Georgia Certificate of Need: An Overview of a Complex Regulatory Structure

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Hospital competition has become an increasingly apparent evil for many hospitals in today's national health care market. Competition in an industry is usually good for pricing and quality of service, however, these hospitals are facing competition that differs dramatically from competition in other industries. Hospitals face competition from within. The very doctors that hospitals rely on for a majority of their referrals are competing for the most profitable procedures. Physician-owned specialty hospitals are allegedly skimming off profitable procedures as physician-owners refer the more costly patients to general hospitals.[1] General hospitals claim that, by focusing on patients with less severe cases, treating fewer Medicaid patients, failing to provide emergency services, and concentrating on certain highly reimbursed diagnosis related groups (DRGs), these specialty hospitals are maximizing profit at the expense of general hospitals.[2]

At the same time, Georgia's healthcare industry is enthralled in another legislative battle. After an overwhelming victory in the 2004 general election, Georgia Republicans held a majority for the first time in many years. They did not waste time in enacting their agenda; in the 2005 session of the General Assembly, legislators again argued over whether tort reform was required to slow the increases in healthcare costs claimed to be tied to malpractice suits. The debate was resolved on February 15, 2005, when Senate Bill 3 was signed into law. Now legislators have turned their attention to another portion of Georgia law in an effort to control health care costs: the Certificate of Need (CON) program. However, this battle differs from the last because it pits the same people against each other who so recently fought together to bring about change: physicians and hospitals.

Currently, Georgia does not have the same problems with physician-owned specialty hospitals as other states because Georgia's CON process requires these specialty hospitals to obtain state approval prior to their creation. Non-profit hospitals claim eliminating the CON process will enable physician-owned specialty hospitals to enter the market, thus spelling financial disaster for non-profit hospitals and leading to decreased access for Georgians. Therefore, they wish to keep, and even strengthen, the CON process. In contrast, physicians believe that allowing Georgia's health care industry to enter into a free-market system, like other industries, will lower health care costs. Therefore, physicians would rather eliminate, or at least amend, the CON process.

This debate will rage throughout the 2007 legislative session and into future sessions. Not even a full four weeks into the session, the debate rose to the forefront of the legislative agenda. This debate promises to provide the citizens of Georgia an opportunity to witness legislative jockeying not unlike that of two years ago during the controversial Tort Reform effort.

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[1] *Specialty Hospitals; Information on National Market Share, Physician Ownership, and Patients Served*, GAO Report, GAO-03-683R (April 2003) (hereinafter GAO Market Share Report)

[2] Medicare Payment Advisory Committee, Report to Congress: Physician-Owned Specialty Hospitals, 28 (March 2005) (available at http://www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf) (hereinafter MedPAC Report)

I. Certificate of Need

In 1975, the National Health Planning and Resources Development Act was passed primarily in an attempt to slow increases in the cost of health care.[3] This act created funding for the administration of CON programs to participating states and conditioned the receipt of other funds to assist in construction and modernization of health facilities on state enactment of CON review legislation.[4] The purpose of a CON program is to insure the availability of adequate health services to meet the needs of a state's citizens, while safeguarding against the unnecessary duplication of services that perpetuate the costs of healthcare.[5] CON programs generally require the state agency in charge of the program to analyze the market need for the proposed facility or service prior to authorizing such a project.[6] If a favorable determination is made by the state agency, a certificate is issued allowing the project to move forward.[7]

a. The Unnecessary Expansion Phenomenon

The main rationale behind restricting entry into the healthcare industry stems from the belief that owners of health care facilities have a tendency to engage in unnecessary expansion of facilities and services.[8] This expansion is due in part to the unique characteristics of the industry's competition.[9] Unlike other industries, competition between hospitals arguably does not reduce costs because hospitals do not compete for patients.[10] Instead, they compete for physicians because physicians usually determine to which hospital a patient is referred.[11]

