



Alabama Law Scholarly Commons

Articles

Faculty Scholarship

1993

Health Care Price Controls and the Takings Clause Commentary

William S. Brewbaker III

University of Alabama - School of Law, wbrewbak@law.ua.edu

Follow this and additional works at: https://scholarship.law.ua.edu/fac_articles

Recommended Citation

William S. Brewbaker III, *Health Care Price Controls and the Takings Clause Commentary*, 21 *Hastings Const. L.Q.* 669 (1993).

Available at: https://scholarship.law.ua.edu/fac_articles/55

This Article is brought to you for free and open access by the Faculty Scholarship at Alabama Law Scholarly Commons. It has been accepted for inclusion in Articles by an authorized administrator of Alabama Law Scholarly Commons.

Health Care Price Controls and the Takings Clause

By WILLIAM S. BREWBAKER III*

Table of Contents

Introduction	670
I. Regulatory Takings and Substantive Due Process	672
A. Regulatory Takings	672
B. Substantive Due Process Compared	673
C. Reconciling Post- <i>Lochner</i> Due Process and Regulatory Takings Jurisprudence	675
II. Balancing Benefits and Burdens: Economic Effects of Health Care Reform	676
A. Process Protection of Property Rights	676
B. Evaluating the Effects of Government Action	681
1. Single-Payer Health Reform: The McDermott- Wellstone Proposal	683
a. Effects on Physicians	683
b. Effects on Hospitals	687
2. Competition Under a Global Budget: The Clinton Plan	689
a. Effects on Physicians	691
b. Effects on Hospitals	693
III. Regulatory Takings Doctrine: Ad Hoc Balancing	695
A. Nature of the Government Action	695
B. Severity of Economic Impact	698
C. Reasonable Investment-Backed Expectations	698

* Assistant Professor, University of Alabama School of Law. LL.M. 1993, Duke University; J.D. 1986, University of Virginia; B.A. 1981, Vanderbilt University. I am grateful to the American Medical Association (AMA) for providing me with a copy of the memorandum setting forth its argument that health care price controls may violate the Takings Clause. I am also grateful to Bryan Fair, Martha Morgan, Kenneth Randall, and Harold See for helpful discussions concerning some of the ideas contained in this Article, and to Professor Fair and Dean Randall for their comments on earlier drafts. Dean Randall and the University of Alabama Law School Foundation made available generous research support. Richard Rouco provided excellent research assistance.

IV. Health Care Price Controls and the Public Utility Cases	702
A. The Significance of Public Utility Status	702
B. Price Regulation of Entities Other than Public Utilities	706
Conclusion	707

Introduction

In response to a perceived cost and access crisis, President Clinton has proposed a dramatic reorganization of the American health care industry.¹ A controversial feature of the Clinton proposal is its strategy of using price controls to limit health care spending. Under the plan, a national health board would set national and regional expenditure caps.² In order to enforce these caps, health plan premiums (and, in turn, provider payments) would be reduced pro rata by an amount necessary to bring spending into compliance.³ The Clinton proposal also provides for separate controls on the prices of physician services under "fee for service" health plans.⁴

Opponents of the Clinton plan, chiefly organized medicine, have charged that the plan's price controls could amount to an unconstitutional regulatory taking.⁵ If prices are set too low, they argue, providers would be deprived of the economic benefit of investments in their professional practices or facilities in violation of the Fifth Amendment. Drawing on precedent protecting public utilities against confiscatory rate regulation, opponents contend that prices under the Clinton plan must be set at a level that gives providers the opportunity to recoup their costs plus a reasonable return.⁶ They also claim that

1. See Health Security Act, H.R. 3600, 103d Cong., 1st Sess. (1993) [hereinafter HSA].

2. *Id.* §§ 6001-6003.

3. *Id.* §§ 6011, 6012.

4. *Id.* § 1322(c).

5. See Edward Felsenthal, *AMA to Fight Limits on Doctors' Fees*, WALL ST. J., Sept. 9, 1993, at B7; Brian McCormick, *Constitutional fights loom on reform plan*, AM. MED. NEWS, Oct. 25, 1993, at 3; Robert Pear, *Doctors Planning Battle Against Health Care Providers*, N.Y. TIMES, June 15, 1993, at A20. The legal theory on which the AMA's opposition to price controls is grounded is explained in a memorandum prepared by the AMA's counsel, Sidley & Austin. See generally Memorandum from Sidley & Austin to American Medical Association (June 1993) [hereinafter AMA Memorandum] (copy on file with the *Hastings Constitutional Law Quarterly*).

6. See AMA Memorandum, *supra* note 5, at 3-18.

government must establish procedures for individualized rate-setting to take into account cost variations among providers.⁷

The argument that price controls in the health care industry might amount to a regulatory taking is facially attractive. Price regulation is questionable policy,⁸ and is one of the most unpopular forms of government intervention. Moreover, the public utility cases, rooted in regulatory takings doctrine, provide ostensible legal precedent for the position.

This Article argues that, despite the facial appeal of a regulatory takings challenge to health care price controls, the Fifth Amendment places no significant limits on industry-wide health care price regulation. Part I argues that the property interests at stake in health care price regulation are identical to the "economic liberty" interests protected under substantive due process doctrine during the *Lochner*⁹ era. As a result, regulatory takings doctrine cannot be expanded to include economic scrutiny of price controls without creating the sorts of tensions between the legislative and judicial branches that ultimately led to *Lochner's* demise.

Part II argues that, despite the unavailability of other constitutional limitations on redistributive regulation, the legislative process is itself likely to provide significant protection for the economic interests of health care providers. Moreover, even if legislatures do not safeguard provider interests, courts would face an impossible task in determining whether health care providers have suffered or benefited from government policy taken as a whole.

Part III examines the balancing test traditionally employed by the Court in regulatory takings cases. The test suggests that, like most other regulatory takings claims, a challenge to price controls in the health care sector is likely to fail.

Part IV demonstrates that the public utility rate-setting cases upon which potential regulatory takings claimants might rely are distinguishable from the Court's judgments in other takings cases. The mere fact that Congress has regulated prices, as opposed to other features of the health care market, justifies no special constitutional scrutiny.

7. *Id.* at 18-21.

8. See, e.g., Elizabeth McCaughey, *Price Controls on Health Care*, WALL ST. J., Nov. 22, 1993, at A14.

9. *Lochner v. New York*, 198 U.S. 45 (1905); see discussion *infra* Part I.B.

I. Regulatory Takings and Substantive Due Process

A. Regulatory Takings

Until Justice Holmes' famous opinion in *Pennsylvania Coal Co. v. Mahon*,¹⁰ the reach of the Takings Clause of the Fifth Amendment was limited to "physical appropriation" of private property.¹¹ In *Mahon*, however, the Supreme Court held that if government regulation diminished the value of property significantly enough, the Takings Clause might require compensation even though government did not take physical possession of the property.¹² Justice Holmes reasoned that regulations preventing the profitable exploitation of one's property have "very nearly the same effect for constitutional purposes as appropriating or destroying it."¹³ In the same opinion, however, Holmes noted that, as a practical matter, the regulatory takings idea could not be pressed to its logical extreme: "Government hardly could go on if, to some extent, values incident to property could not be diminished without paying for every such change in the general law."¹⁴

The Court has never found a conceptually consistent approach for reconciling the tensions expressed in the *Mahon* opinion. Reading *Mahon* to prohibit uncompensated redistributive regulation altogether would recognize that the economic effects of regulation may be just as severe as those of "physical takings," but at the price of imposing enormous practical burdens on government. Reading *Mahon* more narrowly, on the other hand, would force some citizens to bear uncompensated burdens, but would let government operate without subjecting the incidental effects of its every decision to judicial scrutiny.¹⁵

In effect, the Court has reached a practical accommodation of these two conflicting policies. It decides regulatory takings cases using a combination of ad hoc balancing and per se rules. If a regulation

10. 260 U.S. 393 (1922).

11. See *id.* at 417 (Brandeis, J., dissenting) (noting that state did not, through the regulations challenged in *Mahon*, "appropriate [the restricted property] or make any use of it"); see also *Mugler v. Kansas*, 123 U.S. 623, 668-69 (1887) (holding that prohibition on use of property pursuant to police powers "cannot, in any just sense, be deemed a taking or an appropriation of property for public benefit"); JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW § 11.12, at 427 (4th ed. 1991) (characterizing pre-*Mahon* takings jurisprudence as turning on whether there was a "physical appropriation").

12. *Mahon*, 260 U.S. at 413.

13. *Id.* at 414.

14. *Id.* at 413.

15. See generally Carol M. Rose, *Mahon Reconstructed: Why the Takings Issue is Still a Muddle*, 57 S. CAL. L. REV. 561, 587-97 (1984) (describing the fundamental tension in *Mahon* as between wealth maximization and civic virtue).

amounts to a physical invasion of property¹⁶ or prevents all economically beneficial use of land,¹⁷ compensation is due without further inquiry. Otherwise, the Court balances three factors in deciding regulatory takings cases: the nature of the governmental interest in the challenged regulation, the extent of the resulting diminution in value, and the nature of the expectations unrealized pursuant to the regulation.¹⁸ Practically speaking, however, unless the regulatory takings claim can be forced into a per se category, it will almost certainly fail: the Court has "never once clearly applied the open-ended balancing test in favor of a takings claim and against a regulating government."¹⁹

B. Substantive Due Process Compared

The Court's pragmatic constriction of regulatory takings doctrine bears a strong resemblance to its abandonment of *Lochner*-era substantive due process protection of economic liberties.²⁰ In the *Lochner* era, the Supreme Court frequently invalidated business regulation that diminished "freedom of contract" or otherwise adversely affected vested economic interests.²¹ Judicial nullification of New Deal legislation eventually led to a political conflict between President Roosevelt

16. *Lucas v. South Carolina Coastal Council*, 112 S. Ct. 2886, 2893 (1993) (citing *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419 (1982); *Kaiser Aetna v. United States*, 444 U.S. 164 (1979); *United States v. Causby*, 328 U.S. 256 (1946)).

17. *Id.* at 2893 (citing *Nollan v. California Coastal Comm'n*, 483 U.S. 825 (1987); *Keystone Bituminous Coal Ass'n v. DeBenedictis*, 480 U.S. 470 (1986); *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264 (1981); *Agins v. City of Tiburon*, 447 U.S. 255 (1980)). Public utility regulation constitutes an additional category of per se takings. See discussion *infra* Part IV.A.

18. *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 124-25 (1978). The three-part test has been most recently employed in *Concrete Pipe & Products, Inc. v. Construction Laborers Pension Trust*, 113 S. Ct. 2264, 2289 (1993).

19. Frank Michelman, *Takings, 1987*, 88 COLUM. L. REV. 1600, 1621 (1988). Since Michelman wrote, the Court's only decision in favor of a regulatory takings claimant has been *Lucas*. *Lucas* rested on the trial court's finding that the regulated land was "rendered valueless by [government] enforcement of [a] coastal-zone construction ban." *Lucas*, 112 S. Ct. at 2896. The Court thus applied a per se rule requiring compensation unless "the proscribed use interests were not part of [the landowner's] title to begin with." *Id.* at 2899.

20. In the technical sense, the Court did not "abandon" substantive due process review of economic legislation. It merely reduced the degree of scrutiny to the minimal "rational basis" standard. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 (1938). See LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 8-7, at 582 ("[T]he Court never wholly abandoned the position that legislatures, at least in their regulatory capacity, must always act in furtherance of public goals transcending the shifting summation of private interests through the political process.").

21. See NOWAK & ROTUNDA, *supra* note 11, § 11.3; TRIBE, *supra* note 20, §§ 8-2 to 8-6.

and the Court.²² When the judiciary yielded, it became settled that whatever protection of economic interests against majoritarian exploitation the Constitution provided lay largely in the legislative process itself.²³ No distinct constitutional crisis precipitated the Court's generally cautious approach to the Takings Clause. Nevertheless, one reason for the Court's refusal to give the Clause broader application has surely been to avoid conflict with the elected branches.²⁴

The economic interests protected in the *Lochner* era and those asserted by claimants in regulatory takings challenges to economic regulation are also strikingly similar. A business making a regulatory takings claim alleges, by definition, that government regulation has diminished the value of its property.²⁵ In economic terms, the business claims that the challenged regulation has diminished the income stream that would otherwise be associated with ownership and operation of the property.²⁶ Because assets generate revenues through market transactions, the regulatory takings claimant is arguing that, but for the regulation, it could have exploited its property more successfully by bargaining on more favorable terms. This is exactly what parties in the *Lochner* era argued when they challenged government regulation based on "liberty of contract". But for the challenged regulation, they argued, it would have been possible to purchase labor more cheaply,²⁷ extract commitments from employees not to engage

22. See LEO PFEFFER, *THIS HONORABLE COURT* 295-320 (1965); see also Franklin D. Roosevelt, *Reorganizing the Federal Judiciary*, in *FREE GOVERNMENT IN THE MAKING* 679-82 (A.T. Mason & G.E. Baker eds., 4th ed. 1985) (transcript of Roosevelt's radio address arguing for his court-packing plan).

