

Leveling the Healing Field: Specialty Hospital Legal Reform as a Cure for an Ailing Health Care System

Mike J. Wyatt*

*Fair play, and an open field, and freshest laurels to all who have won them!*¹

I. INTRODUCTION

For the last forty years, a rising tide of costs has been swelling the banks of a river that we call the American health care system. Our burgeoning demand for health services and the drive for unreasonably high profits will soon overwhelm the debris-choked channels, breach our dams and levees, and flood our fertile lands. However, hope lies on the horizon: like dredges, reinforced levees, new dams, and additional waterways, fair competition in the health care industry will lower these costs and suppress the menacing tide.

With a price tag of nearly two trillion dollars and accounting for approximately one sixth of our gross domestic product (GDP), health care is the most expensive of all American goods and services.² The

* B.A. 2004, Washburn University; J.D. Candidate 2007, Washburn University School of Law. I would like to thank Bill Pitsenberger for sharing his inestimable health care law expertise throughout the course of my research and writing. I am extremely grateful for the efforts of the Editorial Board of the *Washburn Law Journal* under the direction of Michael Shultz. Particularly, I thank Matthew Holcomb for his tireless efforts to improve the quality of my note and Molly McMurray for her willingness to lend an extra set of eyes on short notice. As always, I owe everything to my faith, family, and friends. I offer a special thanks to the two most important women in my life—my wife, Jamie, and my mother, Mary—for their love and support. I dedicate this piece to the memory of my father, Jay Dean Wyatt, who will always be watching and reading.

1. JOSEPH SLATER, *THE COLLECTED WORKS OF RALPH WALDO EMERSON: VOL. IV REPRESENTATIVE MEN* 18 (Harvard 1987).

2. REPORT BY THE FED. TRADE COMM'N AND THE DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION*, Executive Summary 2 (2004), available at <http://www.ftc.gov/reports/healthcare/04723healthcarerpt.pdf> [hereinafter *IMPROVING HEALTH CARE*]; William M. Sage & Dev N. Kalyan, *Horses or Unicorns: Can Paying for Performance Make Quality Competition Routine?*, 31 J. HEALTH POL. POL'Y & L. 531, 532 (2006); Unmesh Kher, *The Hospital Wars*, TIME, Dec. 5, 2006, <http://www.time.com/time/magazine/article/0,9171,1565524,00.html> [hereinafter *The Hospital Wars*]. Commentators attribute this massive component of the GDP to rising health care costs. See *IMPROVING HEALTH CARE*, *supra*, Executive Summary, at 3. Throughout this entire note, it will be assumed that a low-cost health care system is optimal, and the analysis will center on achieving a cost-efficient system. However, commentators often disagree, contending that the quality of care is more important. *Id.* ("Many health care providers and health services researchers treat the cost of care (and the resources of consumers) as immaterial; for them, you either provide high quality care to a particular patient or disease set, or you do not."). Indeed, both factors are important, and the solutions suggested *infra*, although aimed at lowering costs, will also have positive quality implications.

high cost of health care renders health insurance a pricey necessity for policyholders and greatly increases public expenditures for government-funded coverage.³ There is little question that if costs continue to rapidly rise, health insurance will become even less accessible to the American public. As a daunting example, Medicare, the primary source of coverage for senior citizens, is expected to become insolvent by the year 2018.⁴ Only to exacerbate these problems, America's aging population will soon create a steep demand for health care services.⁵ Without drastic legal reform that will encourage lower costs in our health care system, the financial strength of our nation is in jeopardy.⁶

This note's purpose is to suggest a workable legal reform that will reduce the burden of our health care system by encouraging lower costs. It is central to this analysis that many of our nation's stifling health care costs can be viewed and explained through the lens of the specialty hospital debate. It will be suggested that addressing the legal problems attendant to specialty hospitals will also correct major cost-related flaws in the system as a whole.⁷

Part II of this note will describe the nature of specialty hospitals and their role in our health care system, the current state of specialty hospitals after a congressional lifting of the ban on their introduction, and both sides of the raging debate over specialty hospital proliferation. Part III will introduce three specific problems that have inhibited specialty hospitals from acting as competition and lowering costs: (1) legal barriers to entry that prevent health care competition; (2) the inefficient prospective payment system through which most health services are purchased; and (3) the lack of health information technology in the transfer and use of health care data. Thus, this note's purpose of suggesting cost-lowering legal reform will be achieved in the context of these three vexing legal failures.

Part IV of this note will evaluate potential solutions to these problems. The first solution, which is already set to take place within the next decade, is the introduction of a national Health Information Tech-

3. See BARRY. R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 498 (Thomson West 5th ed. 2004).

4. *Paying to Get it Right*, CHICAGO TRIBUNE, Sept. 5, 2006, at 14 [hereinafter *Paying*]. The government pays for approximately forty-five percent of all care health services in the United States. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 2. Private insurance companies purchase forty percent of all health care services, followed by consumers who pay for the remaining fifteen percent out of pocket. *Id.*

5. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 3.

6. *Paying*, *supra* note 4 (“[T]he problems with the American health-care system are so huge, so pernicious, and so threatening to the nation’s long-term fiscal health . . .”).

7. The problems associated with specialty hospitals are characterized as legal problems or legal failures because they either result from bad statutory law—as is the case with certificate of need requirements and our health care reimbursement system—or they result from failure to take legislative action earlier—as is the case with the lack of Health Information Technology. See *infra* Part III.A-C. Further, as it will be discussed *infra* Part IV.A-C, all of the problems have legal solutions.

nology system. The next solution, which is currently being tested for feasibility, is the implementation of what theorists have labeled a pay-for-performance reimbursement mechanism. The last solution is to abolish competition-inhibiting certificate of need laws. Once our health care system incorporates modern technology, employs pay-for-performance rationale, and operates in the absence of barriers to entry such as certificate of need laws, the looming health care cost crisis will be significantly ameliorated. Finally, it will be proposed that correcting the problems associated with specialty hospitals will not only alleviate the financial strain of our health care system, but will also address a major criticism: the health care industry does not function like a true market.

II. COMPETITION AND SPECIALTY HOSPITALS

Lack of competition among major health care providers (providers) such as general hospitals is a significant cause of the high cost of health care in the United States and has long been the subject of debate.⁸ The relatively small number of providers creates structures similar to monopolies and oligopolies.⁹ Legal barriers to entry often operate to strengthen these monopolistic market structures by preventing competition, allowing high-priced and low-quality care to go unchecked.¹⁰ This apparent over-regulation of the health care industry has led observers to suggest that an open market, free of impediments, would facilitate a much more efficient and cost-effective health care system.¹¹ Conversely, opponents of the free market approach contend that health care is a special type of service that, because of its very nature, must be subject to significant government intervention.¹² The recent physician-owned specialty hospital debate has been the modern embodiment of the battle over *laissez faire* versus regulation-based policy.¹³ Accord-

8. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 1; David N. Heard, Jr., *The Specialty Hospital Debate: The Difficulty of Promoting Fair Competition Without Stifling Efficiency*, 6 Hous. J. Health L. & Pol'y 215, 216-17 (2005). "Providers" will be the term used throughout this note to refer to any health care provider, including specialty hospitals and general hospitals.

9. Clark C. Havighurst, *Monopoly is Not the Answer*, HEALTH AFFAIRS, Aug. 9, 2005, at 374.

10. See *infra* Part III.A for an explanation of why certificate of need laws operate as substantial legal barriers to entry for specialty hospitals.

11. See, e.g., IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 28-29.

12. *Id.* at 1 ("For much of our history, federal and state regulators, judges, and academic commentators saw health care as a 'special' good to which normal economic forces did not apply."); *id.* at 4-5 ("[I]n health care, some commentators see competition as a problem to be tamed with top-down prescriptive regulations, instead of an opportunity to improve quality, efficiency, and enhance consumer welfare."). See generally Sage & Kalyan, *supra* note 2 (noting that government intervention in the health care market is essential).

13. See Heard, *supra* note 8, at 218. Non-physician owned specialty hospitals have been in the health care industry for decades, while physician-owned specialty hospitals are relatively recent. IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 17. For the purposes of this note, the term specialty hospital will be used to describe physician-owned and non-physician-owned specialty hospitals

ingly, the lack of competition as a substantial cause of the high cost of health care will be examined in the context of this controversy.¹⁴

A. *The Nature and Role of Specialty Hospitals*

In contrast with general hospitals that provide a vast array of health care services, specialty hospitals are often physician-owned¹⁵ and provide services that restrict care to a particular specialty, most often cardiac or orthopedic surgery.¹⁶ Because specialty hospitals aim to capture a much narrower sector of the health care market, they are generally less complex in structure than general hospitals, requiring significantly smaller surgical, nursing, and administrative staff.¹⁷ Further, given that many specialty hospitals do not carry a not-for-profit tax status, they are not required to house emergency rooms or offer emergency services.¹⁸ For all of these reasons, specialty hospitals have become a significant form of competition for general hospitals that offer similar services.¹⁹

Specialty hospitals are appealing to physician-investors for several reasons: (1) their smaller size and simpler structure allows physician-investors to easily participate in management;²⁰ (2) their concentrated operations enhance efficiency and increase profitability;²¹ and (3) physician-investors generally exercise a degree of control over the specialty hospital's patient volume and scheduling.²² Although specialty hospitals are extremely appealing to physician-investors, they are equally loathed

because both function as competition. *Id.* However, the discussion of the recent specialty hospital debate is centered on physician-owned specialty hospitals. See *infra* Part II.B for an explanation of the debate.

14. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 1 (“Imperfections in the health care system have impeded competition from reaching its full potential.”); Heard, *supra* note 8, at 216-17.

15. The physician-owned nature of many specialty hospitals is an exception to the general prohibition against physicians referring patients to facilities in which they have financial interests. 42 U.S.C. § 1395nn(a)-(b)(2)(B) (2005) (“[If] a physician . . . has a financial relationship with an entity specified in paragraph (2), then—(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter[.]” except when the entity “is wholly owned by such physician or such group practice.”); IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 17 n.79. This section of the Stark Law is commonly known as the “whole hospital” exemption. See Jessica B. Applegate & Kathy Kuhagen, *Deficit Reduction Act of 2005 Addresses Various Health Care Issues*, 18 HEALTH LAW 31 (2006).

16. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 15 (“Newer single-specialty hospitals (SSHs) tend to specialize in cardiac or orthopedic surgery . . .”).

17. Maureen Kwiecinski, *Limiting Conflicts of Interest Arising From Physician Investment in Specialty Hospitals*, 88 MARQ. L. REV. 413, 439 (2004); David Armstrong, *Doctor-Owned Specialty Hospitals Get a New Lease on Life*, THE WALL STREET JOURNAL, Aug. 29, 2006, at B1.

18. Heard, *supra* note 8, at 219-20; Armstrong, *supra* note 17.

19. *Id.*; See Jennifer Bartels, *The Application of Antitrust and Fraud-and-Abuse Law to Specialty Hospitals*, 2006 COLUM. BUS. L. REV. 215.

20. See IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 18-19 (“[P]roviders desire greater control over management decisions that affect their incomes and productivity.”); Suzanne Strothkamp, *Understanding the Physician-Owned Specialty Hospital Phenomenon: The Confluence of DRG Payment Methodology and Physician Self-Referral Laws*, 38 J. HEALTH L. 673, 684 (2005).

21. *The Hospital Wars*, *supra* note 2.

22. See Strothkamp, *supra* note 20, at 684-85.

by general hospitals.²³ In the midst of this disagreement, proponents and opponents of specialty hospital proliferation both offer convincing arguments for their respective positions.²⁴

B. The Specialty Hospital Debate

Proponents maintain that specialty hospitals are necessary because they function as competition for general hospitals, providing lower-priced and higher-quality services to attract patients.²⁵ By focusing on particular specialties in a less complex health care environment, specialty hospitals can operate more efficiently to pass the cost savings onto the purchaser and give a higher quality service to the patient.²⁶ As a result, proponents argue that specialty hospitals lower costs and increase the quality of care in the industry as a whole by serving as direct competition.²⁷ The American public is benefited by a more affordable health care system and is healthier because of a greater quality of care.²⁸

Opponents of specialty hospitals argue that they financially impair general hospitals by diverting only the most well-insured and healthy patients, a tactic known as “cherry picking” or “cream skimming.”²⁹ Well-insured patients present a higher likelihood of reimbursement for providers, and healthier patients generally experience fewer profit-consuming complications.³⁰ Opponents claim that this diversion of profitable patients harms general hospitals which use such patients to cross-

23. See generally IMPROVING HEALTH CARE, *supra* note 2, ch. 3 (noting that several hospital panelists were adamant about excluding specialty hospitals from their markets). See also Armstrong, *supra* note 17 (noting the acrimonious relationship between many specialty hospitals and general hospitals).

24. See Strothkamp, *supra* note 20, at 674.

25. *Id.* at 684; Paul B. Ginsburg & Joy M. Grossman, *When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care*, HEALTH AFFAIRS, Aug. 9, 2005, at 377. Indeed, specialty hospital patients generally experience shorter and more pleasant stays than in hospitals. Armstrong, *supra* note 17, at B1, B10 (“[P]atients often stay in oversized private rooms featuring fancy menus and other perks.”); *The Hospital Wars*, *supra* note 2 (noting that same-day surgery centers in Wichita, Kansas, “have hotel-like touches”). Same-day surgery centers are also known as “ambulatory surgical centers” (ASCs), and are mostly owned by physician investors and hospitals. *Id.*

26. See Strothkamp, *supra* note 20, at 674.

27. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 4 (“Price competition generally results in lower prices and, thus, broader access to health care products and services.”). Quality can be somewhat of an amorphous term in the health care context, and various health care organizations have different definitions. See *id.* at 3.

The Institute of Medicine defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The Agency for Healthcare Research and Quality defines quality health care as “doing the right thing at the right time in the right way for the right person and having the best results possible.” *Id.* For the purposes of this note, the term quality can mean either of these definitions.

28. See *id.* at 4.

29. Strothkamp, *supra* note 20, at 684; Armstrong, *supra* note 17; see also *The Hospital Wars*, *supra* note 2. As Tom Stone, the chief executive of a Louisiana hospital points out, specialty hospitals “definitely pick and choose the cases they do.” Armstrong, *supra* note 17, at B10.

30. See Strothkamp, *supra* note 20, at 681-82, 685 (quoting an October 2004 MedPAC meeting); Armstrong, *supra* note 18.

subsidize the expense of unprofitable patients, including those whose illnesses have low pre-determined reimbursement rates, patients who are not well-insured or are uninsured, and those who are more likely to suffer complications.³¹ Further, unlike specialty hospitals, most general hospitals, in order to be deemed not-for-profit tax entities, must maintain the traditionally less lucrative emergency room services and provide community benefits.³² Opponents contend that this asymmetrical distribution of community health care costs is unfair.³³ Finally, opponents

31. Ginsburg, *supra* note 25, at 377; *The Hospital Wars*, *supra* note 2. The process of diverting patients is known as “patient selection.” See Strothkamp, *supra* note 20, at 679 (quoting the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. §1395nn(d)(3)(B)(2005)). See *infra* Part III.B for an explanation of how reimbursement rates are determined by purchasers. However, as it will be argued *infra* Part III, hospitals are also cross-subsidizing inefficiency, which is much less admirable than making up for the costs associated with providing care to the indigent. See Havighurst, *supra* note 9, at 374-75 (“Resources too easily gained [by hospitals receiving reimbursements for highly-profitable services] may easily be wasted in inefficient operation and spent on things not clearly worthy of public support.”).

32. IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 20 (“Similarly, several panelists noted that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care.”). Kevin Conlin, CEO of the nonprofit Kansas Via Christi Health System, commented that, as a result of the specialty hospital explosion in Wichita, “[w]e’re left with no option . . . but to set limits on how much [charity care] we’re going to do. Only then will we have a public conversation about the issues [that the specialty hospital] phenomenon raises.” *The Hospital Wars*, *supra* note 2. However, Ed French, CEO of MedCath, a corporation that operates twelve specialty hospitals, states an opposing view: “We raise the bar for the community Everybody invests in more equipment and focuses more on nursing care because we set the competitive standard.” *Id.*

33. IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 20. Hospitals have taken steps in recent years to punish physicians for referring patients to specialty hospitals in which the physicians have financial interests. *Id.* at 15. For example, hospitals have stripped involved physicians of access to hospital facilities and of their admitting privileges. *Id.*; *The Hospital Wars*, *supra* note 2. This process is known as “economic credentialing,” and is defined by the American Medical Association as “the use of economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.” *Economic Credentialing: Issues and Answers*, Mar. 14, 2005, <http://www.ama-assn.org/ama/pub/category/10919.html>. The issue of economic credentialing has spawned much litigation. Anne S. Kimbol, *The Debate Over Specialty Hospitals: How Physician-Hospital Relationships Have Reached a New Fault Line Over These “Focused Factories”*, 38 J. HEALTH L. 633, 663 (2005); see, e.g., *Mahan v. Avera St. Luke’s*, 621 N.W.2d 150, 160 (S.D. 2001) (holding that a hospital did not breach its duty of good faith and fair dealing under medical staff bylaws by closing medical staff privileges to mitigate the competitive effects of a newly-opened ASC). Large hospitals that have a great amount of bargaining power with payors have taken steps to exclude competing facilities from their networks. See *The Hospital Wars*, *supra* note 2; see also, e.g., *Complaint at 3-4*, *Heartland Surgical Specialty Hosp., L.L.C. v. Midwest Div., Inc.*, Case No. 05-CV-2164 GTV/DJW (D. Kan. Apr. 26, 2005) (alleging that established providers and an insurance company in the Kansas City market engaged in exclusionary practices prohibited by anti-trust law to keep the plaintiff-surgical hospital out of the referral and reimbursement network).

