Shifting Purpose: Why Iowa's Certificate of Need Law is a Form of Economic Protectionism for Certain Iowa Health Care Providers and Should Be Repealed

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ABSTRACT: The Iowa Legislature enacted the Iowa Certificate of Need ("CON") law in 1977 after Congress passed the National Health Planning and Resource Development Act ("NHPRDA"). The NHPRDA more or less forced states to adopt CON laws as a prerequisite to receiving federal funding. The federal government repealed the NHPRDA in the 1980s after concluding that the statute, and the CON requirement it imposed on the states, did not control health care costs, but rather, contributed to increasing health care cost across the country. Fifteen states have repealed their respective CON law in response to the NHPRDA's repeal, but Iowa has not. This Note argues that Iowa should follow those states, thus the Iowa Legislature should repeal, or significantly amend, the Iowa CON statute because in its current form, the statute does not control cost, but results in economic protectionism and contributes to the continual increase in health care cost for Iowans.

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"Patients and doctors—not state officials—are in the best position to decide what healthcare services are needed."[1]

I. INTRODUCTION

In February of 2012 a patient, twenty-four weeks pregnant, entered LewisGale Medical Center in Salem, Virginia, bleeding and in pain.[2] The patient was suffering from placental abruption.[3] Placental abruption occurs when "the placenta detaches from the inner walls of the uterus and triggers premature labor" and can be deadly for the mother and baby.[4] The doctor at LewisGale rushed to call a neighboring hospital six miles away that had a special treatment center for premature babies, and an ambulance equipped to transport newborns.[5] Before placing the call the doctor thought, "We've got a chance."[6] Unfortunately, the doctor's optimism quickly evaporated. The

1. Lee Birchansky, *Iowa's CON Job: How the State Prevents Competition in Health Care*, DES MOINES REG. (June 22, 2017, 1:14 PM), http://www.desmoinesregister.com/story/opinion/columnists/iowa-view/2017/06/22/iowas-con-job-how-state-prevents-competition-health-care/420390001.

2. Eric Boehm, *How Virginia's Hospital Licensing Laws Led to an Infant's Death*, REASON (Jan. 25, 2017), http://reason.com/archives/2017/01/25/virginia-certificate-of-need-hospital.

3. *Id.*; *see also Placental Abruption*, AM. PREGNANCY ASS'N, http://americanpregnancy.org/pregnancy-complications/placental-abruption (last visited July 2, 2018).

4. Boehm, *supra* note 2.

5. *Id.*

6. *Id.*

only ambulance capable of transporting the baby was not available because it was out responding to another call.[7] The doctor had to tell the mother, who was fighting for her life, that an ambulance that could potentially save her baby was not coming.[8] Ultimately the mother survived, but the baby tragically passed away.[9]

Unfortunately, the baby's fate was foreseeable. In July of 2010 LewisGale applied to the Virginia Department of Health seeking permission to build a neonatal specialty care unit.[10] The Department denied the application.[11] As a part of the denial, the Department concluded that a neonatal specialty care unit at LewisGale "would *foster* institutional competition."[12] It was competition—or at a minimum, the notion of avoiding competition—that contributed to a baby's death. Virginia is not the only state that requires certain health care providers to obtain government permission before opening a medical facility.[13]

Dr. Lee Birchansky is an ophthalmologist in Cedar Rapids, Iowa, offering patients cataract and other outpatient surgeries.[14] Dr. Birchansky operates his medical practice, Fox Eye Laser & Cosmetic Surgery Institute, and offers outpatient cataract surgeries in a surgery center he constructed and equipped next to his medical office.[15] Before offering new services, Iowa law requires health providers to obtain a Certificate of Need ("CON").[16] Essentially, a CON is a permission slip from the government signifying that, *after its determination*, a need exists in the market for the services that the health provider intends to offer. In addition to requiring the government's permission, the process also requires the government to inform the applicant's potential competitors, who then have the opportunity to offer opposing testimony for the project at a public hearing.[17] A simple example illustrates the difficult barriers to entry inherent in the CON process.

Imagine you would like to own a fast-food restaurant. You have decided to open a restaurant in the same area as a potential competitor. If CON applied to the fast-food industry,[18] you would have to approach the state government and plead your case that a need exists for your restaurant. Then,

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7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.*
12. *Id.* (emphasis added).
13. *See infra* notes 91–93 and accompanying text.
14. Birchansky, *supra* note 1.
15. *Id.*; *see also* Cindy Hadish, *Cedar Rapids Doctor, State Clash Over Cataract Surgeries*, GAZETTE (Mar. 6, 2012), http://www.thegazette.com/2012/03/06/cedar-rapids-doctor-state-clash-over-cataract-surgeries.
16. IOWA CODE § 135.63(1) (2017).
17. *See infra* Section II.C.2.
18. Luckily, in Iowa, CON is only applicable in the health care industry.

your competitors could show up to a public hearing and claim that demand does not exist for your business and that the market does not need your restaurant. Moreover, the government might decide, after hearing from your competitor, that there is no need for an additional restaurant in the area and deny your request.

Returning to Dr. Birchansky, the Iowa Health Facilities Council ("Council") denied his request for a CON on four separate occasions.[19] Each time that Birchansky applied for a CON, two local hospitals, that collectively control 100% of the existing operating facilities in Cedar Rapids, have opposed Birchansky's application.[20] The two hospitals opposing Birchansky opening his facility claimed that no need existed for an additional outpatient surgery center, but because of a significant loophole in the Iowa law, one of the hospitals that opposed Birchansky's facility later opened a new outpatient surgery center, just four miles from Birchansky's already constructed facility.[21]

A baby's tragic death in Virginia and Dr. Birchansky's initial inability to open his outpatient surgery center illustrate the spectrum of outcomes that result because of CON. Considering these outcomes, this Note reviews CON's origin and addresses the current framework of Iowa's CON process and argues (perhaps optimistically) that the Iowa Legislature should fully repeal the Iowa CON program, or at a minimum address the statute's significant loophole that violates the U.S. Constitution's Equal Protection Clause.[22] First, Part II explains the origins of CON and federal health planning which led to the creation of Iowa's CON program. Next, Part III takes an in-depth review of Iowa's CON process, highlighting the program's significant deficiencies. This Note then evaluates (1) the economic realities that have developed because of CON's implementation across the United States and why CON has failed to achieve its primary purpose; (2) the negative influence of politics on the CON process; and (3) why an aspect of Iowa's CON statute violates the U.S. Constitution's Equal Protection Clause. Part IV offers two solutions for the Iowa Legislature: (1) Repeal CON in Iowa; or, more realistically given the current political realities, (2) amend the statute to eliminate a loophole that gives rise to economic protectionism and significantly limit CON's scope. Part V concludes.