23. See, e.g., *Ferguson v. Skrupa*, 372 U.S. 726, 731-32 (1963) ("We refuse to sit as a 'superlegislature to weigh the wisdom of legislation . . .'. The Kansas debt adjusting statute [challenged in *Ferguson*] may be wise or unwise. But relief, if any be needed, lies not with us but with the body constituted to pass laws for the state of Kansas." (quoting *Day-Brite Lighting, Inc. v. Missouri*, 342 U.S. 421, 423 (1952))); see also *Williamson v. Lee Optical*, 348 U.S. 483, 488 (1955); *Lochner v. New York*, 198 U.S. 45, 74 (1905) (Holmes, J., dissenting).

24. See *United States Trust Co. v. New Jersey*, 431 U.S. 1, 60-61 (Brennan, J., dissenting) (noting that the Court defers to legislatures in interpreting Due Process, Contract, and Takings Clauses).

25. See *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 413 (1922) (basing application of Takings Clause on diminution in property value).

26. See *id.* at 414 ("What makes the right to mine coal valuable is that it can be exercised with profit."); 1 EDWARD COKE, *INSTITUTES* ch. 1, § 1 (1st Am ed. 1812) ("[F]or what is the land but the profits thereof [?]" (quoted in *Lucas v. South Carolina Coastal Council*, 112 S. Ct. 2886, 2894 (1993))).

27. See, e.g., *Adkins v. Children's Hosp.*, 261 U.S. 525 (1923) (invalidating minimum wage statute).

in union activity,²⁸ or, tellingly, sell goods or services at higher prices than the challenged regulation permitted.²⁹

C. Reconciling Post-*Lochner* Due Process and Regulatory Takings Jurisprudence

The political and economic similarities between *Lochner*-era substantive due process review and regulatory takings analysis help explain the Court's reluctance to read the Takings Clause expansively. However, at least two objections can be made to the analogy. First, the Due Process Clause and the Takings Clause are theoretically distinct. Unlike the Due Process Clause, the Takings Clause does not prevent government from regulating in particular ways or for particular purposes; it merely requires it to "pay its way" by compensating affected property holders.³⁰ There is thus no logical tension between rejection of *Lochner*-era substantive due process review and regulatory takings scrutiny. Nevertheless, the likely real-world effect of requiring compensation whenever regulation diminishes property values would be substantially to mandate a laissez-faire economic system on constitutional grounds. There is thus a practical tension between rational-basis review of economic regulation and an expansive regulatory takings doctrine.

Next, one might argue that even the practical tensions between regulatory takings doctrine and minimal due process scrutiny are open to question. After all, the Takings Clause is currently applied to some categories of regulation,³¹ yet there is no indication that government is "hardly . . . go[ing] on."³² As noted earlier, however, the Court has

28. See, e.g., *Coppage v. Kansas*, 236 U.S. 1 (1915) (invalidating state law prohibiting anti-union activity contracts); *Adair v. United States*, 208 U.S. 161 (1908) (invalidating federal law prohibiting anti-union "yellow dog" employment contracts).

29. See, e.g., *Williams v. Standard Oil Co.*, 278 U.S. 235 (1929) (gasoline prices); *Tyson & Bro.-United Theater Ticket Offices, Inc. v. Banton*, 273 U.S. 418, 429 (1927) (The "right . . . to fix a price at which . . . property shall be sold is an inherent attribute of the property itself.").

30. The "public use" component of takings doctrine requires that exercises of eminent domain be made for public, as opposed to private, purposes. But this requirement has been interpreted as to place no substantial limitations on the purposes for which government may effect a taking. See *Hawaii Hous. Auth. v. Midkiff*, 467 U.S. 229 (1984); *Berman v. Parker*, 348 U.S. 26 (1954); see also *Lucas*, 112 S. Ct. at 2894 (noting that "Fifth Amendment is violated when land-use regulation 'does not substantially advance legitimate state interests'" (quoting *Agins v. City of Tiburon*, 447 U.S. 255, 260 (1980))); Thomas W. Merrill, *The Economics of Public Use*, 72 CORNELL L. REV. 61 (1986) (arguing that "public use" component of Takings Clause mandates judicial scrutiny of whether eminent domain is an appropriate means of achieving a legitimate governmental end).

31. See *supra* text accompanying notes 16-17.

32. *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 413 (1922).

intentionally confined regulatory takings to relatively narrow categories of property devaluations, presumably with the purpose of minimizing judicial oversight of economic regulation. The Court cannot significantly expand regulatory takings review without reviving the *Lochner* problem.³³ Health care reform legislation provides an apt illustration of this reality. Given that there are some 600,000 physicians³⁴ and about 5,500 community hospitals³⁵ in the United States, requiring compensation of health care providers whose interests are damaged by changing regulations (or, for that matter, merely requiring individualized proceedings to determine whether such compensation were due) would, for practical purposes, amount to the invalidation of health reform legislation.

As a practical matter, then, the Court will likely be unwilling to find that a legislative program of the magnitude of comprehensive health care reform results in a regulatory taking, even if price controls create dramatic adverse effects on certain providers. The end of the *Lochner* era has been generally understood to mean that the Constitution does not provide significant independent protection against the infringement of economic liberties. The economic interests that would be at stake in takings litigation based on health care price controls are indistinguishable from those the Court formerly protected under economic substantive due process analysis. Despite the fact that substantive due process review and Takings Clause analysis rest on different theoretical grounds, the practical result of requiring government to compensate parties affected by broad-based regulation would be to limit legislative prerogatives in a drastic way.

II. Balancing Benefits and Burdens: Economic Effects of Health Care Reform

A. Process Protection of Property Rights

The chief difficulty with the argument that the Court generally ought not limit legislative prerogatives is that the Constitution, which the Court is charged with enforcing, was designed with that precise purpose (among others) in mind. A principal theme in the American political tradition has been concern about the dark side of democ-

33. Nor can it limit takings review to price controls. There is no persuasive basis for distinguishing between price and nonprice regulation in terms of economic effects. See *infra* text accompanying note 147.

34. See HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 81 (1991) (projection).

35. *Id.* (1989 figure).

racy—majoritarian exploitation of minorities.³⁶ The Takings Clause, with its focus on preventing property owners from being unfairly singled out to bear the costs of public programs, embodies a constitutional concern about economic exploitation of individuals—one that the courts, as protectors of individual rights, presumably ought to vindicate even at some political cost.

An important answer³⁷ to this objection is that the legislative process itself provides constitutionally adequate protection for the economic interests of affected businesses.³⁸ Under current doctrine, a

36. See, e.g., THE FEDERALIST No. 10, at 80 (James Madison) (Clinton Rossiter ed., 1961) (“When a majority is included in a faction, the form of popular government . . . enables it to sacrifice to its ruling passion or interest both the public good and the rights of other citizens.”).

37. Another response is that the Takings Clause, as a substantive matter, was never intended to reach broad-based economic regulation. See Joseph L. Sax, *Takings and the Police Power*, 74 YALE L.J. 36, 59-60 (1964) (suggesting that Takings Clause was intended to serve as protection against “unfair or arbitrary government” rather than diminution in value of property); *id.* at 55-57 (noting that idea of “just prices” was part of the common law background against which the Takings Clause was adopted). But see Lucas v. South Carolina Coastal Council, 112 S. Ct. 2886, 2900 n.15 (1993) (rejecting originalist interpretation of Takings Clause if it would require “renounc[ing] the Court’s contrary conclusion in *Mahon*”).

38. Footnote 4 of *United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938), is the textual starting point for theories of judicial review arguing that the political process protects substantive rights. Without taking a position on the merits of a process-based theory of judicial review, Justice Powell described it as follows:

The fundamental character of our government is democratic. Our Constitution assumes that majorities should rule and that the government should be able to govern. Therefore, for the most part, Congress and the state legislatures should be allowed to do as they choose. But there are certain groups that cannot participate effectively in the political process. And the political process therefore cannot be trusted to protect these groups in the way it protects most of us. Consistent with these premises, the theory continues, the Supreme Court has two special missions in our scheme of government:

First, to clear away impediments to participation, and ensure that all groups can engage equally in the political process; and

Second, to review with heightened scrutiny legislation inimical to discrete and insular minorities who are unable to protect themselves in the legislative process.

Lewis F. Powell, Jr., *Carolene Products Revisited*, 82 COLUM. L. REV. 1087, 1088-89 (1982). Although the Court has come close to endorsing a process-based review theory, see, e.g., *Ferguson v. Skrupa*, 372 U.S. 726 (1963), it has never “treat[ed] pure political interest balancing and log-rolling compromise as normatively acceptable.” TRIBE, *supra* note 20, § 8-7, at 582 (citing cases); see Cass R. Sunstein, *Interest Groups in American Public Law*, 38 STAN. L. REV. 29, 50 (1985). Nevertheless, given the minimal standard of review to which economic legislation is subjected, one may question whether, in fact, the Court does not implicitly rely almost exclusively on the political process to protect individual property rights. See Sunstein, *supra*, at 54-55 (noting argument that “prohibition against exercises of raw power is merely rhetorical,” but concluding that prohibition is instead an “‘under-enforced’ constitutional norm[]”). But see Powell, *supra*, at 1091 (noting that process-based vision relies on substantive vision in order to judge whether process is functioning

regulatory taking occurs when a property owner is “unfairly singled out . . . to bear a burden that should be borne by the public as a whole.”³⁹ A process-based theory⁴⁰ of constitutional protection posits that minorities (other than those that are unlikely to have full access to the political process) will have adequate means to protect themselves from exploitation by the majority.⁴¹

smoothly); Laurence H. Tribe, *The Puzzling Persistence of Process-Based Constitutional Theories*, 89 YALE L.J. 1063 (1980).

It is, perhaps, especially difficult to justify a purely process-based theory of review where the Takings Clause is concerned. *Carolene Products* footnote 4 itself began with the observation that “[t]here may be narrower scope for operation of the presumption of constitutionality when legislation appears on its face to be within a specific prohibition of the Constitution, such as those of the first ten amendments, which are deemed equally specific when held to be embraced within the Fourteenth.” *Carolene Products*, 304 U.S. at 152-53 n.4. See also Tribe, *supra*, at 1065 (characterizing the Takings Clause as one of the Constitution’s “openly substantive commitments”). Despite this difficulty, it seems likely that the scope courts give the Takings Clause will be influenced in part by their view of the adequacy of process-based protections.

39. *Yee v. City of Escondido*, 112 S. Ct. 1522, 1526 (1992) (citing *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 123-125 (1978)); see *First English Evangelical Lutheran Church v. County of Los Angeles*, 482 U.S. 304, 318-19 (1987) (“It is axiomatic that the Fifth Amendment’s just compensation provision is ‘designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole.’” (quoting *Armstrong v. United States*, 364 U.S. 40, 49 (1960))).

40. See *Carolene Products*, 304 U.S. at 152 n.4 (“[P]rejudice against discrete and insular minorities may be a special condition . . . curtail[ing] the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry.”).

41. At least two justices would reject a process-based theory of the Takings Clause. In *Pennell v. City of San Jose*, 485 U.S. 1 (1988), Justice Scalia, joined by Justice O’Connor, wrote in concurrence that the Takings Clause imposes limits on redistributive regulation of any type. Focusing on the Court’s formulation that the Takings Clause “‘bar[s] Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole,’” *id.* at 19 (Scalia, J. concurring) (quoting *Armstrong*, 364 U.S. at 49), Justice Scalia wrote that economic regulation could not be used to redistribute wealth where the affected parties were neither “the source [n]or the beneficiary” of the social problem at which the regulation was aimed. *Id.* at 22 (Scalia, J., concurring). The rent control ordinance in *Pennell* provided that, in addition to evaluating the reasonableness of landlord rents in order to protect consumers against inordinately high prices, the hearing officer was to consider whether the proposed rent increase would result in hardship to the affected tenant. Justice Scalia argued that once the officer had reached a conclusion that the rent to be charged was reasonable, the landlord could “no longer be regarded as a ‘cause’ of exorbitantly priced housing; nor is he any longer reaping distinctively high profits from the housing shortage.” *Id.* at 21 (Scalia, J., concurring). Once assurance is provided that the landlord is not charging an exorbitant price, the tenant’s hardship does not result from the landlord’s practices, but from the tenant’s poverty—a “public welfare” problem the solution to which “has been the distribution . . . of funds raised from the public at large through taxes, either in cash (welfare payments) or in goods (public housing, publicly subsidized housing, and food stamps).” *Id.*

The process-based theory rests largely on a pluralist understanding of legislative behavior. In the pluralist understanding, legislation reflects not so much the will of any single "majority" as that of shifting coalitions of minorities.⁴² Each minority is likely to have an intense

If adopted by the Court, Justice Scalia's "public welfare" test would significantly reinvigorate the constitutional protection of property interests threatened by economic regulation. Justice Scalia takes pains to observe that nuisance and land-use regulation, and even "emergency" price controls, would not be threatened under his proposed rule, since in each of these cases there will usually be a connection between the evil at which the regulation is aimed and the property restrictions involved. *Id.* at 20 (Scalia, J., concurring).