Although hospitals are financially harmed by specialty hospital proliferation to some degree, they have taken steps to minimize the effect of competition. See *infra* note 40 and accompanying text. One example is the specialty hospital explosion in Wichita, Kansas. In direct competition with Via Christi and Wesley Medical Center hospitals, there are now five physician-owned specialty hospitals in this community of 540,000 people. *The Hospital Wars*, *supra* note 2. There are also twelve ASCs and ten independent diagnostic imaging centers that compete with hospitals in the Wichita health care market. *Id.* When Galichia Heart Hospital began operation in 2001, Wesley lost nearly sixteen million in net revenue from its cardiovascular program. *Id.* When the Kansas Spine Hospital opened two years later, Wesley lost an additional nine million in net revenue. *Id.* However, as co-founder of the Kansas Heart Hospital Gregory Duick notes, “[t]he fear that emergency rooms and cardiovascular programs would close at community hospitals . . . has not been borne out over seven years in Wichita.” *Id.*

argue that referring physicians who own interests in specialty hospitals are more likely to refer patients for unnecessary medical services in an effort to yield greater profit.³⁴

Health care purchasers, providers, patients, and policy theorists all have differing views on this debate.³⁵ Each side has strong and weak points, and it is difficult to determine which argument is more convincing. Recently, however, the federal government, as the primary purchaser of health care services in the United States, entered the fray by defining the proper role of specialty hospitals.³⁶

C. The Federal Government's Current Position

In August 2006, following a report authored by the Medicare Payment Advisory Commission (MedPAC) detailing the actual effects of specialty hospitals, the Bush administration decided not to extend a thirty-one month moratorium on the introduction of new specialty hospitals.³⁷ In the report to Congress, MedPAC concluded that specialty hospitals do not unduly harm general hospitals.³⁸ The report also determined, however, that legitimate concerns raised in a 2005 report regarding specialty hospitals still existed, and that specialty hospitals did not contribute to lower health care costs.³⁹

The report noted that:

Specialty hospital's inpatient services are not less costly than community hospitals' services, as might be expected from a "focused factory" hypothesis.

....

While the specialty hospitals took profitable surgical patients from the competitor community hospitals (slowing Medicare revenue growth at some hospitals), most competitor community hospitals appeared to com-

34. IMPROVING HEALTH CARE, *supra* note 2, ch. 3, at 21-22 ("Several panelists also suggested that physicians that have an ownership interest in a SSH have an incentive to overrefer patients to that facility to maximize their income."); Armstrong *supra* note 17.

35. Strothkamp, *supra* note 20, at 674, 684. In fact, some commentators have described the specialty hospital debate as a "war," equating the technological upgrades that hospitals implement to compete with specialty hospitals to an "arms race." See *The Hospital Wars*, *supra* note 2.

36. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 2 (noting that the federal government purchases forty-five percent of health care services in the United States).

37. Armstrong, *supra* note 17. The original moratorium by Congress was only eighteen months, set to commence in December 2003 and expire in June 2005. *Id.* The ban was effectively extended, however, in June 2005 when the Centers for Medicare and Medicaid ceased certifying applicant specialty hospitals for six months, claiming that it needed to further study the effect of specialty hospitals. *Id.* Without this certification, providers cannot receive federal reimbursements for services. *Id.* Congress then extended the moratorium six more months to August 2006. *Id.* Shortly after the ban, physician-investors quickly went to work in planning for specialty hospital construction. *Id.* Daniel R. Tasset, chief executive of Neuterra Healthcare L.L.C. in Leawood, Kansas, a specialty hospital development company, noted that specialty hospitals were "back in business again" as they "have renewed interest from banks and lenders and renewed interest from physicians." *Id.*

38. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, Executive Summary, vi-viii (Aug. 2006) [hereinafter MedPAC 2006].

39. See *id.* at v-vi.

pensate for this lost revenue.⁴⁰

In short, the administration's position is that, although specialty hospitals are not helping drive the cost of health care down, they certainly are not as financially harmful to general hospitals as opponents contend.⁴¹

Despite the federal government's lukewarm approval of specialty hospitals' innocuous effect on the health care industry, proponents of free enterprise are left unsatisfied with the realization that specialty hospitals do not lower health care costs as expected. Indeed, one of their most appealing aspects is that, as a form of competition, they should operate to drive prices down.⁴² As it will be shown in the next section, three significant factors underlie the failure of specialty hospitals to lower health care costs.⁴³

III. THREE FACTORS INHIBITING SPECIALTY HOSPITALS

The recent proliferation of specialty hospitals has not lowered health care costs for three reasons: (1) certificate of need laws prevent specialty hospitals from acting as competition in many state and local health care markets;⁴⁴ (2) the current prospective payment system uses skewed rates and reimburses general hospitals and specialty hospitals at the same level, not taking into account the lower operating costs of specialty hospitals;⁴⁵ and (3) the current system of health information transfer is antiquated, leading to a dysfunctional prospective payment system and contributing to misaligned reimbursement rates.⁴⁶ In addition to substantially impacting the success of specialty hospitals, these factors also contribute significantly to the high cost of health care. Addressing these concerns will tame the extreme financial burden of American health care.

A. Certificate of Need Laws

Certificate of need (CON) laws operate to limit the supply of new

40. *Id.* at vi, viii. Further, although the MedPAC study was substantial, the drafters agree that the long-term impact of specialty hospitals has not been determined. *Id.* at v.

41. *See id.* at vi-vii.

42. *See* Strothkamp, *supra* note 20, at 684.

43. *See The Hospital Wars*, *supra* note 2 (noting that the specialty hospital phenomenon has failed to improve the health care market). For a more in-depth analysis of how competition will lower prices, see *infra* Part IV.D.

44. *See* IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22.

45. *See id.* at 15 (noting that specialty hospitals are reimbursed at the same rates as general hospitals); *id.* at 16 ("Government-administered pricing by CMS inadvertently can distort market competition. For example, CMS never decided as a matter of policy to provide greater profits for cardiac surgery than many other types of service, but the []PPS tends to do so."). However, the federal government will soon be reimbursing providers differently to attempt to address this problem. *See* Armstrong, *supra* note 17. These measures may reduce the unfairness of equal reimbursement rates for healthy patients, but they will not reduce costs. *See infra* Part IV.B for an alternative solution.

46. *See infra* Part III.C.

health care facilities.⁴⁷ To build a new facility in states where CON laws exist, a potential provider must go through a stringent application process with the appropriate state administrative agency.⁴⁸ For example, the provider may be required to show the location, nature, purpose, and ownership interests of the potential facility.⁴⁹ Most importantly, and perhaps most controversially, CON laws require that the potential provider show a specific need for the health care service in the community in which the facility would be located.⁵⁰ The agency will not grant the applicant the necessary certification or license if it concludes that the new facility would supply the community with an excess of health care services.⁵¹

The recent interest in introducing specialty hospitals in the thirty-six states where CON laws are in force has spawned widespread litigation and has called into question CON law legitimacy.⁵² Further, to some extent, the continued existence of CON laws nullifies Congress's recent approval of specialty hospital proliferation.⁵³ To understand

47. See Patric Hooper & Jordan B. Keville, *Collateral Damages in the Government's War on Health Care Fraud*, 18 HEALTH LAW 28, 34 n.11 (2006).

48. IMPROVING HEALTH CARE, *supra* note 2, ch. 8, at 1 (noting that the CON application process can be time-consuming and expensive); see Hooper & Keville, *supra* note 47. Three-fourths of the one hundred and thirty specialty hospitals are located in seven of the states that do not have CON laws in place, including California, Kansas, Louisiana, Ohio, Oklahoma, South Dakota, and Texas. Armstrong, *supra* note 17. Kansas, Louisiana, Oklahoma, and Texas have more specialty hospitals than all other states combined. *Id.* By comparison, there are approximately five thousand community hospitals in the United States. *The Hospital Wars*, *supra* note 2.

49. In this respect, this requirement is not unlike any other building permit or license application.

50. See Lauretta Higgins Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261, 262 (2001).

51. See *id.*

52. See, e.g., Havighurst, *supra* note 9 (arguing that CON laws do not serve their original purpose). For a list of the states with CON laws in place, see THOMAS R. PIPER, AM. HEALTH PLANNING ASSOC., FEDERAL TRADE COMMISSION/DEPARTMENT OF JUSTICE HEARINGS ON HEALTH CARE COMPETITION QUALITY AND CONSUMER PROTECTION: MARKET ENTRY 8 (2003), <http://www.ftc.gov/ogc/healthcarehearings/docs/030610piper.pdf>; ADRIANE CROUSE, REPORT OF THE SENATE INTERIM COMMITTEE ON CERTIFICATE OF NEED 5 (Mo. 2007), available at http://www.senate.mo.gov/07info/comm/interim/need/CON_Report.pdf (noting that thirty-six states currently have CON laws in place). Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, and Wyoming do not have CON requirements. PIPER, *supra*. CON law disputes, regardless of whether they involve specialty hospitals, have been litigated throughout the last three decades. See, e.g., *Ashtabula County Med. Ctr. v. Thompson*, 352 F.3d 1090 (6th Cir. 2003); *Md. Gen. Hosp., Inc. v. Thompson*, 308 F.3d 340 (4th Cir. 2002); *Paragon Health Network, Inc. v. Thompson*, 251 F.3d 1141 (7th Cir. 2001); *Shawnee Mission Med. Ctr. v. Kan. Dep't Health & Env't*, 685 P.2d 880 (Kan. 1984); *In re Certificate of Need Application by Cmty. Psychiatric Ctrs., Inc.*, 676 P.2d 107 (Kan. 1984); *Olathe Cmty. Hosp. v. Kan. Corp. Comm'n*, 652 P.2d 726 (Kan. 1982); *Kan. Dep't of Health & Env't v. Banks*, 630 P.2d 1131 (Kan. 1981); *In re Certificate of Need Application by Bethany Med. Ctr. for a Six Megavoltage Linear Accelerator*, 630 P.2d 1136 (Kan. 1981); *State ex rel. Metzler v. Sisters of Charity of Leavenworth Health Servs. Corp.*, 605 P.2d 100 (Kan. 1980); *Pratt v. Bd. of Comm'rs*, 597 P.2d 664 (Kan. 1979); *Suburban Med. Ctr. v. Olathe Cmty. Hosp.*, 597 P.2d 654 (Kan. 1979); *Extendicare v. State Coordinating Council for Health Planning*, 532 P.2d 1119 (Kan. 1975).

53. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22 ("Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single[]specialty hospitals—a new form of competition that may benefit consumers—have opened in states that do not have CON programs."); Armstrong *supra*

these criticisms, the history of CON legislation must be examined.

CON laws were a product of the regulation-rampant 1970s.⁵⁴ Because of the rising cost and profitability of health care, due significantly to the cost-based “fee-for-service” method of reimbursing providers for services, regulators feared over-investment in, and excessive supply of, health care facilities.⁵⁵ Proponents of CON regulation believed that an overabundance of health service supply would create more demand due to an increase in unnecessary physician-prescribed services.⁵⁶ As a result, Congress passed the National Health Planning and Resource Development Act of 1974 (NHPDA).⁵⁷ In exchange for federal funding, the NHPDA required participant states to establish CON programs.⁵⁸ Specifically, the NHPDA provided that each state agency shall

administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State.⁵⁹

After the adoption of the NHPDA, forty-nine states agreed to participate in the program.⁶⁰ Although the NHPDA was amended in 1979 and completely repealed in 1986 due to the elimination of the cost-based method of reimbursement, thirty-six states still have CON laws in place.⁶¹ The continued operation of state CON health agencies long after the death of the federal program begs for an answer to the question of why they ought to still exist. As will be shown below, like an infectious parasite, the state laws should have died in 1986 along with their federal host. Yet CON laws still serve as the primary barrier to entry for specialty hospitals, denying the benefit of competition to states where the laws are effective.⁶²

note 17.

54. Havighurst, *supra* note 9, at 373-74.

55. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 8 (noting that the fee-for-service program reimbursed providers for their incurred costs). See *infra* Part III.B.1 for an explanation of why this cost-based reimbursement system failed.

56. Wolfson, *supra* note 50, at 264. The idea of supply created demand was introduced by Sais, an eighteenth century French theorist. Ginsburg & Grossman, *supra* note 25, at 378. This idea seems very counterintuitive given the normal economic tenet that demand facilitated by information creates supply. *Id.* See *infra* Parts IV.A, D for an explanation of why consumer information is essential for any health care market. Studies have shown that physician referral increases when economic interests are involved. Ginsburg & Grossman, *supra* note 25, at 378.

57. Pub. L. No. 93-641 §§ 1-3, 88 Stat. 2225-27 (repealed 1986).

58. *Id.* § 1521(b)(3).

59. *Id.* § 1523(a)(4)(B).

60. IMPROVING HEALTH CARE, *supra* note 2, ch. 8, at 1. Louisiana was the only state that did not adopt a CON program. *Id.*

61. Crouse, *supra* note 52, at 5; Havighurst, *supra* note 9. See *supra* note 52 for a listing of the states that do not have CON laws in place.

62. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22 (“[T]here is con-

The major purpose of the NHPDA was to discourage supply-created demand that would take advantage of the cost-based fee-for-service reimbursement system.⁶³ However, Congress squarely addressed this problem in 1982 when it implemented the Prospective Payment System (PPS), rendering CON legislation nothing more than a state-sponsored monopoly mechanism.⁶⁴ Of course, as the primary cause of the failure of specialty hospitals to lower health care costs, and as a significant factor underlying inflated costs, the PPS turned out to be quite problematic in itself.

B. The Prospective Payment System

Broadly defined, the PPS is the system through which purchasers prospectively set health service rates that determine reimbursements for providers.⁶⁵ In the United States, there are two primary purchasers: (1) the federal government through Medicare; and (2) private insurance companies.⁶⁶ Although private insurance companies often implement a combination of prospective payment and managed care schemes, the federal government has been the driving force behind the innovation and use of prospective payment. Moreover, the government exercises tremendous influence in the health care market given its dual role as both regulator and purchaser.⁶⁷ Thus, the PPS will be evaluated below primarily in the context of Medicare's purchase of health care services. However, the generic term purchaser may refer to the uninsured and private insurance companies as well.

1. The Genesis, Intended Function, and Rationale of the PPS

Congress introduced the PPS in the early 1980s to battle an explosion of health care costs associated with the federal government's cost-

siderable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry.”).

63. *Id.*, *supra* note 2, ch. 8, at 2 (“[T]he passage of the Health Planning Act reflected a congressional belief that market failure plagued the health care market, resulting in ‘excess supply and needless duplication of some services.’”) (quoting JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES AND PRACTICE § 16:1, at 16-4 (2003)); Havighurst, *supra* note 9, at 373.

64. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22 (“CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits.”); Havighurst, *supra* note 9, at 373.

65. See Hooper & Keville, *supra* note 47, at 34 n.12.

66. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 2. See *supra* note 4 for a breakdown of the percentages of services purchased by other purchasers.

67. See *Id.*, *supra* note 2, Executive Summary, at 5 (“The government’s actions as both purchaser and regulator have profound effects on the rest of the health care financing and delivery markets as well.”); Ginsburg & Grossman, *supra* note 25, at 378 (noting that Medicare has been the innovator of the PPS). Because private payors often model their own payment schemes after Medicare’s PPS, it is also logical to discuss prospective payment in the context of the federal program. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 10 (“In some instances, private payors have copied the payment strategies of the Medicare program or have used Medicare payments as a reference price for negotiation with providers.”).

based fee-for-service reimbursement program.⁶⁸ Under the cost-based system, Medicare reimbursed providers for the purported cost of health care services rendered.⁶⁹ Quickly taking advantage of the cost-based system, many providers grossly inflated prices and began to provide unnecessary services in an effort to increase reimbursements.⁷⁰ By 1983, the price tag for health care in the United States rose to a staggering thirty-seven billion dollars.⁷¹ Desperately in need of a solution, policy-makers crafted the PPS to curb the dramatic inflation.⁷²

Through the PPS, Congress intended for the Center for Medicare and Medicaid Services (CMS) to negotiate and pre-determine the reimbursement value of health services for specific illnesses based on data indicating the average cost of services for all such illnesses within a grouping of hospitals.⁷³ Under this approach, each illness is grouped and labeled according to the primary body system affected, the diagnosis, the treatment, and the severity of the illness.⁷⁴ Other factors such as the patient's gender, morbidity, and age are also considered in determining the value of the reimbursement.⁷⁵ These illness groupings are known as Diagnoses Related Groups (DRGs), each having its own corresponding remuneration value.⁷⁶ When a patient is discharged and the DRG is determined, the hospital will be reimbursed for no more than

68. Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 707 (2006).

69. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 8; Strothkamp, *supra* note 20, at 675. These costs were limited to "allowable costs." *Id.* Under the program, Medicare made periodic payments to hospitals for their purported costs throughout the year, then reconciled at the end of the year to reflect the proper amount of allowable costs. *Id.* Although there was a technical cap on reimbursable costs, the system became uncontrollable and costs skyrocketed. See *id.*

70. Diana Vance-Bryan, *Medicare's Prospective Payment System: Can Quality Care Survive?*, 69 IOWA L. REV. 1417, 1418 (1984). This practice encouraged a "spare-no-expense medicine" philosophy among providers. *Id.*

71. Strothkamp, *supra* note 20, at 675. Indeed, the cost of health care skyrocketed during the 1970s and 1980s, accounting for the largest portion of the GDP. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 2. Just four years prior to the 1983 count, President Jimmy Carter declared in his State of the Union Address, "[w]e must act now to protect all Americans from health care costs that are rising \$1 million per hour, 24 hours a day, doubling every 5 years. We must take control of the largest contributor to that inflation: skyrocketing hospital costs." Benjamin P. Falit, *The Bush Administration's Health Care Proposal: The Proper Establishment of a Consumer-Driven Health Care Regime*, 34 J.L. MED. & ETHICS 632 (2006).

72. See 42 U.S.C. § 1395ww (2000).

[I]n determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii) of *the average of such costs for all hospitals in the same grouping as such hospital* for comparable time periods. *Id.* § 1395ww(a)(1)(A)(i) (emphasis added). See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 9.

73. See 42 U.S.C. § 1395ww(a)(1)(A)(i) (2000); IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 9; Ginsburg & Grossman, *supra* note 25, at 379.

74. See Strothkamp, *supra* note 20, at 675-76.

75. *Id.*

76. *Id.*

the pre-set value of the DRG.⁷⁷ As a result, if the cost of an admission is less than the corresponding reimbursement value, the provider will retain the remainder of the payment as profit. Conversely, if the cost of an admission exceeds the reimbursement value, the provider will have to absorb the additional expense as a loss.

To offset discrepancies in compensation and adjust for changes in costs to the provider, the DRGs are supposed to be reassessed at regular intervals.⁷⁸ Similarly, Congress intended CMS to create new DRGs periodically to track changes in demographics, new illnesses, and novel treatment methods.⁷⁹ The goal of this adjustment process is to ensure that providers are accurately reimbursed for services.⁸⁰

The rationale behind the DRG/PPS system is that by setting reimbursements for services based upon the average costs of those services, providers will not be empowered to determine prices on their own.⁸¹ The architects of the PPS further reasoned that setting reimbursements prospectively would incentivize efficiency because providers would strive to keep costs at or below the pre-determined rate to ensure that they do not experience a loss.⁸² The PPS was also designed to encourage providers to be conservative in ordering services, as all services are not reimbursable for all illnesses.⁸³ Overall, the PPS allows CMS to have a great degree of control in dictating which services are necessary for each illness.⁸⁴ However, as is often the case with well-intended federal programs, the PPS has had many undesirable consequences.