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19. Birchansky, *supra* note 1. After multiple attempts, the Iowa State Health Facilities Council ultimately granted Dr. Birchansky a CON in July 2017. The Council issued a written decision on August 24, 2017. *See* Fox Eye Surgery, LLC, (Iowa Dep't Of Pub. Health State Health Facilities Council July 19, 2017), https://idph.iowa.gov/Portals/1/userfiles/50/Minutes%20and%20decisions%20July%2019%20and%2020%20CON%20Meeting%20FINAL%202017-08-28.pdf.

20. *See* Birchansky, *supra* note 1.

21. *Id.*

22. This Note explicitly outlines solutions in response to the Iowa CON statute and program. Although it focuses on Iowa, this Note contemplates that other states that have a CON regulatory framework should join the other states that have already repealed their CON statutes. The equal protection analysis and application this Note offers is in response to the Iowa statute specifically.

II. THE ORIGINS OF CERTIFICATE OF NEED

This Part discusses the origin and history of the federal government's involvement in health facility planning across the country. It then explains Iowa's CON program to demonstrate how Iowa's CON law came into existence and why CON unduly suppresses Iowa patients' access to health care and limits, if not eliminates, certain Iowa medical providers' ability to compete. Although the Iowa Legislature first enacted CON in 1977,[23] it was in post-World War II Washington, D.C., and not under the golden dome in Des Moines, where the initial development of the current CON regulatory framework was born. A review of CON's history illustrates that CON's well-intended policy outcomes have not materialized. Additionally, CON has stifled competition in the health care industry and contributed to increasing, rather than decreasing, health care cost across the country.[24]

A. *FEDERAL HEALTH PLANNING'S ORIGINS*

1. The Hill–Burton Act of 1946

Congress passed the Hospital Survey and Construction Act,[25] more commonly known as the Hill–Burton Act of 1946, based on recommendations from President Harry Truman.[26] Prior to Congress enacting the legislation, President Truman recommended a comprehensive health care program that included five major parts.[27] The first part of Truman's plan provided that "[f]ederal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have."[28] Truman's plea to Congress "called for constructing hospitals and clinics to serve a growing and rapidly demilitarizing population."[29] Congress subsequently passed the Hill–Burton Act, which "provided construction grants and loans to communities that could demonstrate viability—based on their population and per capita income—in the building of health care facilities."[30]

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23. Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CTR. GEO. MASON U. (Sept. 27, 2016), https://www.mercatus.org/publication/40-years-certificate-need-laws-across-america.

24. *Id.*

25. Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. § 291 (1976)).

26. Harry S. Truman, *Special Message to the Congress Recommending a Comprehensive Health Program*, HARRY S. TRUMAN PRESIDENTIAL LIBR. & MUSEUM (Nov. 19, 1945), https://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1.

27. *Id.*

28. *Id.*

29. John Henning Schumann, *A Bygone Era: When Bipartisanship Led to Health Care Transformation*, NPR (Oct. 2, 2016, 6:00 AM), http://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation.

30. *Id.*

The Hill–Burton Act required state government agencies to take certain steps before becoming eligible for federal grants. To qualify for federal government grants under Hill–Burton, state government agencies needed to prepare a "medical facilities plan" that would include information about the number, type, and distribution of medical facilities across their respective state.[31] Medical providers seeking federal funding through Hill–Burton were then required to follow the medical facilities plan that their respective state agency had created and gain approval from the state agency administering the federal Hill–Burton funding.[32] The scope of facilities eligible for Hill–Burton funding grew over time to include more than just hospitals.[33] According to James B. Simpson, now General Counsel at the Public Health Institute, no evidence exists demonstrating that the federal government's health planning legislation was concerned with generating excess capacity; rather, at the time, the legislation appears to have been focused on stimulating private investment in health facilities.[34] As funding became more readily available, Congress worried that excess capacity in the marketplace would potentially lead to rising health care cost.[35] It seemed legislative amendment would best prevent alarming cost increases.[36]

2. Federal Concern with Health Care Cost Containment—Section 1122 of the Social Security Amendment of 1972

Congress' first chance for legislative amendment came after President Lyndon Johnson forever changed the U.S. health care market by signing Medicare into law in 1965.[37] As initially drafted, Medicare paid for health care providers' "capital cost."[38] Although Congress likely hoped that reimbursing

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31. *See* James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1033 (1986) (discussing the history of the Hill Burton Act).

32. *Id.*

33. *Id.* at 1033–34 (explaining that the number of facilities that qualified for funding under Hill–Burton grew extensively). Simpson notes that, originally, grants were available to only hospitals and public health centers, but eventually "nursing homes, rehabilitation facilities, chronic disease hospitals, diagnostic or treatment centers, outpatient facilities, hospital-related extended care facilities and home health services, equipment acquisitions, and emergency rooms" were included as qualifying facilities. *Id.* (footnote omitted).

34. *Id.* at 1035 ("Notably absent from these early federal ventures into health planning is any evidence of concern with distortions in the health care marketplace that might lead to excess capacity. The Hill–Burton program was intended to solve the opposite problem—insufficient private investment in health facilities.").

35. *See id.* at 1038.

36. *See* Pub. L. No. 92–603, §§ 221, 1122, 86 Stat. 1329, 1386–90 (1972) (codified as amended at 42 U.S.C. § 1320a-1 (2012)) [hereinafter Social Security Amend.].

