surgical hospital beds by state ranges from 3.9 and 4.0 per 1000 in Maryland and Connecticut, respectively, to 7.6 and 7.3 per 1000 in North Dakota and Rhode Island. NAT'L CENTER FOR HEALTH STATISTICS, *supra* note 89, at 308. Variations in health status have not been correlated with the bed supply. Klarman, *supra* note 57, at 178.

rationing¹⁹⁹ and rate regulation. Nothing in the legislative history of certificate-of-need laws or in their enforcement suggests a dedication to accomplishing anything approaching such a drastic reduction in the bed-to-population ratio. For example, no state has given the regulators the power to close down unneeded beds.²⁰⁰

The discipline of health planning itself has never threatened to restrict the supply of hospital beds to the degree warranted by the foregoing evidence. The hospital industry's acceptance of health planning suggests that it is not at all fearful that planners will promote fundamental changes. The cartel-like appearance of health planning efforts of the past strengthens this judgment. Even where consumer and community interests have been well represented, provider interests have tended to prevail. So long as duplication is averted, lay participants have been equally content to see more and better health services made available, without much regard to cost. Noncaptive regulators in other settings have similarly revealed a bias toward expanding or maintaining the size of the industries they regulate, irrespective of the dictates of rationality or mandates to engage in planning.

But perhaps the chief source of discouragement about health planning is the complexity of the task. Among the factors relevant in the planning effort are

[the] types, sizes, age, condition, and distribution of facilities; use patterns, including service areas within hospitals; population characteristics and size; availability and accessibility of services and facilities; supply of physicians and other health personnel; income levels; levels of medical technology in the community; health insurance coverage; climate; and the habits of people.²⁰¹

¹⁹⁹ Bed rationing would be required because the "reverse" Roemer effect, the reduction in demand from a *reduction* of supply, is probably weak. Stevens, *Hospital Market Efficiency: The Anatomy of the Supply Response*, in *EMPIRICAL STUDIES* *supra* note 56, at 241, 244. Given third-party payment and provider control of demand, the only way to achieve really efficient hospital use is to force rationing by professionals on the basis of medical need. The only really effective utilization review programs in hospitals have occurred in those hospitals which have very high occupancy rates because doctors are willing to accept control as a price of access to a desirable facility. If the bed supply available to the entire population were limited in such a way as to force such rationing over-all, the use of hospital beds might be efficiently controlled. *But see* notes 242-43 *infra* and accompanying text.

²⁰⁰ New York can close down substandard beds when it wishes.

²⁰¹ GAO STUDY, *supra* note 187, at 879.

Even this list fails to convey the difficulty of projecting changes in population, technology, health care financing, delivery systems, and patterns of utilization,²⁰² all of which are largely beyond the ken of statistics and expert judgment.²⁰³ The complexity is such that the agencies themselves lack confidence in their ability to make hard-and-fast judgments, and the

²⁰² One example may serve to show the primitive state of health planning methodology in practice. The HEW formula for estimating bed needs for Hill-Burton purposes has been quite simple, being based in part on the assumption that past utilization rates will continue into the future even though higher prices and various regulatory and peer-review mechanisms now promise to change utilization patterns substantially. Thus, during a period when excessive hospitalization was widely recognized as a problem, the Hill-Burton program continued to subsidize hospital construction projects the need for which was premised on the continuation of old utilization abuses. GAO STUDY, *supra* note 187, at 883-84; J. LAVE & L. LAVE, AN EVALUATION OF THE HILL-BURTON PROGRAM (1973) (forthcoming); Shonick, *Random Fluctuation*, *supra* note 193. Now that a surplus of hospital beds has been produced, such an example of past "planning" is hardly reassuring.

The 80 percent occupancy rate used for Hill-Burton purposes also arguably contributes to excess capacity. After noting "the tendencies of some features of the present Hill-Burton allocation method to actually aggravate existing imbalances in the distribution of inpatient facilities," Shonick warns that, with certificate-of-need laws, "the consequences of adhering to an inappropriate method for determining bed requirements will become more serious." Shonick, *id.* at 135.

Some planners have begun to make adjustments for obvious overuse in their need calculations. See, e.g., Bureau of Facility Planning, *supra* note 197. The New York State Department of Health's utilization adjustments for nursing homes are described in the Department's Post Hearing Memorandum, In re *Schwartzberg, Lefkowitz & Lefkowitz d/b/a New Rochelle Nursing Home* (no date). Nevertheless, planners still shrink from projections premised on either new methods of financing or stricter bed rationing.

²⁰³ Changes in the methods for estimating need can produce rather dramatic changes in the situation in a local community. One example is reported as follows:

At the request of a local hospital council, [a new and apparently more accurate] method of estimating bed needs was used by the researchers to assess the validity of a forecast showing that about 1,100 more than the existing 1,550 beds would be needed in 1975 to serve a population of nearly 400,000. The results showed that the estimate could be overstated by as many as 600 beds.

GAO STUDY, *supra* note 187, at 884-85. The magnitude of the possible error—an overstatement of total need by nearly thirty percent and of unmet need by over 100 percent—must give pause. Similarly, the certificate-of-need agency in New York State has succeeded in dramatically reducing the number of "needed" beds by introducing a utilization adjustment to the Hill-Burton formula and by reclassifying certain marginally substandard facilities as part of the inventory of available beds. It is apparent that small adjustments in methodology can produce substantial results, betraying a high degree of arbitrariness and a high risk of error, neither of which can be avoided. Even methodology which is highly developed may mask decisions based on other, possibly political, factors, such as in the New York instance, where the heavy emphasis on cost control in the Department of Health contributed to the inclusion of substandard beds in the inventory of acceptable facilities.

result is a lack of firm standards for decision making.²⁰⁴ In such circumstances, the pressures of politics necessarily become dominant.

The prospects for real health planning seem poor enough that they should be given little weight in predicting the behavior of certificate-of-need agencies. Because there is every reason to think that these agencies are expected to serve as political mechanisms and that the areawide planning agencies involved in the process are primarily vehicles for political inputs, the experience of other regulatory agencies, which have also interpreted their mandate in political terms, should serve as a warning signal. It is difficult to find any basis for expecting that the performance of other regulatory agencies can be significantly improved upon in regulating entry into the health services industry.

D. The Regulatory Response to Innovation and Change

The "Producer-Protection" Hypothesis Revisited

One of the best-supported charges against regulatory agencies is that they actively retard desirable changes harmful to the regulated interests and that they particularly resist the weeding-out of obsolete elements and the erosion of established markets by new technology or organizational innovations.²⁰⁵ The regulatory techniques employed in defending the regulated interests vary, but restrictions on entry and service offerings are practically essential to prevent the development of competition harmful to the regulated firms. Much regulatory effort is expended on

²⁰⁴ During visits to several areawide health planning agencies in 1970 and 1971, we learned that the agencies were having difficulty in consistently applying any uniform set of criteria to determine need. Lacking any other basis for decision, approvals or disapprovals of proposed projects were given on the basis of the best judgments of agency staff and board officials, who themselves sometimes disagreed.

Id. at 880. Any expectation that master plans and numbers can make regulation effective should be indulged with Professor Marver Bernstein's warning in mind:

While exactness and precision are desirable, along with flexibility and adaptability, in the regulatory process, they cannot define away political forces. Regulation is and always will be an intensely political process. Its success depends as heavily upon political leadership and widespread public support as it does upon sound techniques and administrative precision.

BERNSTEIN, *supra* note 135, at 183.

²⁰⁵ Regulatory agencies pay a great deal of attention to the effect of a potential innovation on the distribution of wealth within an industry. No matter how beneficial an innovation, it has little chance of timely adoption in a regulated industry if it will lead to a substantial redistribution of wealth among the regulated that cannot be compensated through some clever regulatory device.

NOLL, *supra* note 147, at 25. See also Hilton, *supra* note 105, at 48-53.

extending the agency's jurisdiction to cover new industries or activities which are threatening to the regulated industry.²⁰⁶

The protective attitude adopted by the regulators reflects in part their recognition that the good works subsidized by internally generated funds may be jeopardized if competition is allowed. The agency also often senses that it would somehow be unfair to expose the regulated firms to the full impact of rapid change when their earnings are limited by law and their assets are "dedicated" to the public service. Moreover, regulators tend to view the regulated firms' investments as the agency's special responsibility and to resist any development which would render assets obsolete before they are fully depreciated. This latter attitude has been labelled the "sunk-cost obsession."²⁰⁷ Finally, the pressure from the affected industry and its allies will always be stronger than any other pressure which the agency feels.

If the hospital industry becomes subject to exogenous threats or pressures, its regulators could be expected to afford it aid and protection. Surprising as it may seem, the hospital industry may in fact be in danger of becoming a "declining industry." Currently, the only overt sign of this possibility is the recent decline in occupancy rates, but a range of new factors present in the hospitals' environment reflect major potential problems.