77. Charisse Logarta, *Provider Response to Cost Containment: Fraud & Abuse Issues*, 15 ANNUALS HEALTH L. 373, 375 (2006). The architects of the PPS recognized, however, that there are extreme cases in each DRG where complications would drive the cost of the treatment far beyond the pre-determined reimbursement. See 42 U.S.C. § 1395ww(d)(5)(A)(i) (2000):

Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

Id.; see also IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 9 (“[A]djustments are made for extraordinarily high-cost cases (‘outlier payments’)”).

78. Strothkamp, *supra* note 20, at 677. The process of reassessment is known as “clinical coherence.” *Id.*

79. See OFFICE OF INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OEI-09-00-00200, MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED 3 (2001), available at <http://www.oig.hhs.gov/oei/reports/oei-09-00-00200.pdf> (“[U]pdating payment rates would account for new medical technology, inflation, and other factors that affect the cost of providing care.”).

80. See *id.* (noting that one of Congress’s objectives in creating the PPS is “[t]o ensure fair compensation for services rendered”).

81. See generally 42 U.S.C. § 1395ww (2000) (noting that the government, not providers, shall determine payment).

82. E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges From Tort and Contract*, 59 VAND. L. REV. 1207, 1212 (2006).

83. See *id.*

84. See generally *id.* (noting that purchasers determine the reimbursable services and the remuneration value regardless of the services rendered or the length of the patient’s stay).

2. The Actual Effect and Malfunction of the PPS

Over the last two and a half decades, the goal of fairly compensating providers for services under the PPS has not been realized.⁸⁵ Reimbursement rates often do not properly reflect the costs of services for providers, leading to overcompensation in some cases and undercompensation in others.⁸⁶ A handful of DRGs have become known as more profitable because of their inaccurately high repayment rates.⁸⁷ Similarly, varying severity levels within DRGs are now associated with lower cost-to-reimbursement ratios.⁸⁸ This inaccuracy has led to intentional misclassifications of illnesses and exaggerations of severity within DRGs, allowing the provider to render more services or receive higher reimbursements for services.⁸⁹

The specialty hospital debate vividly illustrates the malfunction of the PPS. Specialty hospitals, which generally operate much more efficiently given lower operating costs, are currently reimbursed at the same level as general hospitals.⁹⁰ Consequently, the services that were already characterized as more profitable because of skewed DRG rates have been the most attractive to specialty hospitals and their entrepreneurial physician-investors.⁹¹ The combination of misaligned reim-

85. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 16-19 (showing that the PPS has created price distortions, allowing certain services to be more profitable than others while providers are not fairly compensated for other services).

86. Ginsburg & Grossman, *supra* note 25, at 376 (“Unintended relative overpayment of some services and the relative underpayment of other services, in combination with other market factors, is driving increased use of expensive care, which in turn could become an important driver of health care cost trends.”).

87. *Id.* Cardiovascular procedures, neurosurgery, orthopedics and high-end imaging are among the most profitable services under the current PPS. *Id.* at 377. As an example, coronary artery bypass graft (CABG), DRG number 107, is seventeen percent more profitable than heart attack failure and shock, DRG number 127. *Id.* at 379. This may be the reason that an August 2006 MedPAC report estimated that CABG procedures increase by nearly nine percent in markets where specialty heart hospitals are introduced. See MedPAC 2006, *supra* note 38, at vii.

88. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 16-19. Generally, lower severity levels entail higher profits because costs can be kept low. See *id.* at 15.

89. See Ginsburg & Grossman, *supra* note 25, at 376 (noting that the inaccurate payment rates are “driving increased use of expensive care”). Of course, the risk of intentional misclassification is always present, as it was a problem under the cost-based system. See *supra* note 70 and accompanying text. Even under private payment methods that are aimed at reimbursing providers at cost, bill charges do not reflect unit cost. Ginsburg & Grossman, *supra* note 25.

90. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 15 (“[P]hysician-investors send healthier, lower risk patients to their SSH and sicker patients to a general hospital to enable the SSH to produce service less expensively yet still be reimbursed at the same rates as the general hospital.”). However, CMS will begin paying hospitals more for complex cases. *The Hospital Wars*, *supra* note 2.

91. Strothkamp, *supra* note 20, at 679 (“[A]ll six of the surgical DRGs, which are more likely to be treated in physician-owned heart hospitals, are more profitable than the national average for all DRGs.”) (quoting an October 2004 MedPAC meeting). In many cases, reduced physician profit margins from services encourage physicians to invest in specialty hospitals. Ginsburg & Grossman, *supra* note 25. However, hospitals, after experiencing profit reduction resulting from managed care contracts and being pressed by Medicare in the 1990s, have also increased initiatives to expand profitable operations and provide new equipment. *Id.* This phenomenon is leading to what some are calling an “arms race” among providers to invest in high-quality equipment to attract patients. See *The Hospital Wars*, *supra* note 2 (reporting that the competitive standard set by specialty hospitals “is fueling a de facto medical arms race”) (citing Paul Ginsburg); see also Ginsburg & Grossman,

bursement figures and a failure to account for cost variations among providers has led to high profit margins for specialty hospitals.⁹² Although high profits *per se* should not be condemned, under the current PPS they often result from inadequate remuneration for other services.⁹³ Further, high profits raise questions in light of steep health care prices and are indicative of a flawed reimbursement system.⁹⁴

The obvious outcome of employing such a bloated health care payment system is that the costs are passed on to the American public, either in the form of taxes to fund Medicare or Medicaid's purchase of overpriced services, or as inflated health insurance premiums in exchange for private insurance companies' purchase of overpriced services.⁹⁵ In short, although Congress designed the PPS in response to a drastic need to address problems associated with gross price inflation in the early 1980s, flaws in the system have led to a host of undesirable consequences.⁹⁶ Without substantial legal reform to the PPS, these problems will only increase.

A major cause of the PPS's failures is CMS's inability to properly track all of the factors that dictate cost in the health care market, including the variables previously mentioned: (1) supply and demand shifts in the health care market; (2) changes in patient demographics; and (3) newly discovered illnesses and treatments requiring additional DRGs.⁹⁷ The ineffectiveness of the current PPS cost-tracking system renders the data underlying reimbursement rates outdated and inaccurate, leading to the previously-mentioned disparities in reimbursements.⁹⁸ In most cases, reimbursement rates are based upon data from the 1980s and 1990s; it follows that the current rates cannot properly account for many of the technological and procedural efficiencies that have been achieved in medicine in the last two decades.⁹⁹ Although technology pervades

supra note 25, at 377-78. Commentators argue that this has been a positive pressure, though, because it has led to an increase in the quality of care. See *infra* Part IV.B.

92. See Strothkamp, *supra* note 20, at 686-87 (noting that there are differences in relative profitability between DRGs, and that "[u]nder the current payment policies, the physician-owned specialty hospitals all have a favorable selection"). As an example, a South Dakota specialty hospital owned by thirty-five physician investors earned 103 million dollars in profit between 2000 to 2004. Armstrong, *supra* note 17, at B10.

93. See Ginsburg & Grossman, *supra* note 25.

94. According to research, hospitals are currently being reimbursed at five percent below cost under Medicare's PPS. *The Hospital Wars*, *supra* note 2. However, hospitals also charge private payors approximately twenty-two percent more than the cost of the services. *Id.*

95. See generally Ginsburg & Grossman, *supra* note 25, at 376 (describing how inadvertent payment incentives are driving up the cost of care).

96. See Strothkamp, *supra* note 20, at 677-78.

97. See *supra* notes 78-80 and accompanying text for an explanation of why it is necessary to track these variables.

98. Ginsburg & Grossman, *supra* note 25, at 378-79. One area in which Medicare has succeeded in tracking cost data and capping reimbursements is physician-administered drugs as required by The Medicare Prescription Drug, Improvement, and Modernization Act of 2003. *Id.* at 380 n.14 (referring to 42 U.S.C. § 1395nn (2005)).

99. See *id.* at 379. Given that private payors base their own prospective payment per diem

the American operating room, it is suspiciously absent from the patient records and cost-accounting departments.

C. Health Information

The health care system, despite being the largest single industry in the United States, is heavily reliant on outdated methods of transferring information and accounting for costs.¹⁰⁰ Because most vital health data are recorded on paper, the movement of health information is slow.¹⁰¹ Further, many providers do not have adequate health care cost-accounting technology to accurately set charges for purchases.¹⁰² Providers have taken steps to electronically store medical records and computerize physician orders, but such efforts have had little effect on the cost of care.¹⁰³

This information lag burdens the health care system by increasing the price of care while decreasing the quality of care.¹⁰⁴ The former problem occurs because lack of efficiency in transferring vital information translates into greater costs.¹⁰⁵ Like many other production costs in the health care industry, this inefficiency is passed on to purchasers. The latter concern arises because quality care is often compromised in the absence of patient information.¹⁰⁶ For example, medical error due to lack of patient history data is often rooted in information delays.¹⁰⁷ With 44,000 to 98,000 deaths per year attributable to medical error in the United States, such delays have tragic and costly ends.¹⁰⁸

These concerns have led to a national movement to introduce a

payment rates on charge data, they also suffer the effects of outdated information. *Id.* at 380. One of the substantial efficiency gains in medicine has been technological advances. Thus, as technology is enhanced to increase efficiency, providers will still be reimbursed at a higher rate that does not reflect the efficiency gain. *Id.* at 381. For example, “percutaneous transluminal coronary angioplasty stent without acute myocardial infarction,” DRG number 517, is sixteen percent more profitable than other DRGs. *Id.* This disproportionate profitability is likely the result of advances in stent technology that have occurred since the DRG number 517 reimbursement rate was last determined. *See id.*

100. *See* IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 1, 6 (“Health care does not employ information technology extensively or effectively. Prescriptions and physician orders are frequently hand-written. Records are often maintained in hard copy and scattered among multiple locations.”).