37. Pub. L. No. 89–97, 79 Stat. 286 (enacted July 30, 1965).

38. *See generally* Eleanor D. Kinney & Bonnie Lefkowitz, *Capital Cost Reimbursement to Community Hospitals Under Federal Health Insurance Programs*, 7 J. HEALTH POL. POL'Y & L. 648 (1982) (discussing "capital costs," i.e., actual costs of interest on capital indebtedness, an allowance for depreciation on

providers for capital cost would help rein in all health care cost, the reality is that the reimbursement mechanism only contributed to increasing health care cost.[39] In response to Medicare's rising capital reimbursement cost, Congress included "Section 1122" in the Social Security Amendment of 1972.[40] Section 1122 was designed to be an oversight mechanism requiring states that wanted to participate in the Medicare capital reimbursement program to review and submit recommended capital expenditures to the Secretary of Health, Education, and Welfare ("Secretary") for approval.[41] Under section 1122 individual states were under contract from the Secretary to review and recommend approval or denial of proposed expenditures by "health care facilities or health maintenance organizations," and the state recommendations were supposed to be based on the state health plans that were created under Hill–Burton.[42]

In a certain context, one could view section 1122 as a precursor to the CON programs that exist today. Simpson notes that although section 1122 is an oversight provision of a federal reimbursement program, and not a regulatory approval process like state CON programs, they both deter private capital investment in projects that state government health care planning agencies determine are not needed.[43] Although section 1122 may act as a gatekeeping mechanism because it attempts to limit the government's involvement in health facility expenditures, section 1122 covers a wide variety of projects and facilities, resulting in an increase in government oversight.[44] Finally, the fact that section 1122 reviewed projects that (1) have capital expenditures over $100,000, or (2) "change[] the bed capacity of the facility", or (3) "substantially change[] the services of the facility"[45] is similar to the requirements many state CON statutes, such as Iowa's, impose on actors in the health care market.[46] Congress later modeled the National Health

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capital assets, and a fixed rate of return on equity capital used by propriety health facilities for patient care); *see also* Simpson, *supra* note 31, at 1038–39.

39. Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH. L. REV. 57, 88 (2015).

40. Pub. L. No. 92–603, § 1122, 86 Stat. 1386–90 (1972).

41. 42 U.S.C. § 1320a-1(b)(1) (2012).

42. Simpson, *supra* note 31, at 1038.

43. *See id.*

44. *Id.* Section 1122 subjected the following health care facilities to review:

> hospitals, psychiatric hospitals . . . tuberculosis hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, providers of outpatient physical therapy services (including speech pathology services), kidney disease treatment centers (including freestanding hemodialysis units), and organized ambulatory care facilities such as health centers, family planning clinics, and surgicenters, which are not part of a hospital but are organized and operated to provide medical care to outpatients.

Id.; 42 C.F.R. § 100.102(e) (1974).

45. 42 C.F.R. §100.103(a)(1) (1973).

46. *See* IOWA CODE § 135.63 (2017).

Planning and Resources Development Act's ("NPHRDA") CON program after section 1122's capital expenditure review process.[47]

B. MANDATING STATE HEALTH PLANNING AGENCIES THROUGH THE NPHRDA

Congress passed the NHPRDA[48] on January 4, 1975, to develop and fund a national health planning policy in response to rising health care costs.[49] Congress realized that the federal government's involvement and introduction of funds into the national health care market played a significant role in the dramatic increases in health care costs, along with the inadequate supply and distribution of medical resources.[50] Thus, the NPHRDA "was 'premised on the theory that the current structure and incentives of the health care industry lead to overinvestment and that unneeded . . . health care resources contribute significantly to rampant inflation in health care costs."[51]

Congressional concerns about rising health care costs in the years leading up to the NHPRDA's enactment were well-founded. Although the consumer price index was rising at 13.7% annually,[52] the cost of medical care was rising by 16.6%,[53] and hospital charges were skyrocketing by 18.7%.[54] In addition to rising health care costs, there was no longer a lack of adequate health facilities in the country; in fact, the country was dealing with a surplus of hospital beds.[55] In a relatively brief time period, the initial issue that propelled Truman and Congress to get involved in health facility regulation in 1946—the lack of health facility supply—appeared to have been overcorrected; thus, Congress turned to the NHPRDA, and specifically its CON requirement, to address the seemingly perpetual issue of rising health care costs.

1. NHPRDA and the Proliferation of CON

The NHPRDA's signature legacy is that it essentially forced states to adopt a CON program.[56] Congress hoped that by forcing states to adopt CON, the NHPRDA would achieve three goals.[57] First, Congress believed that by

47. *See* Simpson, *supra* note 31, at 1043.

48. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93–641, 88 Stat. 2225 (repealed 1986).

49. *Id.* § 2.

50. *See* Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, 23 FLA. ST. U. L. REV. 141, 146–49 (1995).

51. *Id.* at 149 (quoting Randall Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 83).

52. *Id.*

53. *Id.*

54. *Id.*

55. S. REP. NO. 93-1285 (1974).

56. Simpson, *supra* note 31, at 1042.

57. *See* McGinley, *supra* note 50, at 148–49.

implementing CON, states could rein in rising health care costs.[58] Second, Congress hoped that CON would prevent the unnecessary duplication of health services.[59] Third, Congress saw CON as a step towards ensuring equal access to health care for patients across America.[60] As Professor McGinley asserts, when read together, Congress' goals reveal that one singular purpose exists behind CON: to reduce health care costs across the country.[61] Section III.A of this Note discusses how these Congressional goals were not met.[62]

Through the NHPRDA, Congress informally nationalized CON by "incentivizing" states to adopt CON by tying substantial federal funding to the creation and implementation of the program.[63] Because Congress, at the time of the NHPRDA, felt that state CON programs would prevent unnecessary health facility expenditures,[64] the NHPRDA "prohibited federal funding to a state that failed to comply with the requirements of the federal incentive."[65] If states did not have a CON program in place by a certain date, funding under numerous "federal . . . programs to state, local, and private entities . . . would be abruptly cancelled."[66] States reacted to the NHPRDA in a predictable manner, namely by passing statutes to comply with the NHPRDA. By 1978, forty states and the District of Columbia had passed CON in some form,[67] and by 1980, every state except Louisiana had adopted a CON law.[68]

The NHPRDA also required states to create State Health Planning and Development Agencies ("SHPDA").[69] SHPDAs were tasked with administering their state's CON program.[70] Iowa's SHPDA is the Iowa Health Facilities Council.[71] The NHPRDA prescribed that each state's CON program would review "capital expenditures, substantial changes in services [by health

58. *See* S. REP. NO. 96-96, at 42–45 (1979).