Because hospitals have permitted their budgets to become grossly inflated during a period of excess demand and ready cost reimbursement, the market offers opportunities for entry by more efficient, less heavily capitalized providers which can render many hospital services cheaply. Cream-skimming proprietary hospitals,²⁰⁸ HMOs, and a range of other ambulatory substitutes for hospital care are prominent among the threats which are appearing. At the same time, the various third-party payers are becoming more aggressive both in their determinations of hospital

²⁰⁶ The ICC actively assisted the railroads in extending regulation to trucks. W. JONES, *CASES AND MATERIALS ON REGULATED INDUSTRIES* 484-99 (1967). The FCC's efforts to regulate cable television in the interests of over-the-air broadcasters is a modern example. See *United States v. Southwestern Cable Co.*, 392 U.S. 157 (1968); Comanor & Mitchell, *supra* note 164.

²⁰⁷ NOLL, *supra* note 147, at 25-26.

²⁰⁸ An executive of a leading chain of for-profit hospitals is of the opinion that planning agencies in a number of communities have discriminated against his firm. Interview with Mark S. Levitan, Senior Vice President, American Mediacorp, Inc., Oct. 16, 1973. This regulatory behavior is predictable in view of political factors, incumbents' fear of competition, prevailing prejudices against profit-making enterprises in health care, and the speculative character of the benefits of introducing a competitive stimulus.

costs and in their refusals to underwrite unremunerative services and underused facilities. Government programs in particular are actively supporting mechanisms designed to question and reduce hospital utilization. Moreover, hospitals are exposed to an array of conflicting demands by patients, consumer groups, doctors, labor, public officials, bulk purchasers, and the various regulatory and accrediting authorities. Understandably, hospitals would like to interpose an authoritative decision maker on whom the worst political pressures, as well as the responsibility for the industry's financial condition, would devolve. But while certificate-of-need laws provide some relief, more comprehensive regulation will be necessary if the hospitals are to shift from their role as the focal point of political and other pressures to the more desirable one of being the principal pressure-group constituency of a regulatory agency.

In addition to perhaps curbing growth which is unnaturally induced by third-party payment, certificate-of-need agencies will also obstruct market entry by lower-cost providers. By not stepping aside, they can help existing hospitals to recover their perhaps unwise past investments through depreciation charges and to meet their other inflated costs in full.²⁰⁹ A central issue is whether certificate-of-need agencies, in assessing "need," will adequately recognize the appropriateness of allowing a choice between expensive and cheap care. Reasons why they might not view competition favorably include the familiar "sunk-cost obsession" and the desire to protect internal subsidization capabilities. In the hospital industry, these justifications for artificially staving off obsolescence are vastly reinforced by belief in the Roemer effect, by which obsolete facilities allegedly generate new demand and thus higher costs to the public through insurance mechanisms. On the face of it, hospital regulators will be strongly tempted to inhibit certain kinds of technological and organizational change.

The actual costs to the public of regulatory curtailment of technical innovation and institutional change may be difficult to identify. Sometimes, of course, the adverse effects of regulatory action may be reason-

²⁰⁹ The hospitals are thus unlikely to suffer substantial deficits as a direct consequence of their past investment excesses. Cf. notes 53, 141-45 *supra* and accompanying text. Although one may perhaps expect that the capital recovered through depreciation will, under the guidance of certificate-of-need agencies, be somewhat more wisely invested the next time around, it is interesting to note that certificate-of-need laws, ostensibly designed to prevent future overinvestment, condemn the public to keep the hospitals whole for the same unwise investments which prompted the laws' enactment. The instinct which leads to acceptance of this state of affairs is the same "sunk-cost obsession" which has led many regulators into error.

ably apparent, such as where a particular aspirant offering an improved service is turned away, delayed, or required to offer the service on a limited basis.²¹⁰ In other cases, however, the true damage done can be assessed only by estimating the value to consumers of innovations which were never developed.²¹¹ In health care, the costs of regulatory inhibition of cost-saving innovations—particularly methods of substituting outpatient for inpatient care—will be largely hidden from public view, and it will therefore be difficult to obtain legislative correction of even a very costly mistake. Indeed, as long as public officials measure the success of health policy only by the rate of cost increases, little attention will be given to missed opportunities for reducing costs. The political process will quite willingly tolerate huge inefficiencies (which in health care could be measured in whole percentage points of GNP) so long as the costs cannot be convincingly laid at government's door.

*Impact of Certificate-of-Need Laws on Hospital Construction
by HMOs*

A strong argument exists for not extending certificate-of-need statutes to hospital construction by a health maintenance organization. For one thing, HMOs do not have the same perverse incentives for overexpansion which characterize fee-for-service hospitals. Indeed, because they are paid in advance, rather than retrospectively on a cost-reimbursement basis, they have every incentive to conserve their resources and to seek

²¹⁰ Thus, the FCC's restriction of the growth of cable television has been obvious enough to interested observers that estimates of the cost imposed on the public by the FCC's policies have been possible. Comanor & Mitchell, *supra* note 164.

²¹¹ A recent study purports to demonstrate that a net loss of consumer welfare resulted from the 1962 Kefauver-Harris amendments to the Federal Food, Drug, and Cosmetic Act, Pub. L. No. 86-618, §§ 101-103, 201-204, 74 Stat. 397 (codified in scattered sections of 21 U.S.C.), which for the first time required the drug manufacturer to establish the efficacy of his product prior to marketing. Peltzman, *The Benefits and Costs of New Drug Regulation*, Dec. 4-5, 1972 (paper prepared for the Conference on the Regulation of the Introduction of New Pharmaceuticals, University of Chicago). In this case, it was necessary first to demonstrate by some means that there was in fact a reduced flow of new drug products and then to attempt to attach dollar values to the consumer surplus (excess welfare gain over price paid) which would have accrued from those unidentifiable drugs which were never developed because of the higher cost of obtaining marketing approval. Needless to say, this interesting study proved easy to criticize for failing in the nearly impossible task of proving what might have been under circumstances which were not allowed to occur. See *Hearings on the Present Status of Competition in the Pharmaceutical Industry Before the Subcomm. on Monopoly of the Senate Select Small Business Comm.*, 93d Cong., 1st Sess. (1973); Havighurst, *supra* note 134, at 35-37, 43-44.

efficiency. An HMO's decision to build a hospital therefore reflects a belief that operating through existing hospitals is inefficient. Although a few HMOs have operated with some effectiveness through existing hospitals, good reasons support an HMO's desire to control its own facility.²¹² These include the doctors' difficulty in seeing patients at a variety of locations; the burdens which often accompany staff appointments, particularly at teaching hospitals; the loss of the HMO medical group's cohesiveness; and the loss of control over records and other managerial details which may provide much of the HMO's cost and service advantage.²¹³

Of course, when existing hospitals are left oversupplied with beds because the HMO has built its own facility, the system's dependence on cost-reimbursement may combine with provider influence over demand to produce added costs to the public. Although regulators will thus be tempted to penalize the HMO because of the distorted incentives prevailing in the fee-for-service sector, they should also recognize that competition from HMOs induces the fee-for-service sector to avert such inflationary effects by better utilization and cost controls.²¹⁴ By the same token, enforced affiliation with existing hospitals may generate pressures for HMOs to reach accommodations with local providers and to cease the very competition needed to correct inflationary incentives in the fee-for-service sector. Moreover, as the hospitals come to see new construction by an HMO entrant as a credible threat, the HMO should find it easier to purchase an existing hospital suitable for its purposes, thereby obviating the original concern about the bed supply.²¹⁵

Encounters between HMOs and certificate-of-need agencies over facilities construction have already revealed the potential for difficulty. The

²¹² See generally A. YEDIDIA, PLANNING AND IMPLEMENTATION OF THE COMMUNITY HEALTH FOUNDATION OF CLEVELAND, OHIO 70-71 (Public Health Service Pub. No. 1664-3, 1968); G. WILLIAMS, KAISER-PERMANENTE HEALTH PLAN—WHY IT WORKS 22-27 (1971); KAISER HEALTH PLAN, INC., 1969 ANNUAL REPORT 15 (1970); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 907, 910-15 (1971); Shapiro, *Role of Hospitals in the Changing Health Insurance Plan of Greater New York*, 47 BULL. OF THE N.Y. ACAD. OF MEDICINE (2d ser.) 374 (1971); Roemer, *The Hospital's Relation to Prepaid Group Practice: Review and Analysis*, in GROUP HEALTH INSTITUTE PROCEEDINGS 108 (1960); Brewster, *Group Health Association's Use of Community Hospitals*, *id.* at 117; Cutting, *The Role of the Hospital in the Kaiser Foundation Health Plan*, *id.* at 121. See also *American Medical Ass'n v. United States*, 317 U.S. 519 (1943).

²¹³ See also notes 219-20 *infra*.

²¹⁴ See text at notes 246-49 *infra*.

²¹⁵ But see text accompanying notes 66-69 *supra*.

three West Coast states have special concessions for HMOs built into their certificate-of-need laws, but the interpretation of these clauses, which direct agency recognition of the specific needs of the HMO's enrolled population, remains in doubt.²¹⁶ It is unclear, for example, how a new HMO might get permission to build a new facility for a population it has yet to identify. Moreover, both Group Health Cooperative of Puget Sound and the Kaiser Foundation Health Plan, Inc., two of the most substantial and reputable HMOs, have encountered problems in obtaining permission to construct inpatient facilities needed to serve their populations in these states.²¹⁷ Although they ultimately obtained the requisite approvals after substantial delays, it is fair to ask whether smaller or newer HMOs or HMOs organized under less impeccable auspices could survive a similar encounter. In the remaining states, where the legislature has made no special provision for HMOs,²¹⁸ the opportunity for denying certification of need to HMOs is even greater.