The "public welfare" test is subject to at least two objections, however. First, the distinction between regulating property to prevent an evil and asking a property owner to confer a benefit is notoriously problematic. See *Lucas*, 112 S. Ct. at 2897; Frank I. Michelman, *Property, Utility, and Fairness: Comments on the Ethical Foundations of "Just Compensation" Law*, 80 HARV. L. REV. 1165, 1196-1201 (1967); Sax, *supra* note 37, at 48-49. Next, the test implicitly relies on a judicial ability to distinguish the outer limits of the "reasonableness" of price restrictions and other economic regulation. Consider the minimum wage law for example. Under Scalia's test, the regulation would be valid only insofar as it required employers, who presumably would have previously benefited from unreasonably low wages, to pay reasonable wages, perhaps defined as wages that provide a person the means to support himself at some decent level. However, if a legislature set the minimum wage at a level higher than the "reasonable" level, the wage would be viewed, in effect, as a transfer payment from the employer to the employee for which the employer would presumably be entitled to compensation from the public fisc.

Even under Scalia's "public welfare" test, health care price controls ought to pass constitutional muster. A fundamental premise of current health care reform efforts is that health care costs are too high. Health care prices have been artificially inflated by the "moral hazard" associated with pervasive third party insurance, see CHARLES E. PHELPS, *HEALTH ECONOMICS* 287-89 (1992), government tax policy, see *id.* at 298-303, and organized medicine's private regulation of the health care industry, see Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 533-34 (1988); see generally Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986). Moreover, these same factors have contributed to increased output of health care goods and services. Price controls designed to curb utilization (such as those associated with the enforcement of premium caps in the Clinton plan) are not aimed merely at fixing a reasonable price for a fixed quantity of medical care but at encouraging efficiency in health care delivery by changing the inputs associated with medical services. See also *Keystone Bituminous Coal Ass'n v. DeBenedictis*, 480 U.S. 470, 487 n.16 (noting that government policy judgments need not be unassailable in order to pass constitutional muster).

42. THE FEDERALIST No. 10 (James Madison); THEODORE J. LOWI, *THE END OF LIBERALISM* 51 (2d ed. 1979); Sunstein, *supra* note 38, at 32-35; Michael J. Waggoner, *Log-Rolling and Judicial Review*, 52 U. COLO. L. REV. 33, 35-37 (1980). *But see* Sunstein, *supra* note 38, at 39 (arguing that *Federalist No. 10* is not a "conventional pluralist document").

The Supreme Court does not find Takings Clause violations where challenged regulation "arises from some public program adjusting the benefits and burdens of economic life to promote the common good." *Penn Central*, 438 U.S. at 124. It is not clear that the Court was thinking in pluralist terms when these words were written; nevertheless, the quoted phrase is suggestive of the give-and-take conception of the legislative process associated with pluralism.

interest in only a small proportion of proposed legislative actions.⁴³ It may thus trade votes on matters of minimal concern in exchange for support for its own narrow agenda.⁴⁴ Interest group theory suggests that, far from being subject to domination by the "majority," powerful interest groups may hold disproportionate influence in the legislative process.⁴⁵ If the interest group model of legislative behavior is accepted, there is no need to invoke the Takings Clause to protect minority property interests. Well-organized, highly interested groups such as health care providers could be expected to protect their own interests in the legislative process without the need for judicial intervention.⁴⁶

43. Waggoner, *supra* note 42, at 35.

44. *Id.*

45. *Id.* at 36.

46. The pluralist model assumes that the political system is systematically biased in favor of minorities. Professor Neil Komesar has identified four conditions that accompany minoritarian bias in the legislature: "(1) the members of the minority each have much to gain by the resolution of an issue in their favor; (2) the adverse effects on the majority are spread thinly across a large population; (3) the issue is complicated and, therefore, (4) information and organization costs are high." Richard J. Pierce, Jr., *Public Utility Regulatory Takings: Should the Judiciary Attempt to Police the Political Institutions?*, 77 GEO. L.J 2031, 2047 (1989) (summarizing Neil Komesar, *A Job for the Judges: The Judiciary and the Constitution in a Massive and Complex Society*, 86 MICH. L. REV. 657, 671-75 (1988)). The participation of health care providers in the debate over health care reform appears to fit these conditions. Komesar, however, also posits the existence in certain cases, of majoritarian legislative bias. Majoritarian bias may exist where "(1) the minority is discrete, insular, and immutable; (2) the majority is politically active on the issue; and (3) the stakes for the majority can be communicated in the form of simple symbols that facilitate easy communication in the media and inexpensive exploitation by politicians." Pierce, *supra*, at 2047 (summarizing Komesar, *supra*, at 675-83). Physicians and other health care providers have, generally speaking, been remarkably successful in the legislative process, *see infra* notes 50-54 and accompanying text, suggesting that the system has been biased, if at all, to their net advantage. Given the increasing attention of the majority to health care reform issues and the potential for politicians to scapegoat health care providers and others in order to influence the debate, however, conditions could conceivably change so as to create majoritarian bias against health care providers. *Cf.* Pierce, *supra*, at 2047-53 (describing shift from political environment favorable to public utilities to environment suggestive of majoritarian bias against utilities).

At this writing, it appears that health care providers, while certainly not dictating the outcome of the reform debate, continue to exercise influence well beyond their numbers. For example, Dr. James Todd, Executive Vice President of the AMA recently reported several important victories in the AMA lobbying related to the Clinton proposal:

We eliminated enterprise liability as a major proposal. Doctors will be allowed to negotiate fee schedules. The benefits package Mrs. Clinton put together in 1993 looks a lot like the benefits package this house [AMA House of Delegates] put together in 1989 And it's not a coincidence that fee-for-service medicine was going to be restricted, and now it's a requirement. Or that a point-of-service option for HMOs was out of the president's plan, but now it's in. . . . And real liability reform now appears in most of the congressional proposals.

B. Evaluating the Effects of Government Action

The interest group model of the political process is no doubt an oversimplification.⁴⁷ Nevertheless, it suggests important questions about how the effects of government action upon affected groups should be analyzed for Takings Clause purposes. As discussed above, the pluralist model posits that, over time, interest groups can be expected to obtain favorable net results in the legislative process.⁴⁸ The pluralist vision thus suggests that government action's effects on special interests should be evaluated in the aggregate, rather than enactment by enactment.⁴⁹

Evaluating the aggregate economic effects of government action in the health care sector requires two separate inquiries. First, the adverse economic effects of legislation must be considered in light of the effects generated by the enactments that precede and follow it. For example, physicians have enjoyed considerable legislative success over the years.⁵⁰ Government subsidies through Medicare and Medicaid have added to demand for physician services, raising physician

Dr. Todd gives formula for winning reform game plan, AM. MED. NEWS, Dec. 20, 1993, at 5. Even if majoritarian bias were present, it is unclear that judicial intervention would be an effective solution to the problem. See Pierce, *supra*, at 2070-75 (suggesting that, in light of judicial incompetence to supervise utility rate regulation, judicial forbearance would lead in the long run to political solution of public utility problems).

47. Professors Farber and Frickey have criticized the interest group model of the legislative process as incomplete: "Our best picture of the political process, then, is a mixed model in which constituent interest, special interest groups, and ideology all help determine legislative conduct." DANIEL A. FARBER & PHILIP P. FRICKEY, LAW AND PUBLIC CHOICE: A CRITICAL INTRODUCTION 33 (1991); see generally *id.* at 12-37 (surveying and analyzing competing theories of legislative and interest group behavior). Farber and Frickey conclude that because "diffuse groups will generally find it difficult to obtain [socially beneficial] legislation that benefits them at the expense of more compact groups," the Takings Clause should not apply to legislation "where the beneficiaries are substantially more diffuse than those regulated." *Id.* at 72.

48. The model need not be taken to suggest that interest groups win every legislative battle they undertake. See DAVID B. TRUMAN, THE GOVERNMENTAL PROCESS 508 (2d ed. 1971) (describing "total pattern of government" as "a protean complex of crisscrossing relationships that change in strength and direction with alterations in the power and standing of interests, organized and unorganized").

49. Cf. Penn Cent. Transp. Co. v. New York City, 438 U.S. 104, 124 (1978) ("A 'taking' may more readily be found when the interference with property . . . [does not] arise[] from some public program adjusting the benefits and burdens of economic life to promote the common good."); Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 415 (1922) ("average reciprocity of advantage" recognized "as a justification of various laws"); see also Rose *supra* note 15, at 583-85.

50. The text refers to physicians for convenience. Government policies concerning hospital construction finance, Medicare, Medicaid, and private insurance have similarly benefited hospitals and other institutional providers.

incomes.⁵¹ Government tax policy has created incentives for workers to take compensation in the form of health insurance coverage rather than in cash, further decreasing the price sensitivity of consumers in the health care marketplace.⁵² Medical education and research enjoy heavy federal subsidies.⁵³ States have protected physician interests through licensure restrictions and laws prohibiting the corporate practice of medicine.⁵⁴ Each of these has likely had a significant positive effect on the "baseline" value of physician practices. Subsequent regulation that diminishes these values should be evaluated in that context.

Next, both favorable and unfavorable features of health care reform legislation should be taken into account in determining its effects on special interests.⁵⁵ It is, of course, impossible to predict what the nonprice regulatory features of health care reform legislation are likely to be. Rather than consider all possible permutations, the discussion below roughly outlines the economic effects of both price and nonprice regulation on health care providers based on the Clinton health care reform plan⁵⁶ and on the "single-payer" proposal of Representative Jim McDermott (D-Wash.) and Senator Paul Wellstone (D-Minn.).⁵⁷ Comparing the two plans will demonstrate the difficulty of proving that government action has had an adverse net effect on the interests of health care providers. Such proof is, of course, a prerequisite to a regulatory takings claim. Analysis of the Clinton and McDermott-Wellstone proposals also serves as useful background for Part III's evaluation of the status of health care price controls under current regulatory takings doctrine.

51. Cf. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 373 (1982) (noting increase in use of medical services brought about by Medicare and Medicaid); *id.* at 385-86 (describing Medicare's incentives for physicians to inflate prices).

52. GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 138-39 (1990).

53. *Id.* at 710-11.

54. See generally Hall, *supra* note 41, at 507-18; Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987).

55. Conceiving of legislation as a bargain among competing groups suggests that courts should, on fairness grounds, be wary of interfering with legislative activity. Judicial intervention on behalf of regulated parties permits interest groups first to "make their best deal" in the legislative process and then to seek relief from its undesirable aspects in court.

56. See *supra* note 1.

57. The McDermott-Wellstone proposal is entitled "American Health Security Act of 1993." H.R. 1200, 103d Cong., 1st Sess. (1993); S. 491, 103d Cong., 1st Sess. (1993) [hereinafter AHSA] (unless otherwise noted, all citations are to the House version of the McDermott-Wellstone proposal). Other major health reform proposals are not discussed here, primarily because none of these alternative plans employs price controls.

1. *Single-Payer Health Reform: The McDermott-Wellstone Proposal*

As noted above, the legislation sponsored by Representative McDermott and Senator Wellstone would reform American health care under a single-payer model.⁵⁸ Under the McDermott-Wellstone plan, each state must establish an agency to serve as the state's sole third-party payer for a governmentally defined comprehensive package of health care benefits.⁵⁹ Physician and hospital prices would both be regulated, although the price-setting mechanism employed in each case would differ greatly. The proposal's likely net effects on the respective economic interests of physicians and hospitals are considered, in turn, below.

a. Effects on Physicians

Under the McDermott-Wellstone reform proposal, the state would set fees for physician services following negotiations between the state agency administering the plan and provider organizations.⁶⁰ The plan relies primarily on fee-for-service physician payment⁶¹ and would permit patients free choice among physicians.⁶²

Evaluating the net effects of the McDermott-Wellstone price controls on physician practices is likely to be difficult. Physicians will not respond passively to price regulation; instead, they could be expected to respond by altering their practice styles. For physicians who continue to be paid on a fee-for-service basis, a likely response to diminished prices will be to increase the billable services, such as

58. See generally AHSA, *supra* note 57; Paul D. Wellstone & Ellen R. Shaffer, *The American Health Security Act: A Single-Payer Proposal*, 328 NEW ENG. J. MED. 1489 (1993).

59. AHSA, *supra* note 57, §§ 201, 405.

60. *Id.* § 612.