59. *Id.* at 5.

60. *Id.*; 42 U.S.C. § 300k(a)(1) (Supp. V 1970).

61. McGinley, *supra* note 50, at 149.

62. *See infra* Section III.A.

63. *See* Roberta M. Roos, *Certificate of Need for Health Care Facilities: A Time for Re-Examination*, 7 PACE L. REV. 491, 496–503 (1987); Simpson, *supra* note 31, at 1042.

64. S. REP. NO. 96-96, at 5 (1979).

65. Lowell M. Zeta, Note, *Fundamental First Steps Along the Road to Health Care Reform: Eliminating the Bureaucratic Burdens of Certificate of Need Programs and Embracing Market Competition to Improve State Health Care Systems*, 41 CREIGHTON L. REV. 727, 730 (2008) (citing S. REP. NO. 93-1285, at 1 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 7842, 7842–43).

66. *See* Simpson, *supra* note 31, at 1042; *see also* Manor Healthcare Corp. v. Nw. Cmty. Hosp., 472 N.E.2d. 492, 494 n.3 (Ill. App. Ct. 1984) (discussing that Illinois would lose $465 million in federal funds if state CON program is non-compliant).

67. *See* D.R. Cohodes, *The State Experience with Capital Management and Capital Expenditure Review Programs*, BUREAU OF HEALTH FACILITIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH CAPITAL ISSUES 87–88 (DHHS Pub. No. (HRA) 81-14531 (1980)).

68. *See* Mitchell & Koopman, *supra* note 23.

69. Simpson, *supra* note 31, at 1042.

70. *Id.*

71. *See* IOWA CODE § 135.62 (2017).

entities], and additions of beds by health care facilities."[72] The NHPRDA codified procedures for reviewing projects and provided a list of criteria that the SHPDAs should review when evaluating potential projects.[73]

Although the NHPRDA is known as the federal legislation that "effectively required states to adopt certificate of need laws,"[74] CON laws were prevalent across the country prior to the NHPRDA's implementation.[75] However, the pre-NHPRDA state CON laws were typically narrower in scope and substance than those following the NHPRDA. The NHPRDA's coverage provision, which lists the types of health entities the statute covered, was more extensive than the same provision in many existing state CON statutes. As such, the NHPRDA required states to conform to broader federal requirements.[76] Congress formulated these broader federal requirements so that the NHPRDA covered the same entities subject to section 1122 oversight.

The NHPRDA's coverage provision subjected several of the same entities, such as hospitals and skilled nursing facilities, that were regulated under section 1122, to review under the NHPRDA.[77] Notably though, a few of the entities that section 1122 subjected to review were not included in the NHPRDA's coverage provision.[78] Although the absence of regulation for these facilities is noteworthy, the reason the entities were not subject to CON regulation is even more notable. Congress believed that the market, and not government, forces would better regulate the supply of entities and facilities regulated under section 1122 but absent from the NHPRDA.[79]

Congress significantly amended the NHPRDA in 1979 following the continued rise in health care cost.[80] Ill-will in Congress towards the NHPRDA's implementation,[81] CON's apparent inability to control hospital's capital expenditures,[82] and significant litigation all contributed to the statute's revision. Simpson notes that the amendments "narrowed the focus of federally-mandated certificate of need from general health system management to economic regulation."[83]

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72. Simpson, *supra* note 31, at 1042.

73. *Id.*

74. *Id.* at 1026.

75. *Id.* at 1041 ("[W]ell before the adoption of the NHPRDA, the vast majority of states had chosen to implement certificate of need or capital expenditure review.").

76. *Id.*

77. 42 C.F.R. §§ 123.401, 123.404 (1977).

78. Simpson, *supra* note 31, at 1043.

79. *Id.* For a comprehensive discussion regarding how the NHPRDA, before the 1979 amendments, addressed, adopted, or modified certain provisions of Section 1122, and how the NHPRDA differed from various state statutes, see Simpson, *supra* note 31, at 1043–48.

80. Pub. L. No. 96-79, 93 Stat. 492 (1979).

81. Simpson, *supra* note 31, at 1049.

82. *Id.*

83. *Id.* at 1050.

2. Federal Repeal of the NHPRDA

The NHPRDA met its demise in 1986 when Congress repealed the statute.[84] The repeal was significant for states because they "were no longer subject to federal review or withholding of federal reimbursement for Medicare and Medicaid payments."[85] Congress gave two reasons for repealing the statute: First, the nation's health care costs continued to increase after implementation,[86] and second, CON was creating negative consequences for communities.[87] The numbers once again support the claim that CON was not reducing health care costs. Between 1974 and 1989, hospital care expenditures increased from $52.4 billion to approximately $230.1 billion annually.[88] In 1982, health care costs eclipsed 10% of GDP for the first time, totaling $332 billion.[89]

Although Congress repealed the NHPRDA, it did not automatically repeal CON. The repealed federal legislation mandated that states have CON programs to receive funding but did not prohibit CON programs post-repeal; thus, states could continue to operate CON programs even though no federal mandate was on the books. Following the NHPRDA's repeal, 14 states repealed their CON laws.[90] The majority of the 14 states repealed their state CON laws soon after the NHPRDA's repeal, but the debate over whether to repeal continues today. In 2016, New Hampshire became the most recent state to repeal their CON law.[91] Thirty-four states, in addition to "Puerto Rico, the US Virgin Islands and the District of Columbia," maintain some form of CON.[92]

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84. Pub. L. No. 99-660, § 701(a), 100 Stat. 3743, 3799 (1986).