In view of these circumstances, a total exemption from certificate-of-need requirements for HMO hospital facilities is desirable. An alternative would be to allow HMOs to build unless a suitable arrangement were offered by existing hospitals, permitting the HMO to realize the econ-

²¹⁶ See, e.g., ORE. REV. STAT. § 441.095(k) (1971), requiring 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"; references to the needs of a "defined population" may also permit an Oregon HMO to argue the special needs of its subscribers. See also WASH. CODE § 70.38.140(12) (Supp. 1972); ABT ASSOC. INC., *supra* note 77, at 40-41. The California provisions are not quite so clear. CAL. HEALTH & SAFETY CODE § 437.8(a) (West Supp. 1973) (recognizing "the requirements of the population to be served by the applicant"); 17 CAL. ADMIN. CODE § 40518 (1973) (emphasizing comprehensiveness and coordination of services, the importance of innovation and alternatives, and the "views" of groups of users on the need issue).

²¹⁷ Interviews with Kaiser Foundation Health Plan, Inc., officials revealed that construction of a new hospital in Clackamas County, Oregon, was twice approved only by one-vote margins and that the Kaiser Bellflower Hospital in California was approved at one level only in a reversal of an earlier vote. Two votes on a Group Health extended care facility in planning agencies in the State of Washington were likewise decided by one vote, 4-3, one each way.

²¹⁸ But see COLO. REV. STAT. §§ 66-41-10(l) to -10(n) (1973), which contains language favorable to HMOs and particularly to the substitution of ambulatory for inpatient care. MICH. STAT. ANN. § 14.1179(54) (1972) confers a discretionary exempting power as follows:

In instances where a state or federal agency contracts with a health maintenance organization to render comprehensive health care services, a certificate of need may be waived for those inpatient and outpatient facilities that are necessary for the health maintenance organizations to achieve maximum effectiveness in rendering comprehensive health care services.

omies of which it is capable²¹⁹ and reflecting in lower charges the HMO's greater ability to control utilization.²²⁰ But this approach seems less realistic than a total exemption, particularly since a certificate-of-need agency, operating in a political climate, would always instinctively balance the public's interest in HMO development against the interests of the hospitals.

Impact on Ambulatory Care Facilities

The rationale for extending certificate-of-need laws to cover ambulatory care facilities, whether those of HMOs or other kinds, must rest on a theory similar to that offered for limiting HMO hospital construction. If the substitution of ambulatory care for inpatient care should leave hospital beds in the fee-for-service sector empty, past performance suggests that those beds will now be occupied by patients who do not really require hospitalization. HMOs seem to present this risk rather dramatically, since their most effective cost-control technique has been to reduce hospitalization. Even if an HMO should use existing hospitals exclusively, empty beds might result, and on this basis an argument can be contrived for excluding the HMO altogether.

Another type of ambulatory care facility presenting the same problem is the so-called "surgicenter," which provides outpatient surgical services as a substitute for hospital care.²²¹ Abortion clinics,²²² dialysis cen-

²¹⁹ Difficulty in arranging staff privileges, burdensome staff responsibilities (allegedly accounting for 20 percent of physician time in one case), mandatory duplication of previous lab tests, and inability to farm out tests to cheaper or better labs are cited as further obstacles. Schmidt, Lewis, & Rosenberg, *Barriers to HMO Development*, May 1, 1973 (Group Health Ass'n of America mimeo.). See also note 212 *supra* and accompanying text. The possibility that planning agencies might actively assist HMOs to overcome such obstacles is a most attractive one.

²²⁰ "... [L]ack of a medical center inflated operating costs because CHF was unable to negotiate the same reduced rates for hospitalization as its more powerful competitor, Blue Cross." KAISER FOUNDATION HEALTH PLAN, INC., 1969 ANNUAL REPORT 15 (1970). I am told that HMOs seeking a special low rate to reflect their better ability to schedule patients and keep beds full are sometimes told that such a preference would violate antitrust principles. I see no grounds for such an assertion and indeed would consider a hospital's refusal to allow an HMO to realize its cost advantage to be substantially more troublesome from an antitrust point of view.

²²¹ It has been estimated that surgicenter treatment is offered at a savings of 25 percent. See Davis & Detmer, *The Ambulatory Surgical Unit*, 175 ANNALS OF SURG. 856 (1972).

²²² See, e.g., *People v. Dobbs Ferry Medical Pavillion, Inc.*, 40 App. Div. 2d 324, 340 N.Y.S.2d 108 (1973); *People v. Wickersham Women's Medical Center*, 69 Misc. 2d 196, 329 N.Y.S.2d 627 (1972).

ters,²²³ midwives, and acupuncturists may also threaten to reduce hospital occupancy rates, and one can imagine diagnostic centers which could perform on an outpatient basis many services which previously required hospitalization.²²⁴ Although these methods of substituting outpatient for inpatient care promise dramatic cost savings, the planners' argument, premised on assumptions about hospitals' right to full cost recovery and the strength of the Roemer effect, would warrant stopping them all until such time as hospital beds could be closed down to compensate for the impact.

It is worth pondering why existing hospitals, who alone possess the power to decide to reduce the number of their beds, would introduce these innovations on their own if they were confident that others could not introduce them.²²⁵ The answer must be that the incentives to innovate in these ways are at best weak and that, to the extent the hospital's bed count and gross revenues dwindle, managers are motivated in the opposite direction. Thus, if exogenous changes are to be foreclosed, the delays in the adoption of even proven cost-saving techniques are likely to be considerable, and interest in seeking out and experimenting with other innovations will be minimal. The costs associated with these delays and missed opportunities may be much higher than any that can be associated with the excess bed supply and the Roemer effect.

²²³ Proposed Regulation § 81.102(e), 38 Fed. Reg. 20993 (Aug. 3, 1973), covers "kidney disease treatment centers." Entry into this business has also been severely restricted in Medicare regulations. 38 Fed. Reg. 17210 (1973). This cost-control measure could deprive some patients of life-saving treatment and might prevent important cost-saving innovations from materializing.

²²⁴ Nursing homes and other inpatient facilities provide another kind of lower-cost substitute for hospital care. It would be interesting to discover whether hospitals ever intervene in nursing home applications (or take an *ex parte* interest) and whether hospitals' interests are considered in particular cases.

²²⁵ For an instance of certificate-of-need denial raising similar issues, see Review of: Proposed Nevada Institute of Medicine and Surgery, Inc., Minutes of the Nevada State Comprehensive Health Planning Advisory Council, April 7, 1972.

The issue is dramatized in another context by *Monongahela West Penn Pub. Serv. Co. v. State Road Comm'n*, 104 W. Va. 183, 139 S.E. 744 (1927), *appeal dismissed*, 278 U.S. 564 (1928), discussed in SCHWARTZ, *supra* note 49, at 375. Integration of services in multi-modal transportation companies has been proposed as a way around ICC protectionism for interests in established transportation patterns. A. FRIEDLAENDER, *THE DILEMMA OF FREIGHT TRANSPORT REGULATION* 155-59, 166-68 (1969). If applied in health care, this proposed remedy would mean an expanded role for institutions such as the Health Care Corporations contemplated in the AHA-backed Ullman bill, *see* note 30 *supra*, but the remedy is offered solely as a solution to the waste created by ICC regulation itself and not as an alternative to a system featuring free market entry by lower-cost modes.

Perhaps the case for freeing HMOs from certificate-of-need requirements is slightly stronger than that for relieving other types of outpatient facility. The HMO by its entry into the market would supply precisely the competitive check on excessive hospital utilization which is needed to curb the Roemer effect. Other types of outpatient facility do not carry with them the same inherent ability to check the inflationary forces which they can be said to unleash. A total exemption for HMO development may therefore be easily justified.²²⁶ At present, however, the AHA model bill and the laws of eleven states appear to cover ambulatory care offered by HMOs and other institutional providers,²²⁷ and a

²²⁶ This is not to say that HMOs should not be licensed and regulated to assure quality of care. *See, e.g.*, INSTITUTE FOR INTERDISCIPLINARY STUDIES, SPECIFICATIONS FOR A STATE HEALTH MAINTENANCE ORGANIZATION ENABLING ACT (1972). However, a need requirement has implications of a very different kind and should be totally dispensed with. Even though quality- or cost-related entry restrictions are subject to protectionist application, the risk may be somewhat less (and the gain more apparent) than with provisions which are overtly anticompetitive. Nevertheless, high standards set by HMO regulators could produce the outcomes anticipated in the next paragraph in the text even without a need requirement.