61. *Id.* § 612(a)(1), (b). The McDermott-Wellstone plan contemplates, however, that the American Health Security Standards Board "shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services . . . or for a basic group of services. . ." *Id.* § 612(a)(2); see *id.* § 619 (permitting states to establish alternative payment methodologies subject to stated conditions). The plan would also permit HMO-like "comprehensive health service organizations" to operate, although consumers would have no financial incentive to enroll. *Id.* § 303. Payment to comprehensive health service organizations could be made based on either capitation or on a global budget. *Id.* § 613. Subject to limitations on utilization incentive payments, see *id.* § 303(c)(7), these organizations would be free to make their own payment arrangements with participating physicians.

62. Patients who elected to enroll in comprehensive health services organizations would presumably face limitations on their ability to select providers. However, patients would not have financial incentives to enroll in such an organization. See Wellstone & Shaffer, *supra* note 58, at 1490-91.

procedures and tests, they order for each patient.⁶³ Physicians may also lower expenses associated with provision of services by reducing inputs expended in connection with services regularly rendered to patients.⁶⁴ They may, for example, reduce office amenities, spend less time with patients, or permit nurses or nurse practitioners to perform services physicians might otherwise have personally performed.⁶⁵

Of course, it is not clear just how far a physician may safely carry such defensive measures. Decreasing inputs in connection with medical services is feasible as long as other physicians are also forced to do so⁶⁶ and as long as there are no legal barriers. But, for example, state malpractice law or other licensing or quality-oriented regulation may create legal risk if quality is diminished too far.⁶⁷ Increasing output in

63. See PHELPS, *supra* note 41, at 216-17. *But see* Roger Feldman & Frank Sloan, *Competition Among Physicians, Revisited*, 13 J. HEALTH POL., POL'Y & L. 239 (1988) (summarizing economic research and questioning whether physicians can induce demand for their services). The Senate version of the McDermott-Wellstone proposal would employ volume-performance standards to police such behavior by providers. *See* S. 491, *supra* note 57, § 613(b)(2)(C); Wellstone & Shaffer, *supra* note 58, at 1490.

64. Feldman & Sloan, *supra* note 63, at 253-54 (noting that "regulatory agency has one instrument—price—to hit two targets: optimal quantity and quality").

65. The Clinton plan specifically anticipates strategic provider responses to global budget enforcement. Indeed, the purpose of the global budget, and of the premium cap enforcement mechanism, is less to set a "fair" price for medical services as currently delivered, than to squeeze out "waste" in the system—that is, to *change* the way health care is currently being delivered. For example, in response to cutbacks in provider payments occasioned by enforcement of the premium cap, a physician might employ a nurse practitioner to perform certain routine primary care functions. In doing so, the physician would have responded predictably to price controls by substituting cheaper inputs for more expensive ones where possible. At the margin, it seems likely that at least some diminution in the quality of care the patient receives would accompany such a change. A board-certified internist, for example, may well be able to make some difficult diagnoses that a competent nurse practitioner might miss. Nevertheless, the input substitution could be plausibly characterized as the elimination of "waste"—in the vast majority of cases it does not make good economic sense to pay a highly trained internist to perform routine functions.

66. If decreasing inputs would alter consumer demand, a physician that did so would presumably lose patients to competitors who maintained input intensity despite price regulation.

67. The McDermott-Wellstone proposal vests principal authority over quality standards in an "American Health Security Standards Board." *See* AHSA, *supra* note 57, § 401(f). There is no suggestion in the proposal that state laws governing licensure of health care providers would be affected. For an argument that state malpractice laws can accommodate change in the quality of care brought about by resource constraints, see Mark A. Hall, *Health Care Cost Containment and the Stratification of Malpractice Law*, 30 JURIMETRICS J. 501, 509 (1990) (arguing that "[f]or the most part, treatment of the uninsured does not raise a malpractice issue"); Mark A. Hall, *The Malpractice Standard under Health Care Cost Containment*, 17 LAW, MED. & HEALTH CARE 347 (1989). *But see* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987) (questioning flexibility of malpractice standards); E. Haavi Morreim, *Stratified Scar-*

response to price controls is also feasible only if it can be accomplished at negligible time and financial cost to the patient,⁶⁸ and if it can be done without generating legal risk from government programs designed to police fraud and abuse.⁶⁹ Obviously, it is possible that prices could be set low enough that, notwithstanding available defensive measures, providers will eventually withdraw from the regulated market, either because they are unwilling to work for resulting low wages or because they simply cannot afford to keep their doors open.⁷⁰

An evaluation of the effects of price controls should also take into account the existing legal and economic environment. Even without health reform legislation, physician fees are coming under increasing pressure as managed care networks gain market share. Managed care plans frequently force price concessions from physicians in exchange for the continued privilege of treating plan patients. Market pressures suggest that the trend toward integrated, increasingly price-conscious health care delivery will continue regardless of whether comprehensive reform is enacted. Thus, it is not clear that physicians could expect current fee levels to continue.

Even assuming the McDermott-Wellstone price controls, considered alone, would adversely affect physicians, other features of the legislation appear to advance physician interests. Most strikingly, the plan's promise of universal coverage will offset fee reductions to some degree and permit physicians to increase services provided to patients.⁷¹ Similarly, if payment policies encourage primary care and preventive services, opportunities for increasing output for all patients (that is, not just those previously un- or under-insured) is enhanced.⁷²

city: Redefining the Standard of Care, 17 *LAW, MED. & HEALTH CARE* 356 (1989) (distinguishing between "standard of medical expertise" and "standard of resource use").

68. Again, assuming that patients would notice the strategies described in the text as effective responses to price controls, their availability will depend in part upon whether they are adopted by competitors. See *supra* note 66.

69. See AHSA, *supra* note 57, §§ 411-414 (fraud and abuse provisions); see generally Pamela H. Bucy, *Fraud by Fright: White Collar Crime by Health Care Providers*, 67 *N.C. L. REV.* 855 (1989).

70. But see Wellstone & Shaffer, *supra* note 58, at 1490 (stating that physician price schedules under the McDermott-Wellstone proposal "would be designed to increase fees for primary care, while probably slightly reducing fees for specialty care").

71. See AHSA, *supra* note 57, § 102(a) (creating universal entitlement).

72. The McDermott-Wellstone proposal's comprehensive benefits package makes generous provision for primary care and prevention services. Included in the package are basic immunization, prenatal and well-baby care, well-child care, periodic screening for breast, cervical, colon, and prostate cancer, physical examinations, family planning services, routine eye examinations, eyeglasses, contact lenses, and hearing aids. *Id.* § 202(b)(2).

Moreover, there are other, less obvious, benefits for physicians in the McDermott-Wellstone proposal. The legislation preserves free choice of physician, a feature of American health care that seems destined to disappear or be greatly diminished. If current market trends continue, progressively larger numbers of patients are likely to join health care plans that deny or limit payment for services rendered by out-of-plan physicians. These networks are able to offer consumers lower prices by negotiating competitive fee schedules or capitation rates with providers.⁷³ Providers who refuse to accept low fees, or those who are excluded from the network panel for other reasons, may find themselves at a severe disadvantage in selling their services to plan patients.⁷⁴ The larger the market share of such plans in a given community, the more serious the threat to physicians' practices. Specialists, even those who are participating providers, face significant loss of business if the plan requires that its members obtain a referral from a primary care "gatekeeper" before it will pay for specialist services.⁷⁵ The free choice feature of the Wellstone-McDermott plan preserves the centrality of the physician-patient relationship rather than permitting the patient's choice of payer to limit the patient's choice of physician. Presumably, some physicians who would have been losers

73. The ethical principle requiring that physicians deal only with plans that gave patients "free choice" among providers prevented price competition by requiring that "each public or private health insurer must deal with all [physicians] as a guild, and could not split them into competing groups." Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1356 (1984). Not only do exclusive health plans facilitate price competition, they may also contribute to a physician's loss of leverage in dealing with other institutions involved in health care delivery, such as hospitals. Under a "free choice" system, physicians have a considerable say over the purchasing decisions of their patients. See PAUL STARR, *THE LOGIC OF HEALTH CARE REFORM* 26-27 (1992). Where patients' health care decisions become increasingly focused on choice of health plan, the health plan, rather than the physician, wields the economic power of the patients. See *id.*, at 40-41 (describing managed care plans as sometimes "personified . . . by the M.B.A. with 10,000 patients in his briefcase who expects, and gets, lower rates").

74. Predictably, in many states physicians have obtained legislation that protects their "right" to participate in any health plan for which they are willing to meet the terms of participation. *State "Anti-Managed Care" Laws Threatened by Federal Reform Bills*, Health L. Rep. (BNA) No. 3, at 78, 79 (Jan. 20, 1994) (15 states). Other states require health plans to permit enrollees to choose non-network providers. *Id.* (13 states).

75. See Uwe E. Reinhardt, *Reorganizing the Financial Flows in American Health Care*, 12 HEALTH AFF. 172, 190 (Supp. 1993) (noting that "a substantial enrollment of Americans in [managed care] systems could trigger a sizable physician surplus in the fee-for-service sector"); see also Donald M. Steinwachs et al., *A Comparison of the Requirements for Primary Care Physicians in HMOs with Projections Made by the GMENAC*, 314 NEW ENG. J. MED. 217 (1986).

in a market-competitive battle for plan patients would retain a relatively full patient load under the Wellstone-McDermott proposal.

Physician job satisfaction is also arguably enhanced by the fact that physician influence over health care delivery is likely to be greater under a single-payer proposal than if current trends continue.⁷⁶ Administrative simplicity may lead to additional physician satisfaction, as well as better bottom-line performance as physician and affiliated personnel time can be spent on remunerative patient care, rather than on unproductive administrative tasks.⁷⁷

To summarize, evaluating the adverse effects of price regulation on physicians is likely to be difficult. Physicians will respond to price controls in the McDermott-Wellstone proposal by decreasing intensity and increasing output, but there are limits beyond which such a strategy is not likely to be effective. The adverse effects of price controls may be offset by features of past legislation that favor physician interests. Moreover, some features of the McDermott-Wellstone plan, such as universal coverage, the preservation of physician independence from third party payers, reduction of administrative costs, and malpractice reforms, would have meaningful favorable effects on the value of physician practices.

b. Effects on Hospitals

Under the McDermott-Wellstone plan, each hospital negotiates a global budget with the state "based on a nationally uniform system of cost accounting established under standards of the [National Health] Board."⁷⁸ The budget is established prospectively, and hospitals are expected to remain within it while meeting their patients' needs.⁷⁹ While the number of patients and the variety of their ailments are among the many factors taken into account in developing the

76. Senator Wellstone and Representative McDermott have emphasized this virtue of their plan in their communications with the medical community. See Wellstone & Shaffer, *supra* note 58, at 1490 ("Should some practitioners receive somewhat lower fees, the trade-off would be the autonomy to practice medicine without micromanagement by an insurance company."); Janice Somerville, *Singing the praises of single-payer: Doctor-congressman says this model offers the most effective route to reform*, AM. MED. NEWS, Dec. 6, 1993, at 9 (describing McDermott's efforts to persuade fellow physicians to support single-payer health reform).

77. See GAO Report to the Chairman, House Committee on Government Operations, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, June 4, 1991, at 29-33 [hereinafter GAO Report]; see also Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253 (1991) (discussing administrative simplicity of Canadian model).

78. AHSA, *supra* note 57, § 611(b).

79. *Id.* § 611(a).

budget,⁸⁰ hospitals would receive no guaranteed reimbursement per service, patient day, or diagnosis.⁸¹

Once the global budget is established, the hospital can protect itself financially only by reducing the intensity with which services are provided; it can obtain no additional payment by providing more services. Hospitals are thus likely to reduce amenities, eliminate excess capacity, delay investment in new technologies, hire relatively fewer skilled workers, discourage admissions, and discharge high-cost patients "quicker and sicker."⁸² As is the case with physician providers, however, state malpractice law and other quality-oriented regulation may limit the degree to which costs may be reduced. Once again, the aggregate economic effects of the price controls on the value of the hospital's business are difficult to isolate.

Like physicians, hospitals also stand to benefit from favorable features of the McDermott-Wellstone reform legislation. Perhaps most importantly, hospitals have traditionally financed uncompen-

80. See *id.* § 611(b)(2).

81. Hospitals would, however, be obligated to submit discharge information classified by diagnosis-related group. *Id.* § 611(b)(3).