Patients rely on physicians for this advice and advice as to what procedures are medically necessary because they lack the expertise of a physician.[12] The competition for physicians encourages hospitals to purchase high technology equipment and offer sophisticated services without sufficient regard to projected utilization rates.[13] This increase is compounded by the fact that many patients have insurance and, therefore, may only pay deductibles or co-pays, leaving little incentive to question costs or react to cost increases.[14] Health care facilities also are insufficiently deterred from incurring these expansion costs because of the "fee-for-service" payment system.[15]

i. The Fee-for-Service Payment System

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[3] 42 U.S.C. 300k *et seq.* (repealed), 93 P.L. 641, 88 Stat. 2225
[4] *Id*. at 300m-4, 300o
[5] *Certificate of Need, Frequently Asked Questions*, Office of General Council, Georgia Department of Community Health (March 25, 2005) (available at http://dch.georgia.gov/vgn/images/portal/cit_1210/2/53/32470863CON_FAQ_Review_Guide.pdf)
[6] *See, e.g.,* Ga. Code Ann. §31-6-40 (2006)
[7] *Id.*
[8] Scott D. Makar, Antitrust Immunity Under Florida's Certificate Of Need Program, 19 Fla. St. U.L. Rev. 149, 155 (1991) (hereinafter Antitrust Immunity)
[9] Statewide Health Coordinating Council v. General Hospitals of Humana, Inc., 660 S.W.2d 906 (1983)
[10] *Id.*
[11] *Id.*
[12] Mark E. Kaplan, An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change, 19 Fla. St. U.L. Rev 475, 481-482 (1991) (hereinafter Economic Analysis)
[13] *Id.*; See also, Antitrust Immunity, *supra*, note 8, at note 50
[14] Economic Analysis, *supra*, note 12, at 481; Antitrust Immunity, *supra*, note 8, at note 50
[15] Patrick John McGinley, Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System, 23 Fla. St. L. Rev. 141, 151 (1995) (hereinafter Beyond Reform)

"Fee-for-service" payment arrangements were the dominant method of payment in the health care industry at the time of the federal CON mandate.[16] After the patient received care, the health care provider billed the payor based on the provider's costs accrued in rendering the service.[17] These costs included amounts for overhead such as capital expenditures for new technology or facilities and operating costs in general.[18] These costs were ultimately passed to the public through higher insurance premiums or higher Medicare and Medicaid taxes.[19] Therefore, providers were able to expend capital resources for projects without bearing the brunt of the related costs.[20] However, this would soon change.

Four years after the enactment of the federal law mandating CON, Congress reversed its position and repealed its CON mandate.[21] Allegedly, CON failed to reduce the nation's aggregate healthcare costs and had detrimental effects on local communities.[22] However, many states, including Georgia, continued their regulation of health facilities through CON.[23] Some states have recently begun repealing state regulation amid debate over whether CON has had the desired effect.[24]

Opponents of CON programs claim that changes in healthcare payment systems since the inception of the CON process have eliminated the need for such programs.[25] Changes in the health care market have forced health care providers to contain costs and become more efficient.[26] The "prospective payment system" (PPS) has replaced the retrospective "fee-for-service" payment system.[27]

ii. The Prospective Payment System

Under the PPS, the Centers for Medicare and Medicaid Services (CMS) has created more than 500 DRGs classified according to the clinical diagnosis of the patient and procedures performed.[28] CMS assigns each DRG a "relative weight" that corresponds to the relative costliness of typical patients in that group.[29] CMS then sets a national base payment amount per discharge which represents what Medicare will pay for a case with a relative weight of 1.0.[30] These relative weights can be adjusted in exceptionally costly