85. Zeta, *supra* note 65, at 731 (citing Thomas C. Fox et al., *Federal Health Planning Laws*, *in* HEALTH CARE FIN. TRANSACTIONS MAN. § 2:9 (2007)).

86. *See* James Bailey, *How a Medicare Fix Backfires: Certificate of Need Laws Have Failed to Reduce Health Care Spending, and States Should Work to Repeal Them*, U.S. NEWS (Aug. 1, 2016, 11:05 AM), https://www.usnews.com/opinion/articles/2016-08-01/certificate-of-need-laws-havent-cut-the-costs-of-medicare ("In the 1970s, policymakers thought they had a painless solution . . . [b]ut [certificate of need laws] backfired, raising Medicare costs even higher—by 6 percent in many states—as we're only fully starting to comprehend today.").

87. McGinley *supra* note 50, at 156.

88. *Id.* at 157.

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

90. *See* Richard Cauchi & Ashley Noble, *CON-Certificate of Need State Laws*, NAT'L CONF. ST. LEGISLATURES (Aug. 25, 2016), http://www.ncsl.org/research/health/con-certificate-of-need-state-laws (providing an overview of the number of states that have CON laws, and explaining that the states that have repealed CON include Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Hampshire, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, Wisconsin, and Wyoming).

91. *Id.*

92. *Id.* States that currently have CON include Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York,

C. THE IOWA CERTIFICATE OF NEED PROGRAM

1. Iowa's Implementation of the NHPRDA, the Creation of the State Health Facilities Council, and Iowa CON Legislation

In 1978, the Iowa Legislature passed CON legislation in accordance with the NHPRDA.[93] The Iowa statute directs the Iowa Department of Public Health ("Department") to administer the state's CON program by creating and housing the State Health Facilities Council ("Council").[94] The Council, a board of five people appointed by the governor, serves as the governing body for the CON program.[95] The Council members must be geographically representative of the state, no more than three can be from the same political party, and "[e]ach council member shall be a person who has demonstrated by prior activities an informed concern for the planning and delivery of health services."[96] The Council is Iowa's SHPDA, as the NHPRDA previously directed.

The Council's mandate is "to assure that growth and changes in the health care system occur in an orderly, cost-effective manner and that the system is adequate and efficient."[97] The Council's main duty is to make the final decision on whether to approve or deny an applicant's CON request.[98] Under the CON statute, the Council is tasked with reviewing applications from a broad spectrum of health care facilities offering various medical services. Section II.C.2 of this Note discusses the application and review process under Iowa's CON statute.

The Iowa CON statute mandates that "[a] new institutional health service or changed institutional health service shall not be offered or developed in [the] state without prior application to the department for and receipt of a certificate of need."[99] In Iowa, "institutional health facilit[ies]" are subject to the CON statute.[100] The statute defines an "institutional health facility" to include hospitals, health care facilities, organized outpatient health facilities, outpatient surgical facilities, community mental health facilities, and birth centers.[101] The statute further defines health care facilities as including

North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, and West Virginia. *Id.*

93. IOWA CODE §§ 135.61–135.83 (2017).

94. *Id.* § 135.62(1).

95. *Id.* § 135.62(2).

96. *Id.* § 135.62(2)(a).

97. *Certificate of Need—State Health Facilities Council*, IOWA DEP'T. PUB. HEALTH, http://idph.iowa.gov/cert-of-need (last visited July 5, 2018).

98. IOWA CODE § 135.62(2)(f)(1).

99. *Id.* § 135.63(1).

100. Institutional Health Facilities are subject to the CON requirements because institutional health services are offered in institutional health facilities. *Id.* As discussed throughout this Note, CON is designed to regulate the supply of health care facilities.

101. *Id.* § 135.61(14)(a)–(f).

"residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with an intellectual disability."[102]

Like the state's broad definition of "institutional health facility," the CON statute's definition of "new institutional health service" or "changed institutional health service" is comprehensive and wide-ranging.[103] A new or changed institutional health service under the statute includes, *but is not limited to*, the construction or relocation of an institutional health facility, any capital expenditure exceeding $1.5 million by an institutional health facility within a twelve-month period, a permanent change in bed capacity, the acquisition (or replacement of) a piece of equipment over $1.5 million, or the elimination of health services that an institutional health facility previously offered.[104] Thus a medical entrepreneur, or any health care provider, in Iowa that would like to open or expand an institutional health facility, as defined under the statute, or offer a new institutional health service, is subject to the CON requirements.

Health care providers' compliance with the statute's requirements is critical because ignoring the CON regulatory regime will result in the imposition of significant penalties and fines. A party commits a Class I violation under the statute if they offer a new or changed institutional health service without the Council's review and approval.[105] The violating party may be fined up to $300 per day and the Department may also seek injunctive relief.[106] A class II violation occurs when a party that already has an approved CON violates the terms or provisions of their CON.[107] In addition to injunctive relief, the non-compliant party is subject to a potential fine of $500 per day for the period of non-compliance.[108]

With a working knowledge of which health providers and facilities are subject to Iowa's CON statute, and the pitfalls for a party's non-compliance with the statute, it is important to turn to how the application and approval process works.

2. Application, Review, and Appeal Process

An applicant's first step when seeking a CON in Iowa is to file a letter of intent with the Iowa Department of Public Health outlining the applicant's

102. *Id.* § 135C.1(7).

103. *See id.* § 135.61(18) (outlining 16 scenarios that meet the definition of either "new institutional health service" or "changed institutional health service").

104. *Id.* § 135.61(18)(a)–(m).

105. *Id.* § 135.73(2)(a).

106. *Id.*

107. *Id.* § 135.73(2)(b).