A special treatment of the "need" for an HMO is embodied in the Social Security Amendments of 1972. The Secretary of HEW is empowered to ignore a negative decision by the state planning agency and allow Medicare or other federal reimbursement of HMO capital costs if he believes that denial of such reimbursement "would discourage the operation of . . . [any HMO] which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services . . . efficiently, effectively, and economically. . . ." Social Security Act § 1122(d)(2), 42 U.S.C. § 1320a-1(d)(2) (Supp. 1973). Since a provider cannot qualify as an HMO for Medicare purposes without such a demonstration anyway, Social Security Act § 1876(b)(6), 42 U.S.C. § 1320a-1 (Supp. 1973), the provision seems to leave very little room for denying payments attributable to capital expenditures to any HMO. However, it would allow the Secretary to look at a qualified HMO on a facility-by-facility basis and to exclude payments for a new outpatient facility which it built without state approval. Nevertheless, the test of whether the new facility can provide services "efficiently, effectively, and economically" would not allow inquiry into its competitive impact or the adequacy of existing services and would leave only quality, cost, and efficiency issues before the Secretary. *See Proposed Regulations*, 38 Fed. Reg. 20994 (1973). Of course, a state with a certificate-of-need law could effectuate the planning agency's determination by a license denial or an injunction, and therefore the opportunity for special HEW dispensation would exist only in states which do not have such laws. *See text accompanying notes 32-34 supra.*

²²⁷ Arizona, Connecticut, Kansas, Kentucky, Massachusetts, New Jersey, New York, Rhode Island, South Carolina, Tennessee, and Virginia. Only Kentucky, New Jersey, and Virginia refer to HMOs by the customary name, whereas Rhode Island uses the term "health care corporation." Possibly a doctor's office or group practice clinic in which HMO patients are served would be exempt in several states, either because of an express exemption for private offices of physicians (Arizona, Kentucky, Tennessee, and Virginia; *but see* S. Car. State Board of Health, Rates and Regulations for Certification of Need for Health Facilities and Services, ¶ E-1 (Dec. 1972)) or because the auspices is not that of a "corporation" (Rhode Island) or an "institution" (New York).

twelfth state, Florida, has a special HMO statute which incorporates a special "need" requirement independent of the state certificate-of-need law.²²⁸

Although it is currently impossible to document the impact of certificate-of-need laws on HMO development,²²⁹ it is possible to speculate whether certificate-of-need agencies would react to HMO development in the same manner that regulators in other contexts have responded to similar developments. There may be some reason to think that health planners are positively disposed to the HMO concept and might therefore welcome and even encourage HMO development. Nevertheless, many planners appear to value HMO care only for its own sake and not for its possible competitive impact on other providers. For this reason, certificate-of-need laws could eventually lead to determinations that HMOs should be operated by established interests with known "track records," that plans which attract the least opposition should be preferred, and that proprietary newcomers are not needed. Only high-cost HMOs, the safest from a quality standpoint but also the ones least likely to have a major competitive impact on over-all costs, would be admitted. These possible outcomes are consistent both with regulatory experience in other industries and with the need requirement's presupposition that no important price and quality judgments are to be made in the marketplace. The view likely to prevail is that stability is to be preserved once

The Health Insurance Plan of Greater New York, which is largely non-hospital-based, has not sought approval for the practices of its participating doctors. *See also* *People v. Dobbs Ferry Medical Pavillion, Inc.*, 40 App. Div. 324, 340 N.Y.S.2d 108 (1973). Although the North Dakota law expressly covers any "new medical care service," only inpatient facilities are listed in another section as coming within the law's provisions. Similarly, Virginia lists no facilities serving outpatients exclusively. South Dakota covers any "licensed outpatient care facility" but does not as yet license HMOs.

²²⁸ LAWS OF FLORIDA ch. 72-264, § 6(1) (1972); Rules of the Fla. Dep't of Insurance § 4-31.04 (1972). Administratively, HMO need certification is done by the state CHP agency, with advice from "b" agencies, and does not pass through the Hill-Burton agency, which is the decision maker in the usual certificate-of-need machinery. This administrative arrangement plus the promotional mandate in the HMO legislation suggest that there may be little opportunity for protectionist policies to develop in Florida. *But see* LAWS OF FLORIDA ch. 72-264, § 2(5) (1972).

²²⁹ So far as it has been possible to discover, no cases of actual exclusion of a would-be HMO under "need" requirements have yet occurred. Florida had received twelve applications under its liberal HMO statute as of a recent date, but there was no indication that any of these HMOs would be regarded as mutually exclusive or as otherwise unneeded. It is impossible to discover how many HMO developments have been discouraged by the gauntlet of legal restrictions, including certificate-of-need requirements, which fledgling plans must be prepared to run.

a dash of "pluralism" has been supplied. Clearly, curbing HMO development and competitive impact in this manner would entail large but unmeasurable costs.

Certificate-of-need requirements for surgicenters, abortion clinics, and other outpatient facilities also seem poorly conceived. Although some planner-regulators would probably welcome such developments and would grant certificates even without an offsetting curtailment of the bed supply, many others will be willing to sacrifice major efficiencies out of an unshakeable belief in the Roemer effect. The tendency of the hospital interests and the planners to reach out for control over exogenous influences is borne out by the certificate-of-need law enacted in Arizona shortly after an innovative surgicenter had entered a market previously dominated by the hospitals. As a result of the concern generated, the law was expressly drafted to cover ambulatory surgical services requiring general anesthesia,²³⁰ and the clear expectation is that hospital interests will henceforth be consulted before such developments are permitted to occur.²³¹ Direct evidence of the planners' mentality appears in New York Blue Cross's refusal to pay for care at the Phoenix Surgicenter on the ground of its anticipated impact on hospitals and ultimately on cost, via the Roemer effect.²³²

²³⁰ ARIZ. REV. STAT. ANN. § 36-402(3) (Supp. 1972). See also KAN. STAT. ANN. §§ 65-2a01(b), 65-425(a), 65-427 (1972).

²³¹ See Am. Med. News, June 4, 1973, at 7:

The Illinois Hospital Assn. views the proposed [surgicenters] in a skeptical manner, partially because of the competition they could give area hospitals. The IHA hopes that the centers will be subject to licensure and certificate-of-need laws . . .

²³² Remarks of Dr. Peter Rogatz, Senior Vice President, Associated Hospital Service of New York, Health Staff Seminar, Washington, D.C., May 3, 1973. Rogatz, Ambulatory Care: Digging Out from Under the Bricks and Mortar, Aug. 20, 1973 (Address to the American Health Congress, Chicago, Illinois). Illinois Blue Cross has a similar policy. Am. Med. News, June 4, 1973, at 7. Medicare has adopted a similar policy in the past, but the 1972 amendments now permit reimbursement of surgicenters and similar innovative facilities as "experiments and demonstration projects." 42 U.S.C. at § 1320(B). The trap which will lead to obstruction of change is implied by the stipulation that, even if the centers "offer promise of improved care or more efficient delivery of care," full cost reimbursement will not be allowed unless they also "would not result in cost to the program in excess of what would otherwise be incurred for such services." S. REP. NO. 92-1230, 92d Cong., 2d Sess. at 227 (1972). Compare Proposed Rules §§ 81.107(d), .108(b), 38 Fed. Reg. 20997 (1973), which seem to adopt a more positive stance toward ambulatory-care facilities. I have yet to discover a planning agency which has taken (or rejected) a similar view of either surgicenters or HMOs, but the logic will surely seem persuasive. The behavior of Blue Cross and Medicare suggests that, if regulatory authority is assigned to an agency which purchases a substantial amount of care, see text accompanying notes 141-146 *supra*, the risk that shortsighted policies will be adopted will be substantially enhanced.

Against this background, it can be seen that regulators in the health sector will have even stronger grounds for resisting exogenous developments than have regulators in other industry settings. Not only will the "sunk-cost obsession" and the fate of valued internal subsidies affect their judgments, but the logical consequences of faith in the Roemer effect will reinforce the tendency to adopt policies excessively protective of the hospital industry and destructive of desirable change.

V. AN ASSESSMENT OF CERTIFICATE-OF-NEED REQUIREMENTS FOR HOSPITALS

Two distinct issues—benefits and costs—must be addressed in making a final assessment of certificate-of-need laws. It seems clear already, however, that certificate-of-need requirements for nursing homes and other extended care facilities and for free-standing ambulatory-care facilities would produce destructive effects exceeding any possible benefits. Moreover, the benefits of a certificate-of-need law for hospitals seem to have been exaggerated, while potential costs have been largely ignored. Although it is impossible to prove conclusively that a net detriment would result from hospital certificate-of-need laws, the case for a closer examination of other possible measures for dealing with hospital costs is certainly strong.

A. Exaggerated Benefits

The Behavior of Certificate-of-Need Agencies

The political environment of most certificate-of-need agencies is likely to be such that they will have no incentive, and in fact no mandate, to do more than bring about conditions roughly equivalent to those which a hospital cartel would maintain if it could. Among the numerous features of the regulatory climate which confirm the expectation of cartel-like behavior are the dominant political influence of the hospital industry; the general belief in the value of more and better health services shared not only by providers and the regulators but also by consumers involved in the regulatory process; the tendency of costs to be submerged in insurance charges and divorced from the services themselves; the importance of internal subsidies in providing services deemed to be in the public interest; the planners' orientation to incremental change based on consensual processes and bargaining rather than "real" planning; and the regulators' naturally protective attitude toward the regulated firms' investments and revenues.