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[16] *Id.* at 150
[17] *Id.* at 151
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *See* Health Planning and Resources Development Amendments of 1979, 96 P.L. 79, §§ 1-129, 93 Stat. 592 (1979) (codified at 42 U.S.C. §§ 300k *et seq.*); *see also* 99 P.L. 660, § 701, 100 Stat. 3743, 3799 (1986) (repealing the Health Planning and Resource Development Act of 1974)
[22] *See* Beyond Reform, *supra*, note 15, at 157
[23] *See e.g.,* Ga Code Ann. § 31-6-1 *et seq.* (2006); Alaska Stat. § 18.07.021 *et seq.* (2006); 16 Del. C. § 9301 *et seq.* (2006) (repealed effective June 30, 2009); Ky. Rev. Stat. Ann. §§ 216B.010-.310 (Baldwin 2006); Miss. Code § 41-7-171 *et seq.* (2006); Mont. Code Ann. § 50-5-301 *et seq.* (2005)
[24] *See e.g.* 16 Del. C. § 9301 *et seq.* (2006) (repealed effective June 30, 2009); Ind. Code Ann. § 16-29-1-1 *et seq* (2006) (expired by its own terms on July 1, 1998, pursuant to IC 16-29-1-16, and repealed by P.L.1-2001, § 51, effective July 1, 2001); Kan. Stat. Ann. 65-4802 *et seq.* (2006) (repealed July 1, 1997); *See also* Beyond Reform, *supra*, note 15, at 159
[25] *See e.g.,* Economic Analysis, *supra*, note 12, at 484
[26] *See id.* at 485-487
[27] *See e.g.,* 42 C.F.R. § 412.1 *et seq.* (2006); Economic Analysis, *supra*, note 12, at 484
[28] *See e.g.,* 42 C.F.R. § 412.60 (2006); MedPAC Report, *supra*, note 2, at 28
[29] *Id.*
[30] *See* 42 C.F.R. § 412.64 (2006); MedPAC Report, *supra*, note 2, at 28

cases, or "outlier cases," where, because of particular patient circumstances, large losses would be incurred by the hospital.[31] The base payment amount is adjusted by factors, including primarily a wage index, that account for differences in input costs that hospitals have to pay in the local markets.[32] The DRG payment rate is thereafter determined by multiplying the adjusted national payment by the relative DRG weight.[33] This payment rate, however, can also be increased to reflect the hospital's status as a teaching hospital and/or a hospital's treatment of a disproportionate share of low-income patients.[34]

Therefore, unless the patient is considered an "outlier" case, the payor pays the same amount for the treatment of each patient/beneficiary in that particular DRG regardless of the amount of resources that the health care provider uses in rendering the service or treatment.[35] Outlier cases, however, typically only occur in high-cost DRGs because large losses are more likely to occur where average cost per case is high.[36] This technique of uniform prospective payment discourages unnecessary expansion of facilities and services by limiting the effect of those costs on the payment rate.[37] The PPS, therefore, encourages hospitals to operate more efficiently through utilization of only those resources that are medically necessary for the patient.[38]

iii. Managed Care

The entry of managed care also affects efficiency and cost in the health care market.[39] Not only do managed care companies generally utilize a similar prospective reimbursement system, they characteristically control costs by negotiating with providers; exchanging access to a patient referral source for discounted rates.[40] In addition, managed care companies have limited the unilateral decision-making authority of health care providers by requiring pre-approval of non-emergent care and/or post-care review to determine the medical necessity of the service provided.[41]

b. Other Concerns

Opponents of CON programs also contend that CON regulations are ineffective and possibly counterproductive in promoting efficient health care markets.[42] By restricting entry into the market, competition is reduced and therefore there is little incentive for the market participants to utilize innovative and/or more efficient techniques.[43] Opponents also argue that the CON regulatory process protects incumbent firms from competition and innovation because new entrants have the burden of demonstrating that a current unfulfilled need exists in the marketplace.[44] Of course, this burden also lies with existing providers; however, they are in a much better position to

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[31] *See e.g.* 42 C.F.R. § 412.112 (2006); 42 C.F.R. § 412.80 (2006) MedPAC Report, *supra*, note ___, at 28
[32] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28
[33] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28
[34] *See* 42 C.F.R. § 412.64; MedPAC Report, *supra*, note 2, at 28
[35] *See* 42 C.F.R. § 412.80; Economic Analysis, *supra*, note 12, at 484-485.
[36] MedPAC Report, *supra*, note 2, at 28
[37] *See* Economic Analysis, *supra*, note 12, at 484-485
[38] *See id.*
[39] *Id*. at 485-486
[40] *Id*. at 486
[41] *Id.*
[42] Antitrust Immunity, *supra*, note 8, at 155
[43] *Id.* at 155-156 (citing Federal Trade Commission and the Department of Justice, Improving Healthcare: A Dose of Competition (July 2004))
[44] *Id.* at 156