82. See PHELPS, *supra* note 41, at 479. Although Phelps uses the "quicker and sicker" catch phrase in reference to hospitals squeezed by Medicare's prospective payment system, hospitals could be expected to adopt a similar strategy in response to a global budget, at least with respect to above-average-cost patients. In fact, perhaps the best-known Canadian-hospital strategic response to global budget reimbursement is the retention of patients known as "bed-blockers." GAO Report, *supra* note 77, at 45. Canadian hospitals have economic incentives to fill beds, where possible, with long-term patients for whom the cost of treatment is below-average. *Id.* Such patients, estimated to occupy 15% of available Canadian hospital beds at any one time, may be admitted for upwards of 60 days per stay, and their presence "prevent[s] physicians from using acute care beds to treat [higher cost] short-term patients." *Id.* The Canadian hospital also encourages hospitals to reduce service intensity by using "less labor, supplies, procedures and equipment." *Id.* at 47. Specifically, those "hospitals use fewer nurses, drugs, operating rooms[, and] MRI. *Id.*"; see Robert G. Evans et al., *Controlling Health Care Expenditures—The Canadian Reality*, 320 NEW ENG. J. MED. 571, 573-74 (1989). Similarly, access to technology is tightly controlled. GAO Report, *supra* note 77, at 48-51; see Geoffrey M. Anderson et al., *Hospital Care for Elderly Patients With Diseases of the Circulatory System: A Comparison of Hospital Use in the United States and Canada*, 321 NEW ENG. J. MED. 1443, 1446-47 (1989) (noting that Canadians receive, on average, fewer high-tech treatments such as coronary artery bypass surgery, valvular surgery, although more major reconstructive surgery and permanent pacemakers); John K. Iglehart, *Canada's Health Care System Faces its Problems*, 322 NEW ENG. J. MED. 562, 565 (1990) (noting that "Canada has appreciably slowed the diffusion of six major forms of technology: open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extracorporeal shock-wave lithotripsy and magnetic resonance imaging); see generally Allan S. Detsky et al., *The Effectiveness of a Regulatory Strategy in Containing Hospital Costs: the Ontario Experience, 1967-1981*, 309 NEW ENG. J. MED. 151 (1983); Allan S. Detsky et al., *Global Budgeting and the Teaching Hospital in Ontario*, 24 MED. CARE 89 (1986).

sated care by increasing charges to private patients. As payors and employers have become more cost-sensitive, however, cost-shifting has become problematic.⁸³ A global budget would, in theory at least, reward hospitals for treatment of all patients without discrimination, rationalize the payment process, and reduce hospital administrative costs.⁸⁴ Accordingly, price controls resulting in decreased per-diagnosis or per-fee payments (as compared to rates formerly in effect for privately insured patients) would not necessarily result in significant net decreases in hospital revenues.⁸⁵

Continuation of free choice of provider may also benefit hospitals in that hospital management might prefer to market the hospital's services by seeking physician referrals instead of negotiating with health plans, for whom price is likely to be a predominant consideration.⁸⁶ Moreover, incumbent institutional providers would presumably welcome continuation or reinvigoration of health planning regulatory mechanisms that prevent market entry by would-be competitors.⁸⁷ As is the case with physicians, however, the hospital budget could theoretically be set at a rate low enough that the hospital could not reasonably be expected to meet its obligations. Under the McDermott-Wellstone proposal, however, there appears to be a basis for challenging a budget that is unreasonably low because states are statutorily obligated to take into account a set of cost-based factors.⁸⁸ Again, the task of determining the precise adverse effects is likely to be difficult.

2. *Competition Under a Global Budget: The Clinton Plan*

The Clinton health care reform proposal relies on a mix of competition and regulation in order to control health care costs.⁸⁹ Under the plan, the nation would be divided into regions, each of which

83. See Havighurst, *supra* note 41, at 727.

84. See GAO Report, *supra* note 77, at 32-33; Woolhandler & Himmelstein, *supra* note 77, at 1256-57.

85. In addition, the McDermott-Wellstone plan expressly contemplates continued charitable giving to private hospitals, although states are not obligated to provide ongoing budgetary support to operate donated equipment. AHSA, *supra* note 57, § 611(d).

86. See *supra* note 73.

87. See AHSA, *supra* note 57, § 405(a)(3); see also Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1185-87 (1973) (noting that "Certificate of Need" programs tend to favor incumbent providers).

88. See AHSA, *supra* note 57, § 611(b)(2); see also *id.* § 632 (appeals procedures).

89. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN 102 (1993).

would be served by a health alliance.⁹⁰ Health alliances are clearing-houses for the marketing of accountable health plans to consumers.⁹¹ Consumers within each alliance would choose among differently priced health plans offering standard packages of comprehensive health benefits.⁹² Plans would compete on the basis of both the cost and quality of their overall services.⁹³ Most plans would contain costs in part by using primary care physicians as gatekeepers to specialists' services and by negotiating favorable financial and utilization arrangements with limited provider panels.⁹⁴ Alliances would, however, be required to offer at least one plan permitting consumers free choice of their physician.⁹⁵

Although competition among plans is expected to help keep health care costs low, the Clinton plan imposes a global limitation on health care costs in order to ensure that cost-containment goals are met.⁹⁶ Under the plan, a National Health Board would establish a national budget for health care expenditures based on prior expenditures adjusted for inflation and other factors, as well as regional budgets for each alliance.⁹⁷ These regional budgets are enforced by premium caps, that is, price controls on the premiums health plans may charge to plan members. In the event the weighted average of health plan premiums exceeds the regional target, each health plan is assessed a proportional sum designed to bring the weighted premium average across all plans back in line with the budget.⁹⁸ Health plans

90. HSA, *supra* note 1, § 1202. Large employers may elect to form a corporate alliance for their employees, rather than pay for employees' health care through the regional alliance. *Id.* § 1311.

91. *See id.* §§ 1321-1325.

92. *See* Paul Starr & Walter A. Zelman, *Bridge to Compromise: Competition under a Budget*, 12 HEALTH AFF. 7, 9-12 (Supp. 1993).

93. The Clinton plan borrows its emphasis on encouraging consumers to make cost-conscious choices among health plans from the managed competition framework developed by Alain Enthoven. The framework for choice among health plans that Enthoven envisioned, and which the Clinton plan follows to a significant extent, is summarized in Alain C. Enthoven, *The Principles of Managed Competition*, 12 HEALTH AFF. 24, 29-35 (Supp. 1993).

94. These characteristics are implicit in the Clinton plan's reliance on managed care. *See* STARR, *supra* note 73, at 11; John K. Iglehart, *Health Policy Report: The American Health Care System: Managed Care*, 327 NEW ENG. J. MED. 742 (1992) (describing managed care).

95. HSA, *supra* note 1, § 1322.

96. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, *supra* note 89, at 102; Starr & Zelman, *supra* note 92, at 18-21.

97. HSA, *supra* note 1, §§ 6001-6004. The setting of these budgets is immune from administrative or judicial review. *Id.* § 5232.

98. *Id.* § 6011.

are required to "pass through" the premium assessment to their providers by proportionally reducing payments to them.⁹⁹ In effect, then, provider fees are capped at the previously negotiated rate less this proportional reduction.

a. Effects on Physicians

Price controls affecting physician services under the Clinton plan would take two forms. Physician payment through the fee-for-service plan offered in each alliance would be based on a physician fee schedule negotiated between the alliance and providers within the region.¹⁰⁰ The fee-for-service plan would permit "any lawful health care provider"¹⁰¹ to offer services to individuals within the alliance. Physicians seeing patients enrolled in closed or limited panel plans, on the other hand, would be paid in accordance with the contracts they negotiated with the plans and not according to the fee schedule.

For the most part, physician responses to price controls under the Clinton plan should not vary according to whether the adverse effects on physician income are attributable to the fixed fee-for-service schedule or to implementation of the premium cap. As would be the case under the McDermott-Wellstone single-payer system, physicians could be expected to attempt to mitigate adverse effects of price controls by decreasing the intensity of inputs in services already being provided or by increasing output.¹⁰² Providers who are practicing primarily in a fee-for-service plan retain the additional option, however, of responding to decreases in the regional alliance's fixed fee schedule by affiliating with managed-care plans.

The Clinton plan also would encourage existing market trends toward reduced physician influence within the health care system. The substantial control over health care delivery that physicians have traditionally enjoyed has resulted in substantial part from their discretion in determining from whom their patients would purchase secondary services (such as hospital or diagnostic services). The Clinton plan

99. See *id.* § 6012.

100. *Id.* § 1322(c). Since the Act expressly precludes a physician boycott, *id.* §1322(b)(2)(B), it is difficult to understand exactly what leverage providers will bring to the negotiating table. Presumably, providers will have some incentive to keep physician fees they demand at reasonable levels, as the fee schedule will affect the relative cost of the fee-for-service plan.

101. *Id.* § 1322(b)(2)(A)(i).

102. See *supra* notes 63-70 and accompanying text. Fee-for-service payments under the "free choice" plan are subject to prospective budgeting, thus limiting the aggregate (but not necessarily the individual) ability of physicians to compensate for price controls by enhancing output. See HSA, *supra* note 1, § 1322(d).

establishes a health care purchasing framework that will encourage consumers to focus health care purchasing decisions primarily on choice of health plan rather than choice of provider. One would expect this change to result in a substantial decline in physician power. Physicians will no longer be guaranteed the opportunity to attempt to sell their services to all of the patients in a given market. Instead, some physicians will find much of the available patient market foreclosed unless they accede to health plan demands concerning price, utilization, and other matters, which traditionally have been within the physician's prerogative. They may also find their ability to extract concessions from hospitals and other institutional providers compromised as institutions become more concerned with satisfying the payer than the treating physician. Specialists may find themselves in particularly difficult circumstances. Even if the specialist is willing to accede to plan demands concerning price and utilization, plan members are still likely to be required to obtain the approval of a primary care physician before a visit to a specialist will be covered. Managed care plans may discourage patient self-referral to specialists, significantly damaging some physicians' practices. However, physicians will not be completely at plans' mercy. One issue that will presumably be important to consumers selecting health plans is the perceived competence of the provider panel and the degree of choice among specialists the patient could expect in the event of foreseen or unforeseen illness.¹⁰³

The adverse effects of the Clinton plan price controls on the value of physician practices will also be mitigated by those features of the reform package that are favorable to physicians. As was the case with the McDermott-Wellstone single-payer plan, universal coverage, considered by itself, enhances the value of physician practices by reducing the amount of bad debt physicians experience.¹⁰⁴ The Clinton

103. Preservation of the fee-for-service option may enable physicians in certain areas to preserve significant autonomy. For example, since the fee-for-service option is expected to be the most expensive (and will probably, at least initially, be perceived as of higher quality), it seems likely that wealthier areas would contain relatively more patients selecting this option. To the extent hospitals and other area providers cater to these patients, physicians will continue to be able to threaten to "take their patients elsewhere" if hospital management refuses to accede to their demands.

The problem of foreseeable illness suggests one of the apparent design flaws in the Clinton plan. If each plan must hold open enrollment each year, *see* HSA, *supra* note 1, § 1323(d)(1), many patients may choose a cheaper plan on the theory that they are better off waiting to join a more expensive, high quality plan until they get sick. Such consumers would bear the risk only that they would be adversely affected by lower quality health care in the event they required significant treatment before the next open enrollment period.

104. It will also enhance the ability of some physicians, most notably those practicing primary care, to respond to price controls by enhancing output. *But see id.* § 6012(a)(2)(B)

plan also includes malpractice reforms and administrative cost reduction measures that might enhance the value of physician practices by reducing expenses associated with potential malpractice liability and the insurance claims process.¹⁰⁵

b. Effects on Hospitals

The Clinton plan imposes indirect price controls on hospitals. As described more fully above,¹⁰⁶ health plan premium payments are limited to levels that will permit regional budgets for health care spending to be met. The health care plans are required to pass along the required premium cuts to providers, including hospitals, by reducing payments otherwise due. Hospitals' ability to counteract the effects of the passthrough of the Clinton premium cuts will vary depending on the payment and utilization arrangements among the hospital, the health plan, and the plan's physicians. If a hospital were paid on a capitate basis, its response to diminished payment revenues would resemble that predicted under the McDermott-Wellstone plan.¹⁰⁷ The hospital could avoid adverse economic effects only by reducing the intensity with which it provided services; it could not increase revenues by providing additional services. One would thus expect to find hospitals reducing amenities, eliminating excess capacity, delaying or eliminating investment in new technologies, discouraging admissions, and discharging patients sooner.¹⁰⁸ Hospitals paid in a different manner might have other strategic responses available. The adverse effects of the Clinton price controls will, like those under McDermott-Wellstone, be offset by reform provisions favorable to hospitals, chiefly universal coverage and provisions reducing hospital administrative costs and malpractice expenses.¹⁰⁹

The foregoing discussion of the likely effects of the Clinton and McDermott-Wellstone health reform plans on providers raises a

(providing for increase in provider-payment reductions "to take into account any estimated increase in volume of services provided that may reasonably be anticipated as a consequence of . . . a reduction in [provider payments pursuant to the premium cap]").