108. *Id.*

project and other considerations, such as location and financing.[109] Upon receiving a prospective applicant's letter of intent, a 30-day waiting period begins, meaning that an applicant must wait 30-days between submitting his initial letter of intent and filing an application to the Council.[110] During the initial 30-day waiting period, the applicant may request a "preliminary review" of the project.[111] The preliminary review allows the Department to comment on the proposed project and outline factors that may lead to its denial of an applicant's CON, but the preliminary review is certainly not a final decision on the application's merits.[112]

Once the 30-day waiting period is over, the applicant may submit the application to the Department, along with an application fee.[113] The application fee can be substantial. The fee is "equivalent to three-tenths of 1 percent of the anticipated cost of the project."[114] Because the fee is tied to the anticipated cost of the project, the fee varies for each application, but the statute imposes a minimum fee of $600 and a maximum fee of $21,000.[115] An application is "rejected only if it fails to provide all information required by the department;"[116] thus, applications are considered complete once the fee is paid and the proper forms are submitted to the Department.[117]

Once the Department accepts an application, a critical part of the CON process takes place: The Department notifies the applicant's potential competitors and customers of the proposal. After accepting the application, the Department "promptly . . . notif[ies] all affected persons in writing that formal review of the application has been initiated."[118] Under the statute, affected persons include not only consumers who could use the new facility, but also "[e]ach institutional health facility . . . located in the geographic area which would appropriately be served by the new institutional health service proposed in the application."[119] The Department determines "[t]he appropriate geographic service area of each institutional health facility or health maintenance organization."[120] Specifically, the Department determines a project's appropriate geographic service area by looking at the

109. *Id.* § 135.65(1); *see also* IOWA ADMIN. CODE r. 641-202.2(1) (2017) (specifying the letter should include a "brief description of the proposed project; the project's location; the project's estimated cost (site costs, land improvements, facility costs, movable equipment and financing costs); and an explanation of how the project will be financed.").

110. IOWA ADMIN. CODE r. 641-202.2(1).

111. IOWA CODE § 135.65(2).

112. *Id.*

113. *Id.* § 135.63(1).

114. IOWA ADMIN. CODE r. 641-202.4(2).

115. *Id.*

116. IOWA CODE § 135.66(1).

117. IOWA ADMIN. CODE r. 641-202.4(3).

118. IOWA CODE § 135.66(2).

119. *Id.* § 135.61(1)(c).

120. *Id.*

project's county of origin, and then looking at the contiguous counties surrounding the origin county.[121] For example, if an applicant had a project planned for Polk County, the department would look at existing facilities in Boone, Story, Jasper, Marion, Warren, Madison, and Dallas Counties when evaluating the current availability of services that the applicant's project proposes to offer. Unlike the effected institutional health facilities in the proposed project's geographic service area—which receive written notice of the application—consumers and third-party payers are only notified of the application through the Department's website or other news media outlets.[122]

After the applicant's potential competitors and other affected parties are notified of the CON application, the Department begins the formal review process.[123] The formal review process requires two steps: First, the Health Facility Council holds a public hearing on the application.[124] Second, it evaluates the application against 18 different criteria listed in the statute.[125] The Department must, at a minimum, provide ten days' notice of the place and time of the hearing.[126] The format of the public hearing allows applicants to make an initial presentation to the Council, and then any affected person may give oral testimony regarding the project.[127] Following the affected person's time to give testimony, the applicant is given rebuttal time to respond to any comments that an affected person made.[128] The hearing is important because of the specific allowance of time for "any affected person or that person's designated representative" to give testimony.[129] Because the statute allows an affected person's "designated representative" to give testimony, affected persons can hire or have anyone (lobbyists, lawyers, or facility representatives) speak on their behalf. In practice, the public hearing provides the applicant's potential competitors with a platform to speak against the project and protect their interests.[130]

During the evaluation step, the criteria that the Council may consider is non-exhaustive, and no single factor is controlling.[131] Examples of the

121. *See* IOWA ADMIN. CODE r. 641-202.1 (defining "appropriate geographic service area" for applications sponsored by hospitals, health care facilities, and "other" applications).

122. *Id.* r. 641-202.4(4).

123. IOWA CODE § 135.66(3).

124. *Id.* § 135.66(3)(b).

125. *Id.* § 135.66(3)(a)–(b).

126. *Id.* § 135.66(4).

127. *Id.*

128. IOWA ADMIN CODE r. 641-202.6(1).

129. IOWA CODE § 135.66(4).

130. Although the comments made at the public hearing are more likely than not designed for interested parties to speak against the project, parties that support the project are considered affected persons and can speak in favor of the project.

131. The statute lists eighteen different considerations that the Council may consider when reviewing the proposal. IOWA CODE § 135.64 (1)(a)–(r). Not every factor that the statute lists will likely be considered for every project. It is also important to note that the statute contemplates

eighteen different factors the Council consider include "[t]he relationship of the proposed institutional health services to the existing health care system of the area in which those services are proposed to be provided;"[132] "[t]he need of the population served or to be served by the proposed institutional health services for those services;"[133] and "[t]he immediate and long-term financial feasibility of the proposal presented in the application, as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health service."[134]

Even if the Council determines that the applicant satisfies any number of criteria listed in the statute, the Council can only grant a CON to the applicant if they find (based on data the department submits to the Council), in writing, that: "Less costly, more efficient, or more appropriate alternatives . . . [to the applicant's facility] are not available and the development of such alternatives is not practicable;"[135] existing facilities providing similar services to those being proposed are "used in an appropriate and efficient manner;"[136] alternatives to new construction, including "modernization or sharing arrangements have been considered and have been implemented to the maximum extent practicable;"[137] and "[p]atients will experience serious problems in obtaining care of the type which will be furnished" by the applicant's facility.[138]

The Department has 90 days after accepting the application to complete its formal review of the applicant's proposal.[139] Once the Department completes the formal review process, the Council must approve or deny the application.[140] Upon making its decision, the Council issues "written findings stating the basis for its decision on the application and the department shall send copies of the council's decision and the written findings supporting the decision to the applicant and to any other person who so requests."[141] To deny an application, the Council can issue a written denial or can take no action within the ninety-day period.[142] However, an automatic denial due to the

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the special role of the University of Iowa Hospitals and Clinics. *Id.* § 135.64(3). The Council should consider the "unique features of [the University Hospital] relating to statewide tertiary health care, health science education, and clinical research shall be given due consideration. Further . . . the unique capacity of university hospitals for the evaluation of technologically innovative equipment and other new health services should be utilized." *Id.*