101. *See id.*

102. Ginsburg & Grossman, *supra* note 25, at 380-81. Indeed, most providers lack the incentive to implement such cost-accounting systems because their revenues have no bearing on their own charge structure determinations. *Id.* Rather, their charges are determined by decades-old cost data. *See id.* at 379, 380-81.

103. *Id.* at 380.

104. Melissa Steward, *Electronic Medical Records: Privacy, Confidentiality, Liability*, 26 J. LEGAL MED. 491, 491 (2005).

105. Sage & Kalyan, *supra* note 2, at 539.

106. *See id.*

107. *See* Crystal Spivey, *Breathing New Life Into HIPAA's UHID – Is the FDA's Green Light to the Verichip™ the Prince Charming Sleeping Beauty Has Been Waiting For?*, 9 DEPAUL J. HEALTH CARE L. 1317, 1323-24 (2006).

108. *Id.* at 1324 n.33.

universal Health Information Technology (HIT) system.¹⁰⁹ Proponents of the HIT system argue that it would have to be implemented on a national level so that providers, purchasers, and patients could share information over a common network.¹¹⁰ After patient information is put into the network, providers and purchasers would instantly have access to the data.¹¹¹ Similarly, patients would have access to their own health information and data indicating the price and quality of provider services.¹¹² Providers would benefit from accessing data quickly on a network because they would have immediate knowledge of a patient's medical history.¹¹³ Patients would also benefit from better care and enhanced access to information about provider quality.¹¹⁴ Commentators have estimated that, due to efficiency alone, HIT would allow for a health care cost savings of ten percent, or 160 billion dollars annually.¹¹⁵

In addition to costing the health care industry billions, the lack of a national HIT system has contributed to the failure of specialty hospitals to lower health care costs because of its negative effect on the PPS.¹¹⁶ As noted previously, one of the major causes of the PPS's malfunction is its inability to keep track of current cost data, leading to inaccurate reimbursements for providers.¹¹⁷ A fully integrated universal HIT system would provide the PPS with the data processing power necessary to keep DRG cost information current and accurate.¹¹⁸ Given that the current skewed reimbursement system encourages all providers to cherry pick the patients who are the most profitable, enhanced accuracy would eliminate the practice of patient selection.¹¹⁹

109. See *infra* Part IV.A for President George W. Bush's HIT plan.

110. See Spivey, *supra* note 107, at 1324 (noting that President Bush's HIT plan calls for a "national standard").

111. Press Release, Health and Human Services, Thompson Launches "Decade of Health Information Technology" (July 21, 2004), <http://www.hhs.gov/news/press/2004pres/20040721a.html> [hereinafter Thompson Press Release].

112. *Id.* ("[H]ealth information technology also offers much greater access and control of health records by consumers themselves."). Patient access to quality and price information is essential for patients to make informed health care decisions. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 3 ("Information is necessary for consumers to make decisions regarding their care, and determine how well the health care system is meeting their needs."). See *infra* Parts IV.A and D for a further delineation of the importance of patient information access.

113. See Spivey, *supra* note 107, at 1324. Of course, such access would have to be in compliance with HIPAA restrictions.

114. See Thompson Press Release, *supra* note 111.

115. See *id.* (noting that HIT "has the potential to produce savings of 10 percent of our total annual spending on health care, even as it improves care for patients and provides new support for health care professionals"); see also *supra* note 2 and accompanying text. Although the health care industry may realize a ten-percent savings due to HIT-induced efficiency, the savings will certainly be greater if HIT allows for the PPS to function properly. See *infra* Part IV.A for an explanation of why a HIT-enhanced PPS will provide a greater cost savings.

116. *The Hospital Wars*, *supra* note 2 (showing that the specialty hospital phenomenon has failed to improve the health care market).

117. Strothkamp, *supra* note 20, at 686-87; see also *supra* notes 91-94 and accompanying text.

118. See generally Ginsburg & Grossman, *supra* note 25, at 380 (noting that HIT makes it easier for hospitals to track cost data).

119. See Strothkamp, *supra* note 20, at 686-87 (indicating that there are differences in relative

All three problems analyzed above explain why specialty hospitals are not able to function as normal competition and lower health care prices. The lack of HIT has left the PPS, which is already unable to properly track and implement cost data, even more inefficient.¹²⁰ Skewed DRG reimbursements allow all of the efficiency-induced cost savings that specialty hospitals incur to be realized only by specialty hospitals, not purchasers.¹²¹ Further, assuming that the PPS was not flawed, CON laws would continue to prevent specialty hospitals from opening their doors in many states.¹²² By crafting legal solutions for each of these problems, specialty hospitals will be rendered an effective weapon in lowering prices through competition. It is proposed that the legal reform solutions posited below will achieve this goal.

IV. REFORM SOLUTIONS

Three reform solutions are analyzed in this section. All three will address the major concerns associated with specialty hospitals noted above. The first solution is already set to be incorporated, the second is currently being considered by the federal government and private purchasers, and the third is merely a proposal.

A. President Bush's HIT Plan

One outspoken proponent of HIT is President George W. Bush.¹²³ According to an April 2004 GOP news release:

[H]igh costs, uncertain value, medical errors, variable quality, administrative inefficiencies, and poor coordination [] are closely connected to our failure to use health information technology as an integral part of medical care. The innovation that has made our medical care the world's best has not been applied to our health information systems.¹²⁴

The news release also highlights President Bush's ambitious plan of implementing HIT within a decade:

Within the next 10 years, electronic health records will ensure that complete health care information is available for most Americans at the time and place of care, no matter where it originates. Participation by patients will be voluntary.

profitability between DRGs).

120. See generally Ginsburg & Grossman, *supra* note 25 (highlighting the current PPS's cost distortions and inadvertent payment incentives).

121. See *supra* Part III.B.2.

122. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22 ("Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single[]specialty hospitals—a new form of competition that may benefit consumers—have opened in states that do not have CON programs.").

123. See Transforming Health Care: The President's Health Information Technology Plan, REPUBLICAN NATIONAL COMMITTEE, Apr. 26, 2004, <http://www.gop.com/News/Read.aspx?ID=4140> [hereinafter President's Plan].

124. *Id.*

These electronic health records will be designed to share information privately and securely among and between health care providers when authorized by the patient.

President Bush believes that innovations in electronic health records and the secure exchange of medical information will help transform health care in America—improving health care quality, preventing medical errors, reducing health care costs, improving administrative efficiencies, reducing paperwork, and increasing access to affordable health care.¹²⁵

This HIT plan will reduce health care costs across the board by increasing administrative efficiency and minimizing costly medical errors.¹²⁶ Given that the proper function of the PPS requires a tremendous amount of data tracking and analyzing, the HIT plan will also enhance the efficiency and utility of the federal health care reimbursement system.¹²⁷ With HIT rendering the PPS more effective and accurate, providers will not have an incentive to divert any particular class of patients from competing providers because all patients will be equally profitable.¹²⁸

Although HIT will help transform the PPS into what its creators intended it to be, a description of the ideal function of the PPS exposes its inherent weakness: if it operates free of error, it does not allow for providers to receive profit for their services.¹²⁹ Generally, providers only profit under the current system when they receive distorted, excessive reimbursements.¹³⁰ HIT will lower the prevalence of these misaligned rates through accurate DRG classification facilitated by the immediate transfer of health care cost information;¹³¹ profit, along with loss, will be a rare occurrence because the system would reimburse providers more accurately at a rate closer to cost.

Although some theorists may argue that our health care system should be strictly not-for-profit, those who believe that profit drives quality and performance in any industry will be left unsatisfied with the HIT-enhanced PPS.¹³² Regardless of whether medicine should be a profitable venture, it is proposed that adjusting the PPS so that it encourages lower costs through profit incentives will dramatically decrease

125. *Id.*

126. Spivey, *supra* note 107, at 1324.

127. See OFFICE OF INSPECTOR GENERAL, *supra* note 79 (“[U]pdating payment rates would account for new medical technology, inflation, and other factors that affect the cost of providing care.”).

128. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 19 (“[U]nder Medicare’s administered pricing system, some services are much more profitable than others.”); Strothkamp, *supra* note 20, at 686-87.

129. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 9 (noting that under the PPS, providers are merely reimbursed for no more than a pre-determined cost).

130. See *generally* Strothkamp, *supra* note 20, at 686-87 (indicating the skewed DRG rates and the effect on relative profitability).