105. See *id.* §§ 5301-5306 (providing for alternative dispute resolution, certificate of merit as prerequisite for bringing medical malpractice cases, limitations on contingent attorneys' fees, reduction of awards based on recovery from collateral sources and periodic payment of damage awards); *id.* §§ 5101-5106 (proposals designed to increase administrative efficiency).

106. See *supra* notes 96-99 and accompanying text.

107. This is so because the sum of the capitation payments a hospital will receive for the population it must serve amounts to a "global budget" for the institution.

108. See *supra* note 82 and accompanying text.

109. See *supra* notes 83-88 and accompanying text.

number of difficult questions for potential regulatory takings plaintiffs. Since Justice Holmes' opinion in *Mahon*, the starting point for a regulatory takings claim has been a demonstration that the challenged regulation has diminished the value of the claimant's property. As shown above, however, health care providers could be expected to engage in defensive responses to price controls. These responses may greatly complicate the task of isolating the adverse economic effects caused by price controls. Moreover, inquiry into the diminution in property values effected by a given piece of reform legislation should not be limited to the isolated effects of price regulation. If the adverse effect of government action on property value is to be accurately gauged, the net economic effect of the entire legislative package must be assessed. In fact, as argued above, there is no apparent justification for limiting judicial scrutiny even to a single piece of legislation. Even if reform legislation were to result in a dramatic diminution in the value of health care providers' property, a strong case could likely be made that the net effect of government action (including health reform legislation) over the past several decades has been to enrich health care providers. As noted, government has erected trade barriers that have benefited providers, injected significant funding into the health care sector and generally encouraged a spare-no-expense style of health care delivery that has inured to providers' direct and indirect advantage.¹¹⁰ In order to show that government policy resulted in a diminution of provider property values, a takings claimant must either demonstrate that government action, taken as a whole, has had a net adverse economic effect or explain why providers are constitutionally entitled to the continuance of market conditions resulting from health care policies the government presumably had no obligation to adopt in the first place.

The analysis suggested above is, of course, virtually impossible to employ as a practical matter. Courts are ill-equipped to consider the net effects of a single provider's defensive maneuvers in response to price controls, much less to evaluate the cumulative effect of all modern legislation affecting health care providers' property values. Although the existence of "diminution in value" is the starting point for a regulatory takings claim, a court will likely never need to reach the issue. As the discussion in Part III demonstrates, the balancing test applicable to regulatory takings claims suggests strongly that health care price controls will not constitute a taking, regardless of the severity of any associated diminution in value.

110. See *supra* notes 51-54 and accompanying text.

III. Regulatory Takings Doctrine: Ad Hoc Balancing

Determining the extent of any "diminution in value" in a claimant's property is only the beginning of the regulatory takings inquiry. Even where government regulation severely diminishes property values, compensation is not necessarily due under the Takings Clause.¹¹¹ Once a diminution in value has been shown, the central inquiry becomes whether the challenged regulation forces the claimant "to bear public burdens which, in all fairness and justice, should be borne by the public as a whole."¹¹² Implicit in the question whether it is "fair" or "just" to ask an individual to bear a "public" burden is a presumption that in some cases individuals may, in justice and fairness, be called upon to do just that.

Except in the case of government actions that fall into per se takings categories,¹¹³ the Court relies on ad hoc balancing of interests to decide when fairness requires that a property owner be compensated. The factors considered include: (1) the nature of the government action, (2) the severity of the economic impact; and (3) the degree of interference with reasonable investment-backed expectations.¹¹⁴ The discussion below considers their likely application in the event health care price controls are enacted and challenged.

A. Nature of the Government Action

Under the balancing test employed by the Court, the first issue is whether the challenged government action amounts to a "physical invasion" of real property or whether it is a "public program adjusting the benefits and burdens of economic life to promote the common good."¹¹⁵ Generally speaking, regulations in the former category obli-

111. "[A] reduction in the value of the property is not necessarily equated with a taking." *Andrus v. Allard*, 444 U.S. 51, 66 (1979); see also *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 113 S. Ct. 2264, 2291 (1993) (diminution in property value, without more, insufficient to support takings claim); *Lucas v. South Carolina Coastal Council*, 112 S. Ct. 2886, 2910 (1993) (same); *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 131 (1978) (same). The Court has held that no taking existed in the face of quite extraordinary diminutions in value. See, e.g., *Andrus*, 444 U.S. at 51 (prohibiting sale of lawfully acquired eagle feathers); *Miller v. Schoene*, 276 U.S. 272 (1928) (property owners ordered to cut down trees); *Hadacheck v. Sebastian* 239 U.S. 394 (1915) (brickyard closure); *Mugler v. Kansas*, 123 U.S. 623 (1887) (brewery business destroyed by prohibition statute). Measuring diminution in value is problematic because the proportion of the diminution depends upon how the property interests at issue are identified. See *Rose*, *supra* note 15, at 566-69.

112. *Penn Central*, 438 U.S. at 123.

113. See *supra* text accompanying notes 16-17.

114. *Concrete Pipe*, 113 S. Ct. at 2290-92.

115. *Penn Central*, 438 U.S. at 124.

gate the government to pay compensation;¹¹⁶ regulations in the latter category do not.¹¹⁷ Clearly, health care reform legislation falls into the latter category.

The nature of the government regulation at issue is likely to be decisive in regulatory takings cases for reasons that are primarily practical in nature. As discussed in Part I, the Court reviews business regulation deferentially, in part because of its implicit assumption that property owners can protect themselves in the legislative process.¹¹⁸ As argued above, an expansive regulatory takings doctrine is practi-

116. Although a regulation that effects a permanent physical invasion of property or results in a complete diminution in value of land now constitutes a per se taking, *see Lucas*, 112 S. Ct. at 2893, neither one of those conditions would have been dispositive of the takings inquiry under early formulations of the balancing test. *See, e.g., Penn Central*, 438 U.S. at 124 (“A ‘taking’ may more readily be found when the interference with property can be characterized as a physical invasion by the government than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good.” (emphasis added) (citation omitted)). Even where the government regulation does not amount to a per se taking, the Court is influenced in its application of the balancing test by the degree to which governmental action resembles an invasion or physical appropriation of property. *See, e.g., Hodel v. Irving*, 481 U.S. 704, 716-17 (1987) (complete abolition of descent and devise of property may constitute a violation of the Takings Clause); *Webb’s Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 163-64 (1980) (state law making interest from interpleaded funds court property violated Takings Clause).

117. While the Court has been willing to say categorically that certain types of regulatory intrusions constitute takings, *see supra* text accompanying notes 16-17, it has been unwilling to announce categories of regulation that do not amount to takings, as Frank Michelman predicted it might do in 1988:

[T]he Court is finding its open-ended balancing posture hard to maintain and so is moving noticeably towards a reformalization of regulatory-takings doctrine. Doctrine appears to be moving in the direction of resolution into a series of categorical “either-ors:” either (a) the regulation is categorically a taking of property because (i) it works a permanent physical occupation (however practically trivial) of private property by the government . . . or (ii) it totally eliminates the property’s economic value or “viability” to its nominal owner, or (b) the regulation is categorically not a taking.

Michelman, *supra* note 19, at 1622. *Lucas* appeared to confirm Professor Michelman’s prediction, at least with respect to part (a) of his formulation. *See Lucas*, 112 S. Ct. at 2893 (finding that regulations described in (a)(i) and (ii) above are, indeed, per se takings); *see also id.* at 2899 (owner of personal property “ought to be aware of the possibility that new regulation might even render his property economically worthless” (citing *Andrus v. Alford*, 444 U.S. 51 (1979))). Nevertheless, the balancing test reappeared in its traditional form in *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 113 S. Ct. 2264, 2290-92 (1993).

118. *See supra* Part II.A.; *see also Lucas*, 112 S. Ct. at 2894 (noting the Court’s “usual assumption that the legislature is simply ‘adjusting the benefits and burdens of economic life’ in a manner that secures an ‘average reciprocity of advantage’ to everyone concerned” (quoting *Penn Central*, 438 U.S. at 124; *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922))). The fact that isolating the net effects of broad government programs is likely to be difficult may also have encouraged judicial deference. *See supra* Part II.B.

cally inconsistent with the proposition that the legislature, and not the judiciary, should be the primary judge of the wisdom and fairness of economic regulation.¹¹⁹ Accordingly, the Court is sensitive to the need for consistency in the level of protection it gives economic interests in Takings Clause, Due Process Clause, and other constitutional jurisprudence.¹²⁰ The inquiry into the government interest at stake in the challenged regulation is the Court's primary vehicle for maintaining that consistency.

Moreover, compensating all citizens for economic losses they incur as a result of broad-based regulation would create insurmountable administrative burdens.¹²¹ Consider, for example, the costs of permitting individual physicians to make public-utility-style challenges to the adequacy of fees set pursuant to government regulation. Evaluating the reasonableness of government-set prices as applied to individual providers would require a small army of lawyers, economists, and medical consultants even if only a significant minority of physicians were to challenge fee schedules mandated by the government.¹²² And, of course, an interpretation of the Takings Clause that required individual hearings on the adverse effects of health care price regulation could not be easily limited to either price regulation or the health care sector.¹²³ Armed with an expanded interpretation of the Takings Clause, other businesses facing costs imposed by government regula-

119. See *supra* Part I.C.

120. See *Allied Structural Steel v. Spannaus*, 438 U.S. 234, 260 (1978) (Brennan, J., dissenting) ("Decisions over the past 50 years have developed a coherent, unified interpretation of all the constitutional provisions that may protect economic expectations and these decisions have recognized a broad latitude in States to effect even severe interference with existing economic values when reasonably necessary to promote the general welfare."); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 33 (1977) (Brennan, J., dissenting).

121. Cf. *Bowles v. Willingham*, 321 U.S. 503, 517 (1944) (noting that "considerations of feasibility and practicality are certainly germane" to constitutional question whether individualized ratemaking was required).

122. See AMA Memorandum, *supra* note 5, at 21 (suggesting features of price adjustment mechanism for individual physicians); see also *supra* Part II.B (explaining difficulties of determining net effects of government action).

123. See *infra* note 147 and accompanying text (criticizing distinction between price and other regulation). This appears to be the fundamental flaw in the "specific capital" theory proposed by Professor Merrill. The theory gives a helpful account of why some types of price regulation are likely to be more damaging than others. See Thomas W. Merrill, *Constitutional Limits on Physician Price Controls*, 21 HASTINGS CONST. L.Q. 635, 640-41 (1994). Nevertheless, it does not explain why the Takings Clause requires compensation when price regulation results in significant diminution in value of specific capital but does not require compensation where the diminution in value of specific capital results from nonprice regulation. Cf. *Andrus v. Allard*, 444 U.S. 51 (1979) (avian artifacts); *Goldblatt v. Hempstead*, 369 U.S. 590 (1962) (quarry); *Hadacheck v. Sebastian*, 239 U.S. 394 (1915) (brickyard); *Mugler v. Kansas*, 123 U.S. 623 (1887) (brewery).

tion could be expected to argue that cost increases associated with regulatory compliance effectively deprive them of the opportunity to earn a reasonable return on their investments. From a purely administrative perspective, the wisdom of avoiding Takings Clause review of broad-based economic regulation is manifest.

B. Severity of Economic Impact

The second factor in the regulatory takings balancing test is the “economic impact of the regulation on the claimant.”¹²⁴ The Court does not rely heavily on this part of the balancing analysis in deciding cases. Regulations resulting in a complete diminution in value of land are, of course, per se takings.¹²⁵ Anything short of a complete taking, however, is not likely to impress the Court absent other factors. Thus, severe diminutions in value short of “total” takings have been tolerated on a relatively frequent basis.¹²⁶ Indeed, while a threshold showing of some degree of diminution in property value presumably must be made in order to sustain a regulatory takings claim, any showing short of a complete diminution in value is unlikely, by itself to make a difference in the ultimate resolution of the case.¹²⁷

C. Reasonable Investment-Backed Expectations

The third factor in the regulatory takings balancing test considers the “reasonable investment-backed expectations” of the claimant in the devalued property. This factor focuses on both the type of property interest involved and on whether the claimant should reasonably have expected the damaging governmental intervention.¹²⁸ The for-

124. Penn Cent. Transp. Co. v. New York City, 438 U.S. 104, 124 (1978).

125. Lucas v. South Carolina Coastal Council, 112 S. Ct. 2886, 2893 (1993).

126. See Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust, 113 S. Ct. 2264, 2291 (1993) (characterizing regulation at issue in Euclid v. Ambler Realty Co., 272 U.S. 365, 384 (1926), as effecting a 75% diminution in value of the claimant's property; and Hadacheck v. Sebastian, 239 U.S. 394, 405 (1915), as effecting a 92.5% diminution); see also *Andrus*, 444 U.S. at 66 (no taking resulted from prohibition of sale of eagle feathers where claimants “retain[ed] the rights to possess and transport their property, and to donate or to devise the protected birds”).