132. *Id.* § 135.64(1)(g).
133. *Id.* § 135.64(1)(c).
134. *Id.* § 135.64(1)(f).
135. *Id.* § 135.64(2)(a).
136. *Id.* § 135.64(2)(b).
137. *Id.* § 135.64(2)(c).
138. *Id.* § 135.64(2)(d).
139. *Id.* § 135.69.
140. *Id.*
141. *Id.*
142. *Id.*

Council's inaction should not occur because it is the Department's responsibility to ask the applicant to request an extension of the review time.[143]

The Council's decision on the application is final, but the applicant can appeal the Council's decision.[144] A dissatisfied party may, by showing good cause, request a rehearing within twenty calendar days after the Council issued its final decision on the application.[145] The administrative rules provide specific grounds for rehearing, but regulations allowing the Council to rehear a case on "[s]uch other bases as the council determines constitute good cause," give the Council wide discretion.[146] If a rehearing on the application is granted, the Council may either "issue an order modifying the initial final order," or hold a rehearing.[147] The rehearing procedure is very similar to the initial process that the application went through, including a public hearing. Once the Council grants a rehearing, the Council shall issue a final decision within thirty days of either the initial rehearing approval, or within thirty days following the second public hearing on the application.[148] If, following the rehearing process, the applicant or an affected party is dissatisfied with the outcome, they may seek judicial review under chapter 17A of the Iowa Code.[149] Chapter 17A provides that "a person or party who is aggrieved or adversely affected by agency action may seek judicial review of such agency action."[150]

This means that an applicant's potential competitor, or the applicant herself, may seek remedies in state court following the approval or denial of a CON. Extinguishing all available judicial remedies under chapter 17A concludes the Iowa CON process.

In 2002, the Iowa Supreme Court noted that "the primary purpose of Iowa's certificate of need statute is to ensure that the citizens of this state will receive necessary and adequate institutional health services in an economical

143. *See* IOWA ADMIN. CODE r. 641-202.8(3) (2017) (noting that when there is a request for an extension, "the application shall be heard at the next regularly scheduled meeting of the council or at any time agreeable to the applicant and the department").

144. IOWA CODE § 135.70.

145. IOWA ADMIN. CODE r. 641-202.9(1).

146. *See id.* r. 641-202.9(2). Besides the Council's authority to determine what constitutes good cause for rehearing, the rules explicitly list: "New significant, relevant information which was unavailable at the date of the hearing; Significant changes in factors or circumstances relied upon by the council in reaching its decision; [or] Demonstration that the council has materially failed to follow its adopted procedures in reaching its decision," and it also provides specific grounds for rehearing. *Id.*

147. *Id.* r. 641-202.9(4).

148. *Id.* r. 641-202.9(5).

149. *See* IOWA CODE § 17A.19 (describing the process of judicial review in Iowa for agency actions).

150. *Id.* For a discussion about chapter 17A and Iowa's CON statute, see Greenwood Manor v. Iowa Dep't of Pub. Health, State Facilities Council, 641 N.W.2d 823, 833–36 (Iowa 2002).

manner."[151] While it may have been the case in 1977 and 1978 that the primary purpose was to provide "necessary and adequate" health services for Iowans while controlling cost and providing services "in an economical manner," it is clear that the Iowa CON statute's primary purpose has shifted.[152] In the modern health care market, the only rational purpose for maintaining the Iowa CON statute is to protect the politically entrenched economic interest of certain health care providers by shielding them from competition in the health care marketplace.[153]

III. IOWA'S CON STATUTE DOES NOT ACHIEVE ITS PRIMARY PURPOSE

Although CON is a controversial topic in Iowa, and in states across the country, "CON 'has elicited a remarkable evaluative consensus—that it does not work.'"[154] This Part will discuss the economic data demonstrating that CON laws do not achieve their purpose of controlling health care costs, explain why Iowa's CON process places an undue burden on health care providers and disincentivizes investment in the state, and finally illustrate why the loophole in the Iowa statute allowing current CON holders to circumvent the application process when making investments of less than $1.5 million is an example of economic protectionism that does not pass rational basis, and thus violates the Equal Protection Clause of the 14th Amendment of the U.S. Constitution.

Increasing Iowan's access to health care services, while controlling cost, was among, if not the, legislature's primary purpose in enacting the CON.[155]

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151. *See Greenwood Manor*, 641 N.W.2d at 832–33 (citing 1977 Iowa Acts Ch. 75, preamble, and Iowa State Dep't of Pub. Health v. Hertko, 282 N.W.2d 744, 747 (Iowa 1979)).

152. *See* TRACY YEE ET AL., NAT'L INST. FOR HEALTHCARE REFORM, HEALTH CARE CERTIFICATE-OF-NEED LAWS: POLICY OR POLITICS? 4 (2011) ("Hospitals typically view certificate-of-need regulations opportunistically. Hospitals use the process to protect existing share—either geographic or by service line—and block competitors, but they find the CON process onerous if they are attempting to enter a market.").

153. Editorial, *Iowa Health Facilities Council Picks Winners and Losers*, QUAD-CITY TIMES (Mar. 7, 2016), http://qctimes.com/news/opinion/editorial/sunday-editorial-iowa-health-facilities-council-picks-winners-and-losers/article_5975f290-636a-5bec-8cd7-b435afc57737.html (describing that the Iowa CON process is an example of "crony capitalism" and encouraging the Iowa Legislature to "take a hard look at the potentially anti-consumer regulation").

154. 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, 487 (1991) (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).