Cartel-like regulation of the hospital industry would foster continued, though reduced, oversupply rather than the undersupply characteristic of cartels generally. This perpetuation of excess capacity would occur precisely because of the continuance of the same underlying conditions—third-party cost reimbursement and provider influence over demand—which produce excessive hospital growth in the first place. Since certificate-of-need laws would not change these conditions, hospitals would continue to prefer to offer more services than are economically justified. These preferences would translate into political pressures inhibiting enforcement which goes much beyond preventing obvious duplication of facilities and services. Avoidance of “duplication” is of course consistent with a cartel’s preference for minimizing competition, and Feldstein has shown that, as in other industries, some limitations on growth will have price effects which the industry will regard as desirable.²³³

Given the strong pressures which will act upon it, a certificate-of-need agency may fall short of achieving even a cartel’s limited goals for output restriction, much less the public’s. For one thing, it seems unlikely that anyone will press the agency to pursue a really tough policy, consumer groups being satisfied if obvious duplication and waste are eliminated and politicians being content with a normalization of the rate of cost increases. On the other hand, particularly potent applicants for certificates of need may tend to win approvals frequently enough to upset the cartel analogy altogether. It would seem that only the best regulatory programs are likely to be effective even to a degree which a provider cartel would approve.

Characterizing agency performance as at best cartel-like should not obscure the possible desirability of whatever reduction they do achieve in the supply of hospital beds and services. However, the dilemma of whether to accept substantially less than total relief is a real one. It is similar to the choice presented by other cartel-like solutions to the health care industry’s problems. For example, PSROs and the so-called foundations for medical care may also be analyzed as cartels which, though dedicated to improving existing conditions in real and important ways, will ultimately stop well short of delivering to the public all of the benefits which a well-organized competitive market would yield.²³⁴ Indeed,

²³³ See note 60 *supra* and accompanying text.

²³⁴ Both devices have as a goal the reduction of costs by policing physician behavior, but in each case the cartel orientation is clear. Indeed, to ask the question whether physician-dominated agencies such as these will be dedicated primarily to reducing

it is not inaccurate to view the fundamental health policy choice as being between a system controlled directly or indirectly by essentially well-meaning providers who accommodate their public responsibilities with their own self-interest and a system of social control by impersonal market forces allowing consumers a larger impact and assigning government the less intrusive roles of promoter of the competition and referee.

Cartel-like performance in certificate-of-need administration might be avoidable in part by assigning regulatory power to an agency which has major cost-control responsibility—perhaps as regulator of Medicaid rates as in New York State.²³⁵ Given the nature of politics, such an agency would do no more than somewhat retard the rise in health care costs, but this achievement would be better than any result obtainable by regulators lacking direct accountability for costs. Indeed, as population expands, the bed-to-population ratio might gradually fall. Nevertheless, the hospital industry could continue to block the extensive supply restrictions dictated by the public interest.

Effects on Health Care Costs

Even though the rationales for certificate-of-need laws have a great deal of plausibility and intuitive appeal, they need to be evaluated in light of Martin Feldstein's observation that, while new supply does indeed create some new demand—the Roemer effect—, there is a concomitant depressing effect on price.²³⁶ This effect somewhat dilutes hospitals' incentives to grow. Moreover, as a result of the persistence of some of the

health care costs to the level dictated by the public interest—*i.e.*, that which an ideal competitive market would yield—is to answer it negatively. The more important issue may be whether the real but relatively minor benefits to be anticipated can be obtained without foreclosing the much more hopeful long-run impact of HMOs. Unfortunately, PSROs have been given direct regulatory power over HMOs, and foundations have both the incentive and the opportunity to preempt HMO market opportunities, suggesting that HMOs' competitive impact may indeed be effectively neutralized. See Havighurst, *supra* note 81; Havighurst, *supra* note 18, at 769-76; Havighurst, Foundations for Medical Care: An Antitrust Lawyer's Perspective, Aug. 30, 1972 (address to the American Ass'n of Foundations for Medical Care, Sea Island, Ga. [hereinafter cited as Havighurst, *Foundations*]). Compare notes 247 & 252 *infra* on the abuses to which professionally sponsored efforts are subject.

²³⁵ It is difficult to assess cost-consciousness in a state agency. Questionnaires from only Florida, Michigan, and New York of the 14 responding agencies acknowledged responsibility for paying for care under Medicaid, but many agencies were subdivisions of departments having such responsibility. On a possibly significant hazard from combining payment responsibility and certificate-of-need administration in the same agency, see note 232 *supra*.

²³⁶ See note 60 *supra* and accompanying text.

usual impact of supply on price, imposition of a regulatory restraint on the growth of the bed supply will result in somewhat higher prices than would otherwise prevail. This price effect will cancel some of the cost savings which result from the lower utilization produced by controlling supply. Even effective rate regulation would seem incapable of obtaining the price reduction which growth of supply would have generated.

Because certificate-of-need laws look only to certain kinds of hospital costs, they may merely divert inflationary pressures and achieve no control. The mechanism by which prices rise in the hospital sector is complex because of the prevalence of nonprofit firms and financing by cost-reimbursement, which together negate the usual expectation that profits will accrue when demand exceeds supply, as it would under certificate-of-need restrictions. However, Feldstein and others have shown that, instead of the expected profits, new costs emerge rapidly under such market conditions, as managers expand plant and labor force, buy expensive equipment, raise wages, and pay less attention to economizing measures. Consider, for example, how much more likely it is that an unwarranted increase in hospital wages will occur if restriction of the hospital bed supply has increased the hospital's ability to pass the cost on to the public. Although the wage increase might be regarded as socially preferable to the costs associated with uncontrolled growth, the choice between giving extra wages to employees and giving extra hospital care to sick people is not that clear-cut. In any event, other types of cost increases, which are equally likely to occur, will be less appealing.

Against this background, the critical inflationary factor appears to be simply the existence of opportunities for raising prices—that is, the excess demand which is generated by “methods of hospital insurance [which] have encouraged hospitals to raise wage rates and to increase the sophistication and expensiveness of their product more rapidly than the public actually wants.”²³⁷ Under such circumstances, regulatory control of less than all the inputs and their prices seems unlikely to produce a very favorable effect on total hospital costs.²³⁸ Certificate-of-need

²³⁷ FELDSTEIN, *supra* note 1, at 79.

²³⁸ The second circumstance [contributing to regulatory ineffectiveness] is that the regulatory body is incapable of forcing the utility to operate at a specified combination of output, price, and cost. . . . Since [it] cannot effectively control the daily detail of business operations, it cannot deal with variables whose effect is of the same order of magnitude in their effects on profits as the variables upon which it does have some influence.

Stigler & Friedland, *What Can Regulators Regulate? The Case of Electricity*, 5 J. LAW & ECON. 1, 11 (1962). For example, it is possible that control of capital investment could

laws, or even a second generation of regulatory paraphernalia, can probably never reach such things as wage rates, the size and skill of the hospital labor force, the extent of laboratory and radiographic services ordered, and the myriad small upgradings of "quality" which together spell higher and higher costs even if utilization is somewhat limited by supply restrictions.

In the absence of any affirmative evidence of cost-control benefits from certificate-of-need laws,²³⁹ the possibility that these benefits are no more than minimal must be taken seriously. Indeed, one economist has suggested that the various feedback effects of restricting the bed supply could actually produce a net increase in total expenditures for medical care.²⁴⁰ Although these observations are inconclusive, it does appear that expectations of major cost-control benefits are unduly optimistic.²⁴¹

shift the input mix in hospitals toward heavier reliance on labor, which in recent years has had the more rapidly inflating price. If so, there is yet another factor cutting away at any cost savings under certificate-of-need laws. See B. Zellner, *Inflationary Impact of Certificate-of-Need Laws*, January, 1973 (Working note, InterStudy).

²³⁹ One looks in vain for a careful study of New York's experience since 1964. The New York Commissioner of Health claims that the New York program "has disapproved construction of over 51,000 beds, saving approximately \$1.6 billion in capital costs and \$738 million annually in operating costs." Hollis S. Ingraham, *Health Facility Regulation in New York State*, an address before a panel of the National Health Forum, Chicago, March 20, 1973. The alleged savings are not broken down between nursing and hospital beds, but, if even a fraction of savings of this magnitude had occurred in the hospital sector, they should be visible in gross hospital expenditures in New York State. But hospital cost inflation seems to have been no less virulent in New York than elsewhere up to 1970, when rate regulation began. Although growth of the bed supply does seem to have been slowed somewhat and occupancy rates improved slightly, against the national trend, the lack of a detectable impact on gross costs, plus the reasons in the text for not expecting any, must argue for not counting on certificate-of-need laws to ameliorate the problem of inflation.

²⁴⁰ Zellner, *supra* note 238. Not only do supply restrictions seem likely to cause somewhat higher hospital costs than would prevail in their absence, but substitution of outpatient care for inpatient care, where the latter is more strictly rationed, will have costs associated with it. These costs represent further erosion of the apparent savings produced by limiting the bed supply.