fill that need because they already exist in the market and could provide these services with fewer capital expenditures. This burden reduces the possibility of entry by more efficient firms which would provide higher quality and/or lower cost services and, possibly, replace the less efficient firms.[45]

c. Studies

Proponents argue that CON has had the desired effect on containing healthcare costs since its inception in the mid-seventies.[46] A number of studies, however, have found that CON programs are ineffective in controlling costs and may adversely impact the quality of health care services.[47] In one comparison of health care prices and expenses, findings showed that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON.[48]

i. Washington Joint Legislative Audit and Review Committee

A report published by the State of Washington Joint Legislative Audit and Review Committee found that CON is not an effective mechanism for controlling overall per capita health care spending because of the numerous factors contributing to health care costs that are not covered by CON.[49] CON programs generally cover capital expenditures.[50] One of the primary areas CON regulates is bed supply.[51] This report noted that when bed supply was controlled, cost per bed tended to increase because often hospitals increased expenditures in other areas not covered by CON.[52]

Although supply of services has been restrained in some parts of the country, it is unclear whether supply of services is affected by CON repeal.[53] Not all states that have repealed CON have seen surges in supply of those services left unregulated.[54] However, there has been evidence of surges in some states after CON repeal: psychiatric and nursing homes in Utah, nursing homes and open heart surgery in Arizona, home health agencies in Tennessee, and hospitals, ambulatory surgery centers, dialysis, and pediatric services in Ohio.[55] Nonetheless, these surges tend to moderate over time.[56]

ii. FTC/DOJ Joint Report

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[45] *Id.* (citing FTC Letter from John M. Mendenhall to the Honorable John F. Pressman and the Honorable Donald W. Snyder (Mar. 30, 1988))

[46] Citizens Research Council of Michigan, The Michigan Certificate of Need Program, 59 (February 2005) (hereinafter Michigan Study)

[47] Vickie Yates Brown, Barbara Reid Hartung, Andrew J. Murray & Tate M. Bombard, Kentucky Law Issue: Health Care Reform in Kentucky - Setting the Stage for the Twenty-First Century?, 27 N. Ky. L. Rev. 319, nt 48 (2000) (citing William Custer, Certificate of Need Regulations and the Health Care Delivery System, Research Report No. 97-1, Georgia State University Center for Risk Management & Insurance Research (1997); Kentucky Cabinet for Health Services, A Report on Certificate of Need in Kentucky, Health Policy & Analysis Research Branch, Certificate of Need Office (June 12, 1997))

[48] Economic Analysis, *supra*, note 12 at 478

[49] State of Washington Joint Legislative Audit and Review Committee, Effects of certificate of Need and its Possible Repeal, Report 99-1 (1999) (hereinafter Washington Audit)

[50] *See, e.g.,* Ga. Code Ann. §31-6-40

[51] *See e.g. id.*

[52] Washington Audit, *supra,* note 49, at 10 (citing Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of* Health Politics, Policy, and Law, Vol. 23, No. 3, June 1998)

[53] *Id.* at 11

[54] *Id.*

[55] *Id.*

[56] *Id.*

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have jointly concluded that, on balance, CON programs are not successful in containing health care costs.[57] Their report stated that CON programs pose serious anti-competitive risks that usually outweigh their purported economic benefits.[58] Market incumbents can too easily forestall competitors from entering the market by filing objections to a CON application.[59] This report noted that CON programs increase prices by fostering anticompetitive barriers.[60]

However, a leading non-profit supporter of CON, the American Health Planning Association (AHPA), rebutted the findings of the FTC/DOJ report as "doctrinaire posturing".[61] The AHPA claims that the content of the report was expected given the FTC's longstanding opposition to the CON programs.[62]

> Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.[63]