127. See *supra* note 111.

128. The “reasonable investment-backed expectations” formulation first appeared in *Penn Central*. 438 U.S. at 127 (citing *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393 (1922), “for the proposition that a state statute . . . may . . . frustrate *distinct, investment-backed expectations*” (emphasis added)). The Court likely borrowed the phrase from Michelman's article on just compensation. Michelman, *supra* note 41, at 1233 (diminution in value test asks “whether or not the measure in question can easily be seen to have practically deprived the claimant of some *distinctly perceived, sharply crystallized, investment-backed expectation*” (emphasis added)). It is most unlikely that Michelman intended the phrase to be a launching point for a formalistic inquiry into the “type” of property interest involved.

mer inquiry invites a theoretical formulation of what constitutes "property" for Takings Clause purposes. The Court's decisions can be read to create a hierarchy of protected property interests, beginning with land,¹²⁹ followed (in descending order of protection) by personal property, contract rights, and noncontractual expectations of future profits.¹³⁰

As suggested in Part I's comparison of the economic interests protected under regulatory takings doctrine and those protected under the discredited *Lochner* "liberty of contract" analysis, regulatory takings claims always involve regulatory reduction of the revenues expected from the exploitation of an asset.¹³¹ The economic damage suffered by the claimant would not seem to depend in any important way on whether the underlying asset is real property, equipment, a contract, or the goodwill or know-how of a particular business. Therefore, it is hard to make economic sense of employing categories of property interests to distinguish between takings claims.

The more important aspect of the "reasonable investment-backed expectations" inquiry has to do with whether a regulatory takings claimant should have expected that subsequent regulation might diminish the value of his property.¹³² In any investment, one of the relevant business risks is that government action might affect market conditions. If the claimant should reasonably have foreseen such government action, the case for compensation is weakened. Not surprisingly, this dimension of the "reasonable expectations" inquiry is frequently decisive in cases where the takings plaintiff is doing business in a regulated industry.¹³³ In those cases, the doctrine imposes the risk of additional intervention squarely upon the regulated business.

See id. at 1203 n.79 (criticizing Sax's "definitional" approach to identifying protected interests under the Takings Clause); Sax, *supra* note 41, at 61-64 (defining "property" as "the end result of a process of competition among inconsistent and contending economic values").

129. *See Lucas*, 112 S. Ct. at 2893 (per se protection against physical invasions of land and complete diminution in value of land).

130. *See infra* text accompanying notes 134-39.

131. *See supra* text accompanying notes 25-29.

132. *See, e.g., Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 113 S. Ct. 2264, 2291 (1993); *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 227 (1986); *Pension Benefit Guar. Corp. v. Gray*, 467 U.S. 717, 721 (1984); *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15-16 (1976).

133. *See Concrete Pipe*, 113 S. Ct. at 2291 (quoting *Federal Hous. Auth. v. The Darlington, Inc.*, 358 U.S. 84, 91 (1958) ("Those who do business in the regulated field cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end.")).

As it turns out, however, even the inquiry into the reasonableness of a claimant's perceptions about the risk of additional regulation is not entirely divorced from considerations about the type of property interest at stake. For example, the Court has stated that a regulation eliminating all economic value of personal property is not a per se taking: "by reason of the State's traditionally high degree of control over commercial dealings, [the owner] ought to be aware of the possibility that new regulation might even render his property economically worthless."¹³⁴ Contract rights are also deemed especially susceptible to state regulation. While "[c]ontracts may create rights of property,"¹³⁵ "when contracts deal with a subject matter which lies within the control of Congress, they have a congenital infirmity."¹³⁶ The difficulty with this argument, of course, is that the Court might have said the same thing of land use regulation—namely, that while land is certainly "property," reliance on specific land uses suffers from the "congenital infirmity" of the land-use regulation that state legislatures and the Congress may impose. Judicial definition of what expectations are reasonable is often circular; the reasonableness of any given expectation rises or declines with the Court's decisions.¹³⁷

Noncontractual expectations of future gain in the marketplace are entitled to the lowest level of constitutional protection.¹³⁸ In the health care marketplace, those expectations would include expected revenues from the sale of medical or hospitalization services, among others. These expectancies of future profits do not rest on existing contracts; patients will not yet have engaged physicians to treat specific diseases; health plans and providers may not yet have entered into provider agreements extending past the effective date of pending legislation; insurance policies may not yet have been sold. Even so, part of the business value of affected medical practices, payers, and institutional providers consists of estimates as to future profitability. Such predictions are no doubt fraught with uncertainty, but market participants nevertheless make investments designed to pay off in market share and profitability over the longer term. The fact that no contract may have been formed regarding the future sale of services does not diminish the fact that health care providers' investments in

134. *Lucas*, 112 S. Ct. at 2899.

135. *Connolly*, 475 U.S. at 223 (quoted in *Concrete Pipe*, 113 S. Ct. at 2290).

136. *Id.*

137. See *Lucas*, 112 S. Ct. at 2903 (Kennedy, J., concurring); Richard A. Epstein, *Lucas v. South Carolina Coastal Council: A Tangled Web of Expectations*, 45 *STAN. L. REV.* 1369, 1370-71 (1993).

138. See *Andrus v. Allard*, 444 U.S. 51, 66 (1979).

training and facilities may be significantly damaged by government regulation. Even so, the Court treats such interests in "future profits" as "a slender reed upon which to rest a takings claim."¹³⁹

The most plausible explanation for the Court's rather severe restriction on the types of property interests it will protect against regulatory takings is, again, the Court's apparent unwillingness to undermine legislative prerogatives to regulate economic matters. Land-use regulation affects interests that closely resemble those typically associated with eminent domain proceedings. It is, of course, those proceedings to which the Takings Clause most clearly applies.¹⁴⁰ Personal property, contracts, and business goodwill, on the other hand, are the types of interests most likely to be diminished in value by broad-based economic regulation.

State and federal regulation of health care has been intense, so additional regulation should come as no surprise. Even the dramatic changes that would accompany health care reform could hardly be characterized as unexpected.¹⁴¹ As noted earlier, the fact of preexisting regulation raises a more fundamental problem—locating the market baseline against which the economic effects of governmental regulation should be measured. The cost crisis (and with it the eco-

139. See *Chang v. United States*, 859 F.2d 893 (Fed. Cir. 1988); *Kearney & Trecker Corp. v. United States*, 688 F.2d 780, 783-84 (Ct. Cl. 1982), *cert. denied*, 460 U.S. 1051 (1983).

Professor Merrill argues that a physician who is denied access to an unregulated market might effectively be deprived of his "right to practice medicine," a property interest to which the procedural component of the Due Process Clause would apply. Merrill, *supra* note 123, at 659. Merrill argues that, at a minimum, physicians would be entitled to individual post-deprivation hearings on whether they were entitled to relief from group price controls. Merrill, *supra* note 123, at 660-62. The "right to practice medicine" clearly does mean that a physician has a property interest in his or her professional license, *Dent v. West Virginia*, 129 U.S. 114, 123 (1889), and in certain cases, in medical staff privileges. See *Lowe v. Scott*, 959 F.2d 323, 335-36 (1st Cir. 1992). However, it is far from clear that the "right to practice medicine" includes the right to practice medicine in an unregulated market. Cf. *Nebbia v. New York*, 291 U.S. 502, 527-28 (1934) (upholding price controls on milk and rejecting the idea that the Constitution "guarantee[s] the unrestricted privilege to engage in a business or to conduct it as one pleases"); *Faucher v. Rodziewicz*, 891 F.2d 864, 869 (11th Cir. 1990) (economic value of staff privileges is not a protected property interest).

140. Cf. *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 441 (1982) (noting that in the case of a permanent physical occupation of property, "the property owner entertains a historically rooted expectation of compensation, and the character of the invasion is qualitatively more intrusive than perhaps any other category of property regulation").

141. At least since the end of World War II, politicians have regularly proposed government-intensive comprehensive health care reform. See STARR, *supra* note 73, at 280-90, 363-78, 393-405.

conomic success of the medical profession and other health care businesses) can be attributed in large part to government involvement in the health care sector. For the last fifty years, most government intervention in the health care sector has enhanced the economic interests of health care providers.¹⁴² Many, though not all, of the cost-containment problems experienced in American health care can be attributed to these government actions. To be sure, the industry has come to rely on government cooperation, and significant capital investments have been made on the basis of the expectation of the continuation of the status quo. In fairness, however, players in an industry that has sought and accepted so much government protection and largesse cannot claim a constitutional entitlement to the perpetual continuation of gains previously won in the legislature. Nor should they expect the Constitution to prevent legislative actions to remedy the perceived negative effects of such programs.

IV. Health Care Price Controls and the Public Utility Cases

A. The Significance of Public Utility Status

Some courts reviewing takings claims based on price regulation have concluded that the balancing test discussed above should not be applied.¹⁴³ Instead, they have employed the "fair and reasonable re-

142. See *supra* notes 50-54 and accompanying text.

143. Some cases appear to assume price regulation amounts to a per se taking in the absence of mitigating factors such as the presence of an important government interest, see *Bowles v. Willingham*, 321 U.S. 513, 519 (1944); *Western States Meat Packers Ass'n v. Dunlop*, 482 F.2d 1401 (Temp. Emer. Ct. App. 1973); *International Bhd. of Elec. Workers v. Boldt*, 481 F.2d 1392 (Temp. Emer. Ct. App. 1973); *Minden Beef Co. v. Cost of Living Council*, 362 F. Supp. 298 (D. Nev. 1973), limited duration of the controls, see *Block v. Hirsch*, 256 U.S. 135, 157 (1921); John N. Drobak, *Constitutional Limits on Price and Rent Control: The Lessons of Utility Regulation*, 64 WASH. U. L.Q. 107, 118-19 (1986); but see *First English Evangelical Lutheran Church v. County of Los Angeles*, 482 U.S. 304 (1986) (requiring compensation for temporary taking), or the ability of the regulated firm to withdraw from the market, see *Bowles*, 321 U.S. at 517; *Garellick v. Sullivan*, 987 F.2d 913, 916 (2d Cir. 1993); *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986); *Minnesota Ass'n of Health Care Facilities v. Minnesota Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985); Drobak, *supra*, at 119-22; Walter Pond, *The Law Governing Public Utility Rates: A Response to Recent Judicial and Academic Misconceptions*, 41 ADMIN. L. REV. 1, 5 (1989).

Recent cases rejecting the applicability of the "reasonable return" standard of price regulation have tended to regard the regulated party's ability to withdraw from the regulated market as dispositive. See, e.g., *Garellick*, 987 F.2d at 913; *Whitney*, 780 F.2d at 963. The U.S. Supreme Court case most often cited in connection with such a view is *Bowles*. While *Bowles* does rely in part on the regulated party's ability to withdraw from the market, it does so in reliance on *Wilson v. Brown*, 137 F.2d 348 (Emer. Ct. App. 1943). *Wilson* suggests that the decisive distinction is whether the regulated party is a public utility. *Id.* at 351-52; Drobak, *supra*, at 114 n.28; see *infra* note 148.

turn" standard used by the Court to review public utility ratemaking under the Takings Clause.¹⁴⁴ Under the fair and reasonable return standard, public utility regulators must set rates at a level that allows the utility to recoup its reasonably and prudently incurred costs plus a reasonable rate of return; otherwise, the rate is held to constitute a taking.¹⁴⁵ Other courts have applied neither the balancing test nor the fair and reasonable return standard, holding instead that price regulation can never effect a taking as long as the regulated parties are legally free to abandon the market.¹⁴⁶

Cases automatically applying the fair and reasonable return standard to all types of price regulation and those rejecting the possibility of a taking where the regulated party can withdraw from the market are both mistaken because they take the fact of price regulation, by itself, to be of signal importance. Price regulation, however, is largely indistinguishable from nonprice regulation in terms of both economics and of legal doctrine. The economic well-being of a seller of goods or services may be affected equally by either type of regulation. Price regulation limits the amount of revenue the seller can obtain for his goods or services. Nonprice regulation increases the seller's expenses (for example, by mandating quality standards). In either case the seller will attempt in the first instance to pass along the cost of the regulation to the buyer—perhaps by reducing the quality of the product in the case of price regulation, or, in the case of regulation increasing the seller's expenses, by raising the price. And in either case, the regulation might make it impractical for the seller to sell goods or services at all. The damage done to the seller's property interests in each case is constitutionally indistinguishable. There is no reason to assume *ex ante* that price regulation is a greater burden on a business

144. See *Guaranty Nat'l Ins. Co. v. Gates*, 916 F.2d 508 (9th Cir. 1990) (holding that Nevada rate rollback statute was unconstitutional because statute failed to include a procedure for contesting confiscatory rates); see also *Fisher v. City of Berkeley*, 693 P.2d 261 (Cal.), *aff'd*, 475 U.S. 260 (1986) (rent control statute that allowed reasonable return was constitutional). But see *Fireman's Fund Ins. Co. v. Garamendi*, 790 F. Supp. 938, 950-51 (N.D. Cal. 1992) (explaining that *Guaranty National* was decided primarily on procedural due process grounds); see also *Birkenfield v. City of Berkeley*, 550 P.2d 1001 (Cal. 1976) (holding that rent control was within state's police power if the regulation was reasonably calculated to eliminate excessive rents and at the same time provide landlords with just and reasonable return on their property). As a practical matter, the "fair and reasonable return" standard, even if applied, does not provide great protection for regulated parties. See *Pierce*, *supra* note 46, at 2031 (noting that *Federal Power Comm'n v. Hope Natural Gas Co.*, 320 U.S. 591 (1944), has been "widely interpreted as a de facto withdrawal" by the judiciary from ratemaking oversight).