²⁴¹ A final assessment of a certificate-of-need agency's actual performance and impact would be very difficult, requiring special analytical skills and considerable manpower and resources. "The test of the economic effect of regulation is essentially independent of the content of the formal regulations. No degree of care in analyzing the regulations, or even their administration, will tell us whether they rubber-stamp or slightly heckle the state of affairs or substantially alter it." Stigler & Friedland, *supra* note 238, at 2, suggesting the necessity for empirically comparing industry performance in regulated and unregulated markets. New York's early enactment of a certificate-of-need law should provide the data needed for such a comparison. There is an understandable but unfortunate tendency, however, to base judgments on impressions gained in inter-

A final issue which must be confronted is the nature of any cost savings which might be gained. Since some of the savings sought are expected to reflect reduced hospital utilization, it is fair to inquire whether the care forgone is in fact that which is medically unnecessary or not worth the cost. Thus, attention must be directed to the rationing process adopted when facilities are in short supply.²⁴² Unless the rationing system is in fact rational, any apparent cost savings will be at the expense of patients' health, reflecting the erection of a new barrier to access rather than an improvement in system efficiency. Such an access barrier is likely to affect the disadvantaged patient most directly and to undercut the notion of health care as a right. Certificate-of-need proponents may have assumed too readily that restricting the bed supply would produce more rational use of facilities.²⁴³

The Extent of the Benefits

The evidence suggests that certificate-of-need laws are likely to give the public substantially less than it is entitled to in the way of restrictions on hospital output and that cost-control benefits will be limited by the tendency of inflationary pressures to reappear in effects on costs which are less easily regulated. However, partial effectiveness alone is not a conclusive argument against such laws, and it seems probable that some potential benefits remain.

views and on anecdotes and apparent success in turning away proposals. Counting applications and denials is unreliable because applications may be discouraged (*see text accompanying notes 210-11 supra*) or stimulated (*see note 104 supra*) by certificate-of-need laws and projects denied approval might not have gone forward in any event; indeed, some states include in their box score of projects denied those which were clearly pre-empted by approval of a competing application. *See note 259 infra*.

²⁴² *See* Feldstein, *Econometric Studies*, *supra* note 54, at 21-22; Klarman, *supra* note 57, at 188.

²⁴³ *See note 199 supra*. The common observation that the hospitals with high occupancy rates seem to ration effectively may ignore physicians' use of alternative hospitals and other factors. However, a study by Rafferty, *Patterns of Hospital Use: An Analysis of Short-Run Variations*, 71 J. POL. ECON. 154 (1971), suggests that rationing is more rational in high-occupancy months than in low-occupancy months in the two hospitals in a single town. Nevertheless, no socioeconomic variable was examined to detect an access barrier, and mere postponements of hospitalization to a low-occupancy month were not distinguished from decisions not to hospitalize at all. Perhaps physicians are more cooperative with respect to postponements. The issue needs both further study and a benchmark for determining whether performance is only slightly improved or approaches optimality. Professional bed-rationing may prove to be either another imperfect cartel solution, *see note 234 supra* and accompanying text, or an efficient non-market allocative mechanism.

Even if a certificate-of-need law were administered as if the job had been entrusted to a cartel, it would at least go part of the way toward correcting the incorrect incentives for growth in the hospital sector. Hospital administrators would be curbed in their pursuit of growth and in their nonprice competition for doctors, to whom it would be much easier to say "no." Moreover, real social gains may be obtainable by directing new investments away from useless new hospital beds or duplicative facilities and into projects which are in some sense more "needed" even if they are not fully worth their cost—community services or higher wages, for example. Finally, some quality gains could probably be expected from coordination of services among institutions and from discouraging plans which are poorly conceived, which frustrate attainment of scale economies, or which are excessively profit-oriented.

Thus, the projected benefits of regulation appear to lie as much in the areas of assured quality and reduced resource misallocation as in cost control. Even though these benefits are of a somewhat different nature than those projected by certificate-of-need proponents, they may nevertheless be real. For this reason, the extent of any costs which certificate-of-need requirements might impose must be analyzed to determine if they exceed a reasonable estimate of the benefits.

B. Potential Costs

Administrative and Compliance Costs

The only obvious costs imposed by certificate-of-need laws are the administrative costs of the regulatory program itself. These include not only the costs of operating the state agencies but also the costs incurred by areawide planning bodies in performing their review and comment functions. Slightly less obvious are the costs of compliance incurred by the applicants themselves. These costs are largely absorbed in providers' overhead and ultimately appear in their charges as costs of "health care." Among the compliance costs are those associated with delay, including those resulting from rises in construction costs while applications are pending.

It is sometimes alleged that the review and comment functions of CHP agencies divert them from other, possibly more useful, activities, suggesting the existence of opportunity costs greater than the actual dollar outlays and recalling the "brushfire-wars" hypothesis explored earlier. A great deal would remain on the health planner's agenda if his mandatory

facilities planning functions were curtailed, for the local challenges in dealing with alcoholism, emergency care, drug abuse, community mental health, neighborhood health centers, and a wide range of other matters are immense. Indeed, the planners' past fascination with facilities in the face of other problems of so much greater magnitude argues for a major reordering of priorities.²⁴⁴

Hospital Competition

The loss of both actual and potential competition among hospitals, which a need requirement necessarily imposes in some degree, will not seem critical to many observers. Because of limited opportunities for consumer choice, such competition has seldom been a strong force. Where it has appeared, it has not been dependably conducive either to better quality or to lower prices. Instead, it has often produced nonprice competition for doctors, emphasis on amenities and image-building, and cream-skimming at the expense of services to the poor and other socially desirable activities.

Removal of opportunities for hospital competition will nevertheless cause some loss in technical (input-output) efficiency and responsiveness to consumer desires. It may also generate losses from distortions resulting from continued discriminatory pricing and from forgone opportunities for substituting low-cost for high-cost care. Moreover, if competition is restricted, needed changes in the methods of pricing and paying for health care may prove less likely to appear or less effective in improving performance.

Losses in Innovation and Change

Even though it may be difficult to attribute high costs to the loss of hospital competition per se, certificate-of-need legislation also sacrifices significant potential gains from technical innovation and institutional change which competition might induce. Losses from this effect are unmeasurable but would occur if uncertainty surrounding the need requirement reduces the likelihood that innovators will receive economic benefits from their innovations. Thus a lower rate of innovation would result from the prospect that some innovations might be excluded altogether, delayed in introduction, or admitted to the market only on limited terms or only after existing providers had been able to imitate them.

²⁴⁴ This argument probably holds *a fortiori* for nursing homes.

Regulation of entry and premarketing clearance requirements in other industries have had such effects. Moreover, the sympathy which customarily springs up between the regulated and the regulators, as well as the regulators' "sunk-cost obsession" and the perceived need to protect internal subsidies, leads inexorably to policies which inhibit drastic change.

It is unrealistic to rely as heavily as the health world now does on the initiatives of existing providers or on health planners to produce needed change. Protected against sudden competitive developments, the providers have no incentive to innovate in anticipation of them. Some innovations will undoubtedly occur because providers take their public responsibilities seriously, but cost-saving changes have customarily received low priority in comparison to technically sophisticated developments. For these reasons, exogenous influences seem essential to stimulate innovation and organizational flexibility. Commercially inspired efforts, even if sometimes troublesome from a quality standpoint, will usually more than repay their short-term costs in long-term system improvements.

Faith in governmental impetus for change also seems misplaced. Health planners and public administrators have uniformly reported difficulty in effecting major alterations in existing structures, and government in general, reflecting the same environmental factors which influence the performance of regulatory agencies, remains a powerful bulwark of established interests. Even though efforts to work through governmental processes are worthwhile, the likelihood of success is not great enough to warrant foreclosing private initiatives.

The Irrevocability of Choosing Regulation

Of course, the hospital industry is already heavily regulated, not only by governmental agencies but also by accrediting organizations, third-party payers, and professional organizations.²⁴⁵ Aside from the possibly temporary federal price controls, however, extensive economic regulation is not the universal rule. Yet the pressure for comprehensive regulation, encompassing entry, service responsibilities, rates, and quality of care, is strong. Although the tipping point is hard to identify, the enactment of a certificate-of-need law seems likely to be the first irrevocable step down the road to public utility controls. Seemingly a small step in itself, it may take us past the last decision point at which a choice might

²⁴⁵ See generally A. SOMERS, *supra* note 41.

still be made for some continued reliance on market forces to organize the health care industry.

It should be assumed for all practical purposes that enactment of a reasonably broad certificate-of-need law is irreversible, even if a considerable amount of evidence accumulates to suggest its failures. Shortcomings such as discouraging innovation and protecting inefficiency will be difficult to establish. Moreover, regulation creates strong vested interests in its continuation, including a bureaucracy with interests of its own, and these interests oppose major policy changes, particularly those strengthening competition or reducing the gross revenues of, or the resources employed in, the industry. Indeed, emendations of regulatory statutes nearly always widen the scope of regulation rather than narrow it, and instances of substantial deregulation of an industry, though widely advocated on the basis of proven social costs, are practically unheard of. Such a serious loss of policy flexibility is another important cost of starting down the road to public utility regulation.