The AHPA instead cite as more reliable three studies that generally favor CON.[64] These three studies 'try to discern quality effects of CON regulation," instead of being regression or correlation studies that do not demonstrate or explain cause and effect.[65]

iii. The Automakers Report

The three studies cited by AHPA as being more reliable are those of the major American automobile manufacturers: Ford, Daimler-Chrysler, and General Motors.[66] These studies focused on a smaller group instead of the "macro-level" analyses that are more difficult to decipher because of states' differing benefit plans, varying demographics, and health status of the populations.[67] Each manufacturer conducted studies of relative costs per employee in states where they have significant employee

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[57] Federal Trade Commission and the Department of Justice, Improving Health care: A Dose of Competition (July 2004)
[58] *Id.* at 22
[59] *Id.*
[60] *Id.*
[61] American Health Planning Association, The Federal Trade Commission & Certificate of Need Regulation, An AHPA Critique (January 2005) (hereinafter AHPA Critique) (available at http://www.ahpanet.org/files/AHPAcritiqueFTC.pdf)
[62] AHPA Critique, *supra,* note 61, at ___.
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] Michigan Study, *supra* note 46, at 34

presence.[68] Whereas other studies do not take into account state differences, these studies allegedly were comparing similar demographics in each state because of the manufacturers' tendency to employ similar employees regardless of the state.[69] Further, employee benefits do not differ from state to state.[70]

Each of these studies concluded similar results.[71] Indiana and Ohio, states that have eliminated CON programs, consistently had the highest relative costs.[72] Michigan, a state with a CON program, consistently had one of the lowest costs.[73]

II. Georgia's CON Commission

Now, it is Georgia's turn to examine the economic effect of eliminating its CON program. In 2006, the General Assembly created the State Commission on the Efficacy of the Certificate of Need Program (the Commission).[74] The Commission's purpose was to study and collect information and data relating to the effectiveness of the CON program in Georgia.[75] The Commission studied and evaluated the effectiveness and efficiency of Georgia's certificate of need program by reviewing the costs associated with the program, the benefits of continuing or discontinuing the program, the financial impact of continuing or discontinuing the program, and the impact on the quality, availability, and cost of health care if the program is continued or discontinued.[76] The Commission also evaluated and considered the experiences and results in other states that use CON programs.[77] A final report was to be issued, including proposed legislation, if any, to the Governor and the General Assembly on or before June 30, 2007.[78] However, as discussed below, the Commission wasted no time in publishing the report.

a. Final Report

On December 29, 2006, the Commission released its Final Report to the Georgia General Assembly and Governor Perdue. This report is an important document for the forthcoming legislative battle over Georgia's CON program. This report highlights for the healthcare community the issues that will be most controversial during the legislative session and provides readers with an inside look at what may be on the legislative horizon.

The majority of the recommendations within the report were unanimously decided with the three *ex officio* members abstaining. The recommendations not only focus on streamlining the review, appeals, and opposition process, but will increase sanctions for failures to comply with the CON guidelines. If the recommendations are followed, statutory fines for failure to obtain a CON would increase to $5,000 per day for the first month, $10,000 per day for the second month, and $25,000 per day for subsequent months. Further, the recommendations permit fines for failure to provide annual and

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[68] *Id* at 59.
[69] *Id.* at 34; The Daimler-Chrystler study was adjusted for age, gender and geography. *See id.* at Appendix G
[70] *Id.* at Appendix G
[71] *See id.*
[72] *Id.* at Appendix G
[73] *Id.*
[74] Ga. Code Ann. § 31-6-90 *et seq.* (2006)
[75] Ga. Code Ann. § 31-6-91 (2006)
[76] Ga. Code Ann. § 31-6-94 (2006)
[77] *Id.*
[78] *Id.*

periodic data surveys, conditional CONs that may be revoked when conditions are not met, and provide the Department of Community Health with the authority to revoke specific parts of any CON that are not timely implemented.

Some of these recommendations would directly affect local hospitals. For instance, review thresholds for capital expenditures would be raised while the equipment threshold would be maintained. The acute care licensure statute would be amended to permit detailed licensure standards on a clinical service level instead of the current facility level analysis. Non-clinical projects, like parking decks, medical office buildings, and improvements to physical plant infrastructure would be exempt from review. Any relocation of an existing facility within a limited distance would also be exempt from review. However, regulation of open heart surgery and pediatric catheterization would be maintained.