145. *Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989); *Hope*, 320 U.S. at 591.

146. See *supra* note 143.

than is nonprice regulation, and, accordingly, no reason to create separate constitutional standards for its review.¹⁴⁷

Instead, the "reasonable return" standard is appropriately employed in lieu of the traditional balancing test only when the regulated entity is a public utility; it is the nature of the utility enterprise and of utility regulation, and not the presence of price controls, that is constitutionally significant.¹⁴⁸ Public utility regulation merits close scrutiny

147. The Supreme Court recognized this fact as early as 1934:

The thought seems . . . to have persisted that there is something peculiarly sacrosanct about the price one may charge for what he makes or sells, and that, however able to regulate other elements of manufacture or trade, with incidental effect upon price, the state is incapable of directly controlling the price itself. This view was negated many years ago. . . .

Price control, like any other form of regulation, is unconstitutional only if arbitrary, discriminatory or demonstrably irrelevant to the policy the legislature is free to adopt, and hence an unwarranted interference with individual liberty.

Nebbia v. New York, 291 U.S. 502, 539 (1934); see also *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 223 (1986) (including price controls in general category of routinely-created acts "regulating commercial and other human affairs"); cf. *Merrill*, *supra* note 123, at 663-665 (discussing the circumstances under which government regulation amounts to a "price control").

148. See *Duquesne*, 488 U.S. at 307 (noting the "partly public, partly private" nature of public utility property); *Smyth v. Ames*, 169 U.S. 466, 522-26 (1898) (rate regulation could deprive carrier of its property); see also *Wilson v. Brown*, 137 F.2d 348, 351-52 (Emer. Ct. App. 1943) ("[W]e are satisfied that principles derived from the law of eminent domain are not the proper constitutional criterion for determining the validity of a nation-wide program of price and rent control enacted by Congress under its war powers. In the case of public utilities there is an extensive and permanent regulation of the use of the properties in the public interest, of which the regulation of rates is only a part. The situation more nearly approaches a 'taking' of the properties, or the use thereof, than in the case of wartime rent regulation." (cited in *Bowles*, 321 U.S. at 517)).

The Court's decision in *The Permian Basin Area Rate Cases*, 390 U.S. 747 (1968), is consistent with the statement in the text. The independent natural gas producers whose rates were at issue in *Permian Basin* were not public utilities. Nevertheless, the Court's apparent use of the *Hope* doctrine to evaluate their claim is readily explainable. The Court divided its analysis of the constitutional status of the price controls in *Permian Basin* into three parts: (1) whether the legislature has the power to impose price controls, *id.* at 768-69; (2) whether there is any constitutional obstacle to group, as opposed to individualized, ratemaking, *id.* at 269-70; and (3) whether the rates might amount to a taking. *Id.* at 770.

The first two issues deal primarily with the limits, if any, the substantive component of the Due Process Clause imposes on price regulation. Under the Due Process Clause, a legislature or agency may engage in price regulation. *Id.* at 768. Price regulation is not invalid per se under either the Due Process Clause or Takings Clause, *id.* at 769, but the ratemaking body must have before it information sufficient to permit it to have some rational basis for the rates it sets. *Id.* Further, the rates may be neither "arbitrary, discriminatory, or demonstrably irrelevant to the policy the legislature is free to adopt . . ." *Id.* at 769-70 (quoting *Nebbia*, 291 U.S. at 539). The third part of the analysis (relating only to the Takings Clause) is unusual because the gas producers, while themselves not public utilities, were regulated under the Natural Gas Act. In a case involving a public utility, the Court had already concluded that rates made pursuant to the requirements of the Natural Gas Act were adequate under the Takings Clause. *Id.* at 770 (citing Federal Power

because of its intensity and the virtual appropriation of private utility property into public service.¹⁴⁹ As a result, judicial analysis proceeds directly to the compensation issue; that is, whether the utility is receiving a fair return.¹⁵⁰

Public utility ratemaking, then, may aptly be characterized as an additional per se category in regulatory takings analysis.¹⁵¹ The extensive regulatory and service requirements imposed on public utilities verge on a physical taking of the utility's plant and other property and are easily analogized with traditional concerns about state "appropriation" of property. Moreover, limiting per se treatment to the category of public utilities permits oversight of public utility rates without infringing upon the legislature's general authority to set economic policy in broader contexts.¹⁵² Such oversight may be especially appropriate because individual utilities may be substantially more likely to be singled out in the legislative process than an entire industry. Also, providing individual review of decisions affecting public utilities, which are usually monopolists in their respective service areas, does not

Comm'n v. Natural Gas Pipeline Co., 315 U.S. 575, 586 (1942)). There was thus no need to reach the substantive issue of whether non-utility price regulation constituted a taking in the case at bar. If the rates for the independent natural gas producers were made in conformity with the Natural Gas Act, they would be constitutionally sufficient in any event.

149. While there is no precise definition of what constitutes a public utility, several characteristics are frequently associated with public utility status: (1) economies of scale, (2) the provision of an "essential" service, (3) heavy capital requirements, (4) production of services or nonstorable goods, (5) demand and cost fluctuation, (6) exclusive franchises, and (7) the obligation to supply services to anyone willing to pay the price. JAMES C. BONBRIGHT ET AL., PRINCIPLES OF PUBLIC UTILITY RATES 8-10 (1988). Regulated aspects of public utilities include "[p]rices; entry and exit; new, extended or abandoned service offerings; service standards; financial structure; accounting methods, and a host of other elements." *Id.* at 6.

Using these rough characteristics as a guide, one might not be surprised to find that hospitals in a jurisdiction that regulated prices and controlled entry into the market through certificate of need and other programs could be classified as "public utilities." Indeed, most hospital ratemaking appears to be based on a public utility model, frequently guaranteeing the hospital a "fair and reasonable return" as a statutory matter. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2803(2)(a)(ii) (McKinney 1985 & Supp. 1993) (rate schedule "shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities"). Where a regulating agency has complied with a statutory scheme designed to ensure a fair and reasonable return, a regulated hospital is unlikely to be able to get a court to second-guess ratemaking on constitutional grounds. *See Hope*, 320 U.S. at 606-07.

150. *See Duquesne*, 488 U.S. at 308 (taking occurs "[i]f the rate does not afford sufficient compensation").

151. *See id.* at 307 ("This partly public, partly private status of utility property creates its own set of questions under the Takings Clause of the Fifth Amendment.").

152. *See Pierce*, *supra* note 46, at 2031 (characterizing the *Hope* doctrine as withdrawal of judicial scrutiny).

place an impossible administrative requirement on the other branches of government.¹⁵³

B. Price Regulation of Entities Other than Public Utilities

The question remains, however, as to how price regulation of firms other than public utilities should be analyzed. As noted above, a significant number of cases appear to hold that price regulation can never amount to a regulatory taking where the parties are legally free to abandon the regulated market.¹⁵⁴ Under this view, if price regulation is valid under substantive due process scrutiny, the Takings Clause would not impose any additional obstacle to its implementation.

It is hard to imagine a plausible theoretical justification for the idea that, unlike other forms of broad-based economic regulation, price controls could never amount to a regulatory taking where the regulated party is free to abandon the market.¹⁵⁵ Price regulation is as likely to inflict economic damage on regulated parties as nonprice regulation. While nonprice regulation (outside the per se categories) is rarely found to offend the Takings Clause, the Court has nonetheless declined to hold categorically that it never results in a taking, even where parties are legally free to abandon the regulated market. Price controls merit similar treatment.¹⁵⁶

153. See *The Permian Basin Area Rate Cases*, 390 U.S. 747, 767 (1968) (administrative difficulties legitimate grounds under constitutional analysis); *Bowles v. Willingham*, 321 U.S. 503, 517 (1944).

154. See cases cited *supra* note 143.

155. Some courts have been understandably skeptical that a party's legal ability to withdraw from the regulated market should be constitutionally decisive. See *Guaranty Nat'l Ins. Co. v. Gates*, 916 F.2d 508 (9th Cir 1990); *Calfarm Ins. Co. v. Deukmajian*, 771 P.2d 1247 (Cal. 1989); *Aetna Casualty & Sur. Co. v. Commissioner of Ins.*, 263 N.E.2d 698 (Mass. 1970); *Hutton Park Gardens v. Town Council*, 350 A.2d 1, 14-15 n.9 (N.J. 1975); see also *Drobak*, *supra* note 143, at 123-30 (suggesting that where a firm has invested in specialized assets which cannot be readily converted to other uses, economic theories of opportunistic behavior suggest that the "reasonable return" standard should apply). Undoubtedly, the fact that a public utility is statutorily required to continue providing service despite unfairly low prices has been a significant factor in judicial decisions treating utility rate regulation as a per se taking. See *Duquesne*, 488 U.S. at 307; *Bowles*, 321 U.S. at 513. Nevertheless, the fact that price controls generally do not constitute a per se taking, see *Yee v. City of Escondido*, 112 S. Ct. 1522, 1531 (1992); *Pennell v. City of San Jose*, 485 U.S. 1, 13 (1988); *FCC v. Florida Power Corp.*, 480 U.S. 245, 252 (1987), does not necessitate a conclusion that they could never amount to a regulatory taking. See *Merrill*, *supra* note 123, at 647 (arguing that *Yee* and *Pennell* are inconsistent with the "legal obligation" theory).

156. See *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 223 (1986); *Hope*, 320 U.S. at 601 ("The fixing of prices, like other applications of the police power, may reduce

Despite the flaws in their reasoning, cases holding that price regulation can never effect a taking when the regulated party is free to leave the market are easily understandable in practical terms. The Supreme Court's general unwillingness to use the Takings Clause to invalidate broad-based business regulation is well-known. As argued above, the main reason for the Court's decisions is to avoid threatening legislative prerogatives.¹⁵⁷ Cases that simply dismiss takings challenges to price controls outside of the public utilities context are likely to be consistent in result, if not in reasoning, with those that rely on ad hoc balancing. Regardless of how the decision is framed, the Court has consistently refused to find that price controls outside the context of utility ratemaking amount to regulatory takings.¹⁵⁸ On the other hand, since other types of broad-based regulation are not immune from Takings Clause scrutiny, price regulation should not be automatically validated merely because the claimant is legally free to abandon the market.

Conclusion

The balancing test employed in regulatory takings cases suggests that takings claims by health care providers based on the imposition of price controls are unlikely to be successful. The economic interests of providers so strongly resemble those the *Lochner*-era Court protected from regulation in the name of "liberty of contract" that today's Court could not find a regulatory taking without resurrecting the political conflicts that led it to abandon *Lochner* in the first place. Moreover, there is little practical cause for worry that providers are being "unfairly singled out" in Congress' zeal to make things better for society. Given the political clout of those who stand to lose from health care reform and their remarkably successful track record in Congress and state legislatures, the political process seems likely to allocate social benefits and burdens fairly over the long haul.

Even if it were desirable to subject health care price controls to judicial review, it would be an impossible task. The impact of price controls and other features of health care reform legislation would have to be weighed against offsetting beneficial features of reform legislation. Just as important, perceived adverse effects should be evalu-

the value of the property which is being regulated. But the fact that the value is reduced does not mean that the regulation is invalid.").

157. See *supra* Part I.C.

158. See, e.g., *Yee*, 112 S. Ct. at 1522; *Pennell*, 485 U.S. at 1; *Bowles*, 321 U.S. at 503; *Block v. Hirsch*, 256 U.S. 135 (1921).

ated in light of market trends that might have resulted in similar economic difficulties for providers and in light of government actions that previously benefited them. The difficulty of making such judgments counsels for judicial caution in overruling the decisions of representative bodies, especially since patients have a stake in a smoothly functioning health care system. If price controls so restrict the economic opportunities of providers that patient care is compromised, there should be adequate political incentives available to resolve inequities.

This is not to say that the arguments against health care price controls as policy should not be taken seriously. Depending on the level at which prices are set, price controls may produce results that are unsettling not only to health care providers but to patients as well. If the Court holds firm to modern constitutional doctrine, however, it will leave questions as to the wisdom and fairness of health policy, including price controls, to the elected branches of government.