If certificate-of-need laws do in fact disappoint expectations of a favorable impact on health care costs, more extensive hospital regulation is certain to follow. Because the various adverse consequences of comprehensive rate and service regulation do not appear on the face of the legislative package and because the regulatory "solution" purports to address the problems more forthrightly than any other approach, legislators will be tempted to adopt it. As a well-advertised legislative product containing fine sentiments and betokening only the best intentions, it is eminently salable in the legislator's marketplace, and the resulting legislative bias in favor of the regulatory package is reinforced by the preferences of the most prominent interest groups. The difficulty of resisting the pressures for public utility regulation is thus apparent. For this reason, the probable social costs of a system run under these principles must be anticipated in evaluating proposals for certificate-of-need legislation.

VI. CERTIFICATE-OF-NEED LAWS VERSUS THE ALTERNATIVES

Once the benefits and probable costs are weighed realistically, it is hard to understand how a certificate-of-need law could seem a very attractive device for addressing the rising cost of medical care. Its effect is likely to be very slight, probably undetectable in gross figures, and its potential for destructive impact is considerable. In these circumstances, state legislatures could rationally conclude that excessive hospital growth should be tolerated or dealt with by a variety of other mechanisms which,

though also imperfect, may carry a lower degree of risk. Although this is not the place for a detailed examination of the alternatives which might help in this effort, some directions may be pointed.

A. Fundamental Reforms

HMO development is perhaps the most promising nonregulatory strategy for bringing the excessive use of health care resources under effective control.²⁴⁶ Because the prepayment feature of HMOs leads them to conserve resources, their presence in the marketplace would be felt by the fee-for-service sector as a pressure to reduce costs. There is already evidence that HMOs' competition has stimulated the fee-for-service sector to begin doing privately the cost-control job which many are looking to public agencies to do.²⁴⁷ Such cost-control efforts have so far concentrated on curbing hospital utilization, thereby reducing hospitals' incentives for inappropriate growth. One could also expect

²⁴⁶ See, e.g., Ellwood, Anderson, Billings, Carlson, Hoagberg, & McClure, *Health Maintenance Strategy*, 9 MED. CARE 291 (1971); Havighurst, *supra* note 18. The simplest conceptualization of the HMO's potential impact is as a "close substitute" for the services sold by the fee-for-service "monopoly." Because of the immense difficulty of altering the numerous economic and political conditions fostering the monopoly power of individual fee-for-service providers—consumer ignorance, provider control of demand, third-party payment, inhibitions on insurer competition based on cost control, and so forth (see *id.* at 767-69)—creation of opportunities for independent marketing of a substitute service is probably the best policy alternative available. In technical terms, introduction of such a substitute tends to flatten the demand curve for the monopolized service, lowering the monopolist's profit-maximizing price. If consumers find the two services reasonably interchangeable, "cross-elasticity of demand" is high, and the monopoly of one service is of lessened, or no, consequence. Cf. *United States v. E.I. duPont de Nemours & Co.*, 351 U.S. 377 (1956). Attention must be directed to maintaining competition between the two modes by facilitating entry, preventing collusion, and barring one mode from being controlled by interests having a stake in the other. See generally Havighurst, *supra*, at 759-95; Havighurst, *Foundations*, *supra* note 234.

²⁴⁷ The activities of those so-called foundations for medical care which follow the "California model" of claims review, pioneered by the San Joaquin Foundation for Medical Care, appear directly motivated by HMO competition, which is much more active in California than elsewhere. See Sasuly & Hopkins, *A Medical Society-sponsored Comprehensive Medical Care Plan*, 5 MED. CARE 234 (1967). See also STEINWALD, *supra* note 92, at 6-25; Havighurst, *supra* note 18, at 769-77; Havighurst, *Foundations*, *supra* note 234. Similar physician-sponsored plans in Oregon, particularly the Physicians' Association of Clackamas County, were inspired by similar competitive and ethical concerns in the 1930s and 1940s. See Brief for the United States at 25-29, 36-41, *United States v. Oregon State Medical Society*, 343 U.S. 326 (1952). Other mechanisms which the fee-for-service sector can employ in fighting HMO incursions through cost control include PSROs, planning agencies, and third-party-payer claims review and utilization controls. See note 234 *supra* and notes 252 & 256 *infra*.

that, under a competitive stimulus, physicians and third-party payers as well as the hospitals themselves would come to scrutinize the investments being made in order that insured-fee-for-service care in the community would be kept competitive with HMO membership. If the institutional arrangements and attitudinal changes necessary for such cooperation in cost control were not forthcoming, competing HMOs would prosper.

It is commonly asserted that HMO impact is both far-off and uncertain and that other cost-control measures are therefore needed. Although this argument has some merit, it is usually overstated, since the benefits of changed incentives in the fee-for-service sector begin to be realized as soon as the environment becomes congenial to HMO development. Effective "potential competition" can be nearly as beneficial as actual competition in stimulating better performance by industry incumbents. Indeed, many of the widely heralded cost-control efforts of foundations for medical care and other provider groups have been inspired in large measure by concerns about HMO entry into the marketing area.²⁴⁸ For these reasons, facilitation of HMO market entry should be given the highest priority by state legislatures.²⁴⁹ Clearing the way for a market test of the HMO idea would have a beneficial impact on many of the problems which certificate-of-need laws are meant to address.

Among the other fundamental reforms which might be implemented to address the problems which prompt certificate-of-need proposals are several designed to restore consumer price-awareness in obtaining care. For example, government might abandon insuring on a first-dollar basis and provide universal health insurance having a very high annual deductible, perhaps ten percent of income. Such a plan would restore the consumer to a purchasing role and dethrone cost-reimbursement as the principal method of price determination.²⁵⁰ A similar result could be obtained by encouraging health insurers to pay per diem indemnities to their insureds rather than actual hospital charges.²⁵¹ A further, though highly speculative, possibility is active price competition among health insurers which features, among other things, aggressive cost-control ef-

²⁴⁸ See note 247 *supra*.

²⁴⁹ See Havighurst, *Foreword—HMOs in Policy Perspective*, in HEALTH LAW CENTER, ASPEN SYSTEMS CORP., HMO SOURCEBOOK—1973 EDITION vii (1973).

²⁵⁰ Feldstein, *A New Approach to National Health Insurance*, PUBLIC INTEREST, Spring 1971, at 93; see also M. PAULY, NATIONAL HEALTH INSURANCE: AN ANALYSIS 33-48 (1971).

²⁵¹ See Newhouse & Taylor, *How Shall We Pay for Hospital Care?*, PUBLIC INTEREST, Spring 1971, at 78.

forts, perhaps even including requirements for prior authorization of certain procedures.²⁵²

B. Symptomatic Relief

Remedies for the health care industry's cost problems might be less sweeping than the ones just suggested. One possibility would be a switch from cost reimbursement to some kind of rate regulation, preferably a system of incentive reimbursement. For example, hospitals could be grouped and paid an amount adequate to cover costs of the average hospital in the group.²⁵³ In these circumstances, the more efficient hospitals or those located in areas of high demand would have surpluses and therefore the means and borrowing capacity to modernize and expand, while others would suffer losses and be deprived of the ability to expand. Although such a system would not directly address the problem

²⁵² Insurers demonstrate little inclination to compete in policing the appropriateness of care and the cost thereof, however, mainly because of the medical profession's willingness to boycott insurers who attempt to second-guess medical judgments and charges. See, e.g., Rosenberg, *He Challenged Aetna's Hard Line Fee Policy—and Won*, MED. ECON., Sept. 11, 1972, at 31, and Letters to the Editor, MED. ECON., Dec. 4, 1972, at 23, 27-29. Although Blue Cross and Blue Shield plans have moved gingerly in the direction of some claims review, there is no basis for expecting that active insurer competition in cost control would be tolerated by doctors. Indeed, when such competition broke out in Oregon in the 1940s, the medical profession's response was to establish a plan of the Blue Shield variety, which eventually brought insurers into line, apparently by means of disciplinary (below-cost) pricing and threats of boycott against insurers who refused to follow Blue Shield's lead. *United States v. Oregon State Medical Soc'y*, 343 U.S. 326 (1952).

As doctors persuasively allege, insurers may not be trustworthy in interfering in the process of rendering medical care; on prior authorization, for example, see the alleged "horribles" in Brief for the Oregon State Medical Society at 146-53, *id.* Moreover, in many cases they might wield monopsony power, enabling them to exploit physicians unfairly. Nevertheless, regulation to curb abuses, but otherwise to legitimize and encourage insurers' cost-control efforts, should be considered. So far as I know, no one has advocated or even studied this approach. Carried to its logical conclusion, this competitive model would yield a variety of insurance plans, most of them offering as a "closed panel" those physicians and hospitals who voluntarily accepted the particular cost-control program. With policies covering only care obtained from these listed providers, insurers would very nearly become, in effect, HMOs. Almost certainly, the prospects for such developments are dim, but real freedom for HMO development would achieve many of the benefits of a system like the one described.