Undoubtedly, the areas that were not unanimously recommended will be hotly contested on the floor of the General Assembly. In regard to acute care centers, the Commission was unable to decide unanimously whether to maintain CON regulation, deregulate expansions while maintaining regulation for new facilities, or amend the exemption for short stay hospitals when the facility has reached utilization of 75% for the prior 12 months.

Another area that may drastically effect local hospitals is the regulation of ambulatory surgical centers (ASCs). The Commissioners, including the *ex officio* members, were divided on whether to abolish the exemption for free-standing single specialty office based ASCs. Replacing this exemption would be a review process for physician-owned limited purpose ASCs that would be required to make indigent and charity care commitments. Dissenters instead recommended complete abolishment of the ASC exemption in favor of CON review consistent with all other ASC facilities and thus including "need" analysis. However, the Commissioners agreed that all providers of ambulatory surgical services should make indigent and charity care commitments.

III. Legislative Update

There were approximately twelve bills that were introduced into the General Assembly. Each of these bills differed in numerous respects. Three of the first bills introduced are discussed below.

The first bill introduced was Senate Bill 53. This bill proposed an exemption for the development and offering of new institutional health services by acute cancer hospitals with 50 or fewer beds that specialize in advanced cancer treatment and have a majority of their patients originating from outside the State of Georgia.[79] State Senator Tommie Williams (R-Lyons) said that this bill would permit the construction of a $200 million cancer facility by Cancer Treatment Centers of America.[80] The facility would be located near Atlanta's Hartsfield-Jackson International Airport and would provide world-class patient-based holistic approach cancer treatment.[81]

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[79] Senate Bill 53 (amending Ga. Code Ann. § 31-6-47) (available at http://www.legis.ga.gov/legis/2007_08/fulltext/sb53.htm)

[80] Hendrick, Bill, Bills Challenge Health Facility Planning, The Atlanat Journal Constitution, February 2, 2007 (hereinafter "Hendrick")(available at http://www.ajc.com/metro/content/metro/index/legis07.html)

[81] *Id.*

Another bill, House Bill 263, proposed the complete repeal of CON.[82] The bill cites the FTC and DOJ studies that claim CON poses certain anticompetitive risks that generally outweigh any benefits.[83] The bill also noted that Georgia's CON Commission, the Federal Trade Commission, and the U.S. Department of Justice have cited the benefits of ambulatory surgery, such as convenience for patients in a less threatening and non-institutional environment, specialized staff, and proven cost efficiencies.[84]

Representative Austin Scott (R-Tifton) also introduced House Bill 210. Essentially this bill would have rewritten the CON rules by requiring more and better reporting of data from hospitals and ambulatory facilities, streamlining the CON process, abolishing the Health Planning Review Board, increasing capital expenditure thresholds, and exempting new ambulatory surgery centers.[85] The bill also provided for more indigent care accountability by all providers.[86]

The CON issue "died" during the 2007 session's cross-over, thereby effectively ending any chance of legislation being passed in 2007. The controversial nature of this issue has proven itself tough to conclude in short order. Nonetheless, many legislators and citizens are working hard to draft and pass legislation that will best address the needs of the healthcare community in Georgia. Nonetheless, as the General Assembly recently established during the 2005 session and corresponding Tort Reform, the controversial nature of an issue will not stand in the way of legislative action.

IV. Conclusion

The legislative battle over Georgia's CON has yet to reach its peak. Not even half-way through the 2007 session there were numerous distinctly separate bills being debated. This battle promises to be one unlike any other in recent memory, pitting former allies against each other who so recently fought together to bring about reform to Georgia's Civil Practice Act. The resulting legislation could bring about great change to the healthcare industry in Georgia by either opening or closing avenues of providing care. Either way, healthcare providers need to stay abreast of the situation and contact their legislators with opinions or ideas.

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[82] House Bill 263 (available at http://www.legis.ga.gov/legis/2007_08/fulltext/hb263.htm)
[83] *Id.*
[84] *Id.*
[85] House Bill 210 (available at http://www.legis.ga.gov/legis/2007_08/fulltext/hb210.htm)
[86] *Id.*