131. See *generally* President’s Plan, *supra* note 123 (noting the efficiency advantages of a HIT system).

132. See, e.g., *Paying*, *supra* note 4 (arguing that a reward-driven health care system will encourage higher quality and lower costs).

the price of health care in the United States. Following the lead of private insurance companies, the federal government is experimenting with applying such a profit-based approach to the PPS.¹³³ However, before any pilot initiatives began, theorists had already conceived the mechanics of this profit scheme, labeling it a Pay for Performance (P4P) methodology.¹³⁴

B. Pay for Performance

P4P theory is straightforward: pay providers more for keeping costs low while maintaining or increasing quality.¹³⁵ Under P4P schemes, providers are given bonuses for using cost-effective and quality-enhancing methods.¹³⁶ Cost-effective methods and qualitative results are pre-determined by the purchaser and provider based upon current medical practices and quality standards.¹³⁷ As an example, studies have shown that taking the basic precaution of providing heart attack patients with an aspirin upon arriving in the emergency room is an effective tool in cardiac care.¹³⁸ Under a P4P plan, a purchaser may give a provider a bonus for taking this simple step, or the provider may receive a higher reimbursement if the aspirin leads to a faster recovery without costly complications.¹³⁹

P4P reimbursement rates would be effective on a sliding scale. The more that providers adhere to cost and quality standards, or the more that providers produce high-quality and low-cost results, the greater the above-cost reimbursement, or profit, will be. Conversely, such a P4P-

133. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 12 (“Public and private payors are also experimenting with payment for performance (P4P) initiatives.”); Sage & Kalyan, *supra* note 2, at 534 (making reference to the Medical Value Purchasing Act of 2005); *The Hospital Wars*, *supra* note 2; see also Donald M. Berwick et al., *Paying for Performance: Medicare Should Lead*, 22 HEALTH AFF. 8 (2003), available at <http://content.healthaffairs.org/cgi/content/full/22/6/8> (encouraging Medicare’s development and experimentation with P4P programs).

134. See Berwick, *supra* note 133.

135. Sage & Kalyan, *supra* note 2.

136. See *id.*; *Paying*, *supra* note 4. Many health care professionals dislike the idea of being paid more for what they are already professionally obligated to do: provide the best care. *Id.* However, this criticism misses the point. P4P will reward providers not just for making better care decisions at the physician-patient level, but also for taking steps to administratively reduce error and enhance efficiency. Berwick, *supra* note 133 (“At issue is not the dedication of health professionals but the lack of systems—including information systems—that reduce error and reinforce best practices . . .”).

137. See Sage & Kalyan, *supra* note 2, at 534. There are currently over 100 AMA quality standards. *Paying*, *supra* note 4.

138. *Paying*, *supra* note 4. Under a P4P plan, health care professionals would have greater incentives to take such steps. In fact, Premier Inc., a hospital participating in a Medicare P4P pilot program, reported that its P4P initiative prevented 235 heart attack patients from dying. *Id.* One of the quality measures was administration of aspirin upon arrival. *Id.* In addition, as part of a voluntary quality-reporting program, the Federation of American Hospitals, the American Hospital Association, and the Association of American Medical Colleges are currently working with the CMS, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, and the Agency for Healthcare Research and Quality (AHRQ). Berwick, *supra* note 133.

139. See *Paying*, *supra* note 4.

based PPS plan would require that providers who deviate from cost and quality standards only receive at-cost or below-cost reimbursements. This system will encourage providers to meet standards while penalizing those who do not—much like a free market.¹⁴⁰ The reasoning underlying P4P is unbelievably intuitive, but it stands diametrically opposed to the rationale behind the current system.¹⁴¹ The PPS does not encourage low costs, but rather incentivizes low quality, inflated prices, and duplicious services.¹⁴² As one commentator notes, “the system is backward. It often inadvertently rewards poor performance. Doctors do more—tests, operations, follow-up care—they get paid more. There’s little penalty for failing”¹⁴³

Despite P4P theory’s apparent simplicity, implementation would be a substantial task.¹⁴⁴ Unlike the aspirin example, P4P application becomes increasingly complex when one considers the thousands of complicated medical standards and procedures employed in the health care industry.¹⁴⁵ As with our current PPS, given treatment complexities and standard of care variations, such a system would require measuring and assessing legions of variables.¹⁴⁶ Further, like the current PPS, it would be a tremendous task to create and maintain multi-level reimbursement scales correlated to cost and quality standards.¹⁴⁷

Although an across-the-board execution of a P4P program may be daunting, it will not be Herculean given the existing DRG framework. New groupings and categories may be necessary, but many illnesses, treatments, and other measurable variables are already categorized under the existing PPS.¹⁴⁸ Additionally, the universal HIT program will

140. See *infra* Part IV.D. for an explanation of why all of the reforms suggested in this section would make health care more market-like.

141. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 9 (“Hospitals receive this predetermined amount regardless of the actual cost of care”); Sage & Kalyan, *supra* note 2, at 533 (“In health care, caregivers traditionally have been paid the same amount regardless of likely or actual success.”). As one proponent, Medicare Chief Dr. Mark McClellan, succinctly notes, “[y]ou get what you pay for.” *Paying*, *supra* note 4.

142. See MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (June 2003), *available at* http://www.medpac.gov/publications/congressional_reports/June03_Entire_Report.pdf (noting that the PPS is “largely neutral or negative towards quality At times providers are paid even more when quality is worse, such as when complications occur as the result of error.”).

143. *Paying*, *supra* note 4; *The Hospital Wars*, *supra* note 2; see also IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 4.

144. Sage & Kalyan, *supra* note 2 (“[S]timulating quality-based competition by using pay for performance will require major infusions of both funding and regulation from the public sector.”).

145. Berwick, *supra* note 133 (“The complexity and sensitivity of measures, standards, and quality-reporting regimes often discourage providers from embracing voluntary quality initiatives and fuel resentment of the costly data-gathering burden that quality improvement may entail.”); Strothkamp, *supra* note 20, at 676 (noting that there are many variables that are involved in DRG classification).

146. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 3 (“Commentators and panelists note that treatment patterns vary significantly.”).

147. See *id.* at 13 (“The development of P4P programs will require better measurement of, and information about, health care quality.”); Berwick, *supra* note 133; Strothkamp, *supra* note 20, at 676.

148. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 21 (“A great deal of work already has been done on measuring quality. Quality measures exist for a considerable number

only enhance the processing power of the current framework, allowing new categorizations to be made and providing an environment conducive to a P4P-based PPS.¹⁴⁹

Implementation of President Bush's HIT program and reformation of the PPS to reflect a P4P reimbursement scheme would be major steps toward allowing specialty hospitals to lower costs. However, even if the steps were taken, CON laws in a majority of states would still prevent specialty hospitals from serving as competition.¹⁵⁰ It follows that if the previously mentioned solutions are to be effective, CON laws must be abolished.

C. CON Law Abrogation

As noted above, commentators believe that CON laws do not serve their intended purpose of preventing truly unwarranted supply-created demand.¹⁵¹ Rather, they are merely monopolistic market structures that increase health care prices through their anticompetitive effects.¹⁵² These structures are still in place because of political backing by CON law proponents such as well-established general hospitals.¹⁵³ Thus, abrogation in states that have been complacent may be challenging. However, with the realization that specialty hospitals will be able to lower costs, there may be more pressure to repeal CON laws from advocates of competition and potential physician-investors.¹⁵⁴

The solutions discussed previously will have a two-fold positive effect on lowering the cost of health care: (1) they will render specialty

of conditions and treatments."); Strothkamp, *supra* note 20, at 676.

149. See Berwick, *supra* note 133 ("The uneven deployment of nonstandardized information technology in the health sector has frustrated the development of promising opportunities to gather comparative performance information efficiently and to promulgate sophisticated decision-support and error-prevention systems."); Spivey, *supra* note 107, at 1324; President's Plan, *supra* note 123 (describing how the health care market will benefit from HIT's enhanced efficiency).

150. CROUSE, *supra* note 52, at 5 (noting that thirty-six states currently have CON laws). See *supra* note 52 for a listing of the fourteen states that do not have CON Laws in place.

151. See *supra* note 52 and accompanying text.

152. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 22 ("CON programs can actually increase prices by fostering anticompetitive barriers to entry."); Havighurst, *supra* note 9.

153. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 15-16 ("Some commentators state that general hospitals have used certificate of need (CON) laws to restrict entry by SSHs."); *id.* at 14 (noting that hospital networks often seek "to forestall entry by new competitors, such as single-specialty hospitals"). One powerful political proponent of the ban on specialty hospitals is the American Hospital Association. Armstrong, *supra* note 17, at B10.