²⁵³ See Lave, Lave & Silverman, *A Proposal for Incentive Reimbursement for Hospitals*, 11 MED. CARE 79 (1973). See also K. BAUER & P. DENSEN, SOME ISSUES IN THE INCENTIVE REIMBURSEMENT APPROACH TO COST CONTAINMENT: AN OVERVIEW (Harvard Program on Health Care Policy, Discussion Paper No. 7, 1973). For a survey and critique of similar proposals in other regulated industries, see Posner, *supra* note 48, at 627-32.

of the Roemer effect—which might persist in hospitals threatened with losses and extinction—it might improve the rationality of new hospital investments.

The advantages of rate regulation over certificate-of-need laws include preservation of both entry possibilities and some opportunities for market tests of provider performance. Rate regulation may also be used temporarily, either while the market pressures supplied by HMOs are strengthening or to cushion the inflationary impact of national health insurance. The federal Cost of Living Council appears to be operating in the spirit of returning one day to a market-oriented health care system.

A possibility deserving more attention than it has received is the improvement of the mechanisms whereby a hospital may be encouraged to leave the industry when the need for it has evaporated. Whereas certificate-of-need laws turn off the spigot of fresh supply, it would be preferable if supply were regulated by processes which allowed inadequate or unneeded providers to go “down the drain.” Attention to the market exit problem could take two forms. Perhaps state nonprofit corporation acts could be amended to induce or compel a nonprofit corporation to liquidate whenever the salvage value of its assets exceeded its “value” as a “going concern.”²⁵⁴ In the event that the liquidation incentives of trustees and managers of nonprofit hospitals could not be strengthened, regulatory powers to condemn or otherwise eliminate unneeded beds or institutions might be considered. Naturally the politics of any such regulatory program would be explosive, but perhaps the matter could be left to judicial decision under objective criteria, with the right to initiate a liquidation proceeding assigned to public or private agencies which had an interest in cost control.

Other measures for dealing with health care costs are likely to reduce provider control of demand, thereby weakening both the Roemer effect and the case for certificate-of-need laws. Utilization review is being undertaken by foundations for medical care under several state Medicaid programs, and PSROs will soon exercise major controls over costs, utilization, and quality under Medicare and other federal programs. Blue Cross plans have intensified claims review in a number of places, and, particularly in those areas where HMOs are strong, foundations for medical care have become involved in reviewing claims for health insurers and even in providing prepaid HMO-type care directly, with cost and utilization controls over participating physicians. These emerg-

²⁵⁴ See note 67 *supra*.

ing mechanisms of claims review will surely affect hospital investment decisions and are probably already reflected in declining hospital occupancy rates. However, because these mechanisms of symptomatic relief are largely in the hands of the medical profession, they seem unlikely to achieve their full potential unless incentives are changed by allowing actual or potential HMO competition to materialize.²⁵⁵

Rejection of the certificate-of-need approach to controlling health care costs need not constitute a denial of the utility of health planning. Planners without regulatory powers have had a desirable impact in many circumstances, succeeding primarily by educating providers, governmental agencies, philanthropic interests, and others to the existence of needs and to their responsibilities for meeting them. Inefficient as operating without teeth may seem, it may strengthen the planners' incentives to develop the credibility and persuasive arguments needed to prod political organs or providers into action on specific matters. Similarly, the planners' cultivation of influence with third-party payers, including Medicare under the 1972 amendments, can provide quite effective control over egregious facilities duplication. Their impact in this regard could be expected to grow as HMO competition stimulates greater cost-consciousness in the fee-for-service sector.²⁵⁶

Quality-of-care concerns also appear in certificate-of-need proposals, and it may be asked whether alternative approaches to this problem are available. Constructive comment on this issue would open up immense complexities, but as a generalization it may be said that regulation expressly based on outcomes of care, now being carefully explored for feasibility, would be much more effective than input regulation under certificate-of-need laws.²⁵⁷ In addition, incentives for improved quality may be strengthened by disclosure of outcomes and by other mechanisms.²⁵⁸ More immediately, PSROs are expected to evaluate quality and would seem capable of taking over whatever quality functions are performed by certificate-of-need agencies.

²⁵⁵ See note 234 *supra* and accompanying text.

²⁵⁶ See notes 234, 246, 247, & 252 *supra*. A certificate-of-need agency might also be a useful mechanism in the fee-for-service sector's response to HMO competition. Even functioning as an agent for a cartel, it would be more aggressive in cost control than it would be in the absence of HMOs, though it would leave HMOs a greater share of the market than under competition. Cf. Havighurst, *Foundations*, *supra* note 234.

²⁵⁷ See note 95 *supra*.

²⁵⁸ See notes 75-76 *supra* and accompanying text.

C. *A Modified Certificate-of-Need Law*

Some observers will probably remain unconvinced that certificate-of-need laws should be dispensed with altogether, since they will still see hospitals as afflicted by perverse incentives to grow in inefficient ways and will not accept the notion that direct action against this manifest problem can be ineffective or destructive.²⁵⁹ Moreover, the pressures for enactment of certificate-of-need laws will remain intense, originating with the hospital industry, health insurers, the health planning and public health establishment, and particularly the federal government, which is currently offering financial support and other encouragement. In view of these circumstances, it may be useful to offer here some specifications for drafting a modified certificate-of-need law which will produce as many of the expected benefits as possible and minimize the costs. Because many of the existing laws leave the regulators a great deal of discretion, some of these specifications may also prove useful in improving the administration of existing certificate-of-need programs.

My recommendations are as follows:

(1) In order to offset provider influence, certification of need should be lodged in an agency which bears direct political responsibility for the cost of health care as a purchaser of care under Medicaid and state employee health programs.²⁶⁰ A substantial advisory or appellate role should be assigned to a part-time board having no more than token provider representation.

(2) Coverage of the law should be limited to hospitals only, excluding nursing-care institutions and all ambulatory-care facilities, particularly those of HMOs.

(3) A total exemption from the need requirement should be given to HMO hospital facilities.

(4) Strict standards of openness in policy formulation and implementation should be established, including requirements for public rule-making as to all general policies and for detailed findings of facts and full statements of reasons and dissenting views as to particular decisions.

²⁵⁹ There is a natural tendency to presume regulatory effectiveness on the basis of perceived regulatory activity. "But the innumerable regulatory actions are conclusive proof, not of effective regulation, but of the desire to regulate. And if wishes were horses, one would buy stock in a harness factory." Stigler & Friedland, *supra* note 238, at 1.

²⁶⁰ However, it should be divorced from any regulation of hospital rates in order that internal subsidy possibilities will be minimized. See text accompanying notes 170-77 *supra*. Most rate regulatory programs have preserved this separation.

(5) Reliance on real planning should be mandatory, with decisions based on published quotas and sound (as opposed to historical) utilization practices.²⁶¹

(6) In so far as possible, grounds for departing from published plans should be articulated in advance, and these grounds should reflect an express commitment to increasing the range of consumer choice, strengthening competition, reducing costs, and encouraging innovation.

(7) The need requirement should be defined so as not to shelter non-cost-related pricing or to prevent entry by providers giving less comprehensive care ("cream-skimmers") except where care of indigent patients would unavoidably be jeopardized.

(8) The law should have a fixed expiration date so that it appears more as a moratorium than as a permanent commitment to regulation.

It is still too early to make the ultimate health policy choice between health planning-cum-regulation and a more market-oriented system which relies primarily on decentralized decisions by providers, consumers, and insurers. Both have their adherents in the policy debate, and neither has proved itself as yet, although the imperfections of the market as we know it have been much ventilated. Perhaps in five years it will be possible to assess with greater assurance the impact of such changes as an improved system of national health insurance, HMO development, utilization controls, and various regulatory experiments. If limited regulation producing a moratorium on hospital construction could get us, uncommitted and with better information, to that decision point, it would have provided a valuable service. It may be unrealistic, however, to think that regulation can be employed as a temporizing measure.²⁶²

This Article has used certificate-of-need laws as the occasion for appraising the imperfections of comprehensive regulatory responses to the health care crisis and has produced a pessimistic judgment. Still, carefully limited regulation having a clear and limited purpose may be use-

²⁶¹ This requirement may be a mistake for two reasons: (1) facilities planning may hold too little promise to be endorsed in this manner, and (2) the added planning bureaucracy entailed by the requirement may become so influential a vested interest that objective reappraisal of the need for such a law in the future will be impossible. See text accompanying note 245 *supra*.

²⁶² Possibly a better expedient than the one presented would be a moratorium on hospital construction imposed at the federal level, with necessary variances granted or withheld without involving the planning agencies. The very arbitrariness of such a scheme would guarantee its temporary nature and would be consistent with the philosophy behind the wage and price controls.

ful in improving the functioning of the health care marketplace, re-ordering the operative incentives, and checking abuses where they appear. The strong temptation to adopt the "solution" of comprehensive economic regulation, which springs from the frustrations of coping with an unruly market, must be resisted in favor of trying approaches which may succeed in preserving the dynamism of a market-oriented system while minimizing its costs.