154. The FTC/DOJ are the most notable advocates of competition and are situated to ensure fair competition. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 29 ("The Agencies play an important role here as well, by making policy makers aware of the costs of impediments to competition, and by advocating for competitive market solutions."). As a timely illustration, legislators in Missouri, torn by the differing interests of their constituents, are currently embroiled in a debate concerning whether to abolish the state's CON laws. See generally CROUSE, *supra* note 52 (summarizing differing positions on Missouri CON law abrogation). The vast amount of conflicting expert testimony found in the January 2007 report of the Senate Interim Committee on Certificate of Need is representative of the national debate, and it is unclear which political pressure will prove to be the most convincing. See generally *id.*

hospitals more capable of lowering prices through competition; and (2) because they remedy significant causes of our broken health care system, they will directly decrease the system's cost.¹⁵⁵ Moreover, all three of the solutions also address one of the most substantial criticisms of the American health care industry: it does not function like a free market.¹⁵⁶

D. The Free Market Character of these Solutions

In a free market, assuming that consumers and producers have access to information, the competitive forces of supply and demand are the key factors that determine the price of goods and services.¹⁵⁷ If supply stays constant while demand increases, price will rise. Alternatively, if demand stays constant while supply increases, price will drop. However, the market does not operate freely in an information-limited industry where supply, demand, and price are restrained by private purchasers and the government.¹⁵⁸ Health care is one such industry, and the three problems associated with specialty hospitals inhibit all three market variables, while the solutions positively affect them.¹⁵⁹

CON laws inhibit supply fluctuations.¹⁶⁰ When a provider sufficiently meets the medical needs of the community it serves in a state where CON laws are in effect, presumably no additional service providers will be granted the right to open a facility in the community.¹⁶¹ Thus, CON laws function as supply ceilings that prevent new providers from offering higher-quality or lower-cost services.¹⁶² The solution of abrogating CON laws will undoubtedly lead to an increase in supply where the laws are currently in operation.¹⁶³ This increased supply by competitors like specialty hospitals will entail a loss of patients by general hospitals, but this loss is merely the product of competition, and it will drive general hospitals to provide better services to retain patients.¹⁶⁴ However, although CON law repeal will affect the quality of

155. See *supra* Parts III.A-C.

156. FURROW ET AL., *supra* note 3, at 500 ("The market for health care, however, does not meet many of these [free market] conditions.").

157. See *id.* at 499-500. See generally Ginsburg & Grossman, *supra* note 25, at 378-80 (comparing the difference between a free market and our current health care industry).

158. See FURROW ET AL., *supra* note 3, at 499-500.

159. See *id.* (noting that the health care market does not operate under normal market conditions); Ginsburg & Grossman, *supra* note 25, at 378-80.

160. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 5 ("Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition.").

161. See Wolfson, *supra* note 50, at 262.

162. See generally *id.* (showing how CON laws prevent new facilities from opening).

163. See Armstrong, *supra* note 17. Specialty hospitals are most prevalent in states where CON laws were abrogated. See *id.*

164. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 4 ("[T]he fact that competition creates winners and losers can inspire health care providers to do a better job for consumers."). See *supra* note 33 for an example of competitor hospitals experiencing losses due to the introduction of specialty hospitals.

services, it cannot lower the prices of services under the current PPS because they are pre-determined and misaligned.¹⁶⁵ Enter solution number two: a P4P-based PPS.

The current PPS inhibits price sensitivity.¹⁶⁶ The system furnishes no way to pass cost savings on to Medicare, it encourages inflated prices and unnecessary services, and its inaccurate data leads to skewed rates that benefit some providers while harming others.¹⁶⁷ Because providers are rewarded for operating efficiently by keeping costs low and quality high under a P4P structure, a P4P-based PPS will allow providers to act as they would in a free market.¹⁶⁸ By implementing a P4P reimbursement system, competitors such as specialty hospitals can lower prices through the effect of competition.¹⁶⁹ However, for supply to be positively affected by the abrogation of CON laws, and for price to be positively affected by a P4P system, it must be assumed that providers and purchasers possess the essential information about price and quality.¹⁷⁰ This information is the purchaser's basis for demand.¹⁷¹ After all, purchasers and providers cannot be sensitive to quality and price variations without knowledge of them.¹⁷² Solution three provides the basis for our information assumption.

The lack of HIT inhibits demand sensitivity. In an economic sense, demand is defined as the "willingness and ability to purchase a commodity."¹⁷³ Having knowledge of price and quality variables affects the ability and willingness to purchase health care services.¹⁷⁴ In the ab-

165. Quality enhancements due to competition are attributable to "non-price competition." See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 4. As noted *supra* Part I, higher quality care and lower prices can be achieved through the suggested solutions.

166. Ginsburg & Grossman, *supra* note 25, at 378 ("[T]hird-party payment [has] removed much sensitivity to price . . .").

167. See *supra* Part III.B; IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 5 ("Price regulation, even if indirect, can distort provider responses to consumer demand and restrict consumer access to health care services. Regulatory rules also can reduce the rewards from innovation and sometimes create perverse incentives, rewarding inefficient conduct and poor results."); Ginsburg & Grossman, *supra* note 25, at 376.

168. See *Paying*, *supra* note 4 (noting that providers are given incentives to adhere to P4P standards).

169. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 28-29 (noting that competition lowers health care costs).

170. See *id.* at 18.

171. *Id.* ("For such strategies to work, however, consumers will need reliable and understandable information about the prices and quality of the services among which they must choose.")

172. See *id.* at 4 ("Competition cannot provide its full benefits to consumers without good information and properly aligned incentives.")

173. Definition of Demand, Merriam-Webster Online Dictionary, <http://m-w.com/dictionary/demand> (last visited Apr. 6, 2007).

174. IMPROVING HEALTH CARE, *supra* note 2, ch. 1, at 17 ("Information regarding quality allows consumers to make their own determinations of how best to balance those attributes that are important to them, obtain value for their money, and drive improvements throughout the system."). Private initiatives to allow consumers greater access to health care quality information have already begun. IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 18. For example, the Health Employer Data and Information Set (HEDIS) provides more than fifty quality measures for consumers and health plans. *Id.* HEDIS measures the quality of services ranging from comprehensive diabetes care to ambulatory care. See Commercial HEDIS Means, Percentiles, and Ratios,

sence of HIT, purchasers have less information about providers, which negatively affects their ability to make demand decisions.¹⁷⁵ HIT will facilitate access to market data for purchasers, allowing them to accurately gauge price and quality variables and, in turn, affect their ultimate demand for services.¹⁷⁶

Although these three changes will add more market features to our health care system, they will never transform the system into a purely free market. The idea of perfect information or perfect competition is only theoretical in complex markets, as it is impossible to account for all measures of quality and track all prices.¹⁷⁷ Similarly, given the lack of perfect information, supply and price will never be completely sensitive to demand.¹⁷⁸ Nonetheless, because of their market-like character, the three solutions proposed in this note will bring our health care system closer to the free-market idea, or at least reap the free-market advantage of lower costs through competition.¹⁷⁹ In considering these solutions, legislators should heed the call of the Department of Justice and Federal Trade Commission in its 2004 Improving Health Care report: “[t]he fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty—even when complex products and services such as health care

<http://www.ncqa.org/Programs/HEDIS/Audit/2004MPR/Commercial.htm> (last visited Apr. 1, 2007). Similarly, the Agency for Healthcare Research and Quality (AHRQ) has also established a compilation of treatment standards. See Berwick, *supra* note 133.

175. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 5 (“A lack of good information also hampers consumers’ ability to evaluate the quality of the health care they receive.”). Although patients, as the ultimate consumer of health care services, should have access to price and quality information, insured patients generally do not make final purchasing decisions. Ginsburg & Grossman, *supra* note 25, at 378. This is why insurance, as a third-party payment method, distorts consumer incentives to make cost-efficient health care decisions. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 5. Pricing information is, however, quite important for the uninsured, which account for approximately fifteen percent of the population. See *id.* at 10. Similarly, pricing information is also important for insureds who take part in high-deductible health plans. *Id.* at 18. For the purposes of the Internal Revenue Code, a “qualified high deductible health plan” is a plan in which “the enrollee is exposed to no less than \$2,100 of out-of-pocket expenses per year, and no more than \$10,500 per year.” See Falit, *supra* note 71, at 633-34 (paraphrasing Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003)) (internal quotations omitted). The purpose of such plans is to give consumers a direct interest in making efficient pricing decisions for medical services that fall under the amount of the plan deductible. See Morreim, *supra* note 82, at 1213. High deductible plans are becoming very popular among private purchasers, as most major insurers offer the plans. *Id.* at 1214.

176. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 18 (“The pricing of health care services is complicated and frequently obscure. Thus, proposals to increase consumer price sensitivity must develop strategies to increase the transparency of pricing.”); Thompson Press Release, *supra* note 111 (noting that HIT will allow patients greater access to quality information).

177. See Heyward H. Bouknight, III, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 60 WASH. & LEE L. REV. 1515, 1529 (2006).

178. Indeed, even if such a perfect state of information were attainable, completely free markets can lead to disastrous consequences. For example, if all barriers to entry in the health care industry were removed, there could be a flood of unlicensed providers offering services.

179. See IMPROVING HEALTH CARE, *supra* note 2, Executive Summary, at 4 (“Vigorous competition, both price and non-price, can have important benefits in health care as well.”).

are involved.”¹⁸⁰

V. CONCLUSION

By addressing and correcting the problems underlying the inability of specialty hospitals to lower costs, lawmakers can reduce the financial strain of the entire health care system. Abrogating CON laws will allow competitors such as specialty hospitals to participate in the health care industry, thus lowering prices through efficiency. Adjusting our PPS to reflect a P4P methodology will further encourage cost savings. Finally, implementing a national HIT system will render the PPS more efficient and capable of operating under a P4P structure, while providing purchasers and patients with better access to price and quality information.

Viewing the flaws in our system in the light of the specialty hospital debate reveals that the nation must take steps to move toward a free market health care industry. After all, if our health care market is structured in such a way that it cannot realize the positive effects of competition, why label it a market at all? From an ambitious perspective, the proposed solutions will effect monumental industry changes that will achieve a cost-effective system. Perhaps less grandiosely, the solutions are merely means to lower costs by encouraging fair competition. The difference in these characterizations may be a matter of semantics. Regardless of how these changes are described, the solutions will quell the rising tide of costs. The solutions will level the healing field.

180. *Id.* at 28-29.