155. *See* Act of July 13, 1977, ch. 75, 1977 Iowa Acts 233, 233–34 ("[I]t is the public policy of this state that the offering or development of new institutional health services be accomplished in a manner which is orderly, economical and consistent with the goal of . . . preventing or controlling increases in the cost of delivering these services."); *supra* note 151 and accompanying text. It is noteworthy that during the 2017 Iowa legislative session, several editorials signed by local hospital administrators, and all similar in form and language, appeared throughout the state advocating for Iowa's CON law. *See, e.g.*, Pat Bira, Opinion, *Certificate of Need Law Should Remain Untouched*, FORT MADISON DAILY DEMOCRAT (Feb. 8, 2017), https://www.mississippivalleypublishing.com/

Although the statute's primary purpose was well-intentioned when enacted in 1977, 40 years later, research shows that CON's purpose has not been achieved. As previously discussed,[156] Congress repealed the NHPRDA in 1986, after determining that CON created negative consequences for communities and that health care costs were skyrocketing, even after CON's implementation across the country.[157] At the time of the NHPRDA's repeal "high medical costs were shown to be especially severe in areas controlled by CON laws."[158] Although the Iowa Legislature has not formally studied the economic effects of CON in Iowa specifically, the data from both national research and state-specific case studies demonstrate that Iowa's CON likely will not rein in health care spending nor increase Iowans access to health care services.

A. NATIONAL AND STATE ECONOMIC ANALYSIS OF CON

Economic analysis at both the state and federal level demonstrate that CON does not prevent rising health care costs. One reason CON laws have failed to control cost is straightforward: CON laws artificially create an output restriction on supply, which creates an artificial shortage of supply, which then leads to increased cost.[159] Basic economic theory reasons that prices increase when demand stays constant, or contrarily, prices increase while supply decreases.[160] In addition to the artificial output restriction, one of CON's inherent flaws is that it is structured to address a market problem that no longer exists.[161]

Since CON's original implementation, health care providers' reimbursement mechanism has shifted from a "cost plus" model to a "fee for

daily_democrat/opinion/certificate-of-need-law-should-remain-untouched/article_9262df2e-8a4f-571b-b313-47720cdaf9eb.html; Bob Kroese, Letter to the Editor, *Why Iowa Still Needs Certificate of Need*, PELLA CHRON. (Feb. 23, 2017), http://www.pellachronicle.com/opinion/to-the-editor-why-iowa-still-needs-certificate-of-need/article_5af8e656-f956-11e6-ae18-6b89f9bf9a9c.html; Mike Riege, Opinion, *Repealing an Iowa Law Could Negatively Impact Rural Iowans' Access to Health Care*, VINTON TODAY (Feb. 8, 2017), https://vintontoday.com/opinion/repealing-iowa-legislation-that-could-impact-rural-iowans-access-to-health-care; Ed Smith, Opinion, *The Case for Maintaining Iowa's Current Certificate of Need Laws*, DAILY TIMES HERALD (Feb. 9, 2017) (source on file with author).

156. *See supra* Section II.B.2.

157. *See supra* notes 84–89 and accompanying text.

158. Lauretta Higgins Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261, 270 (2001).

159. *See* Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 ANTITRUST 50, 51 ("Normally, if you want the price of something to decline, creating an artificial shortage of it is not the way to achieve that. There is no clear reason to expect that basic laws of supply and demand would not apply, either when the states enacted CON laws or today.").

160. Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L.J. 201, 226 (2017) (explaining that CON programs do not reduce the cost of health care given the shift in reimbursement methods used in the market).

161. *See* Ohlhausen, *supra* note 159, at 51.

service" model.[162] The "cost plus" model, which CON was premised on, created a "medical arms race" because hospitals would use the latest technology to attract patients.[163] The "cost plus" model resulted in patients being immune to cost considerations because, at the time, "generous indemnity plans" covered patients.[164] Under the "fee for service" model, the federal government sets Medicare and Medicaid reimbursement rates and "private insurers negotiate payments procedure by procedure rather than by provider cost."[165] The "fee for service" model provides little incentive for health care professionals to make unnecessary capital improvements, thus the market for services is a significant factor when making decisions about facility expansion.[166] Notwithstanding the way health care providers are reimbursed for services has changed, data and research confirm that CON is ineffective.

Professor Parento claims that "[w]hen viewed as a whole, . . . evidence casts considerable doubt on the proposition that CON programs lead to reduced health care expenditures or that their repeal leads to a surge in unnecessary services in the market."[167] Studies show that on average, health care cost are higher in states with CON,[168] and CON may result in an increase in cost per admission.[169] In addition to studies demonstrating CON's inability to control cost, the federal government has become a vocal critic of CON. Over the last 30 years, regardless of which political party controls the White House or Congress, the Federal Trade Commission has consistently advocated against CON laws across the country.[170]

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162. *Id.* The "cost plus" model means that providers were reimbursed for the actual cost of the care delivered. *See* Katherine Restrepo, *Certificate of Need: A Useless Regulation That Harms Rural Health Care*, FORBES (Aug. 17, 2015, 1:28 PM), https://www.forbes.com/sites/katherinerestrepo/2015/08/17/certificate-of-need-a-useless-regulation-that-harms-rural-health-care.

163. Restrepo, *supra* note 162.

164. *Id.*

165. *See* Ohlhausen, *supra* note 159, at 51.

166. *Id.*

167. Parento, *supra* note 160, at 227–28. *See generally* Peter Doherty, *Certificates of Need: A Bad Idea Whose Time Has Passed*, J. JAMES MADISON INST., Winter 2001, at 10 (discussing how CON was well intentioned but has failed to deliver on lowering health care cost); Jon Sanders, *Certified: The Need to Repeal CON*, JOHN LOCKE FOUND. (Oct. 25, 2013), https://www.heartland.org/_template-assets/documents/publications/spotlight445con.pdf (looking at North Carolina's CON program and then concluding that it should be repealed).

168. Patrick A. Rivers et al., *Does Certificate of Need Really Contain Hospital Costs in the United States?*, 66 HEALTH ED. J. 229, 240–41 (2007).

169. Patrick A. Rivers et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, J. HEALTH CARE FIN. 1, 11 (2010).

170. The FTC has issued a number of statements discussing the negative impact of CON on health care cost and competition. Additionally, and in response to state legislatures asking for the FTC's comment on CON, the FTC has provided comment. *See Prepared Statement of the Federal Trade Commission Before the Standing Committee on Health, Education & Social Services of the Alaska House of Representatives on House Bill 337*, 2 (Alaska 2008) (statement of U.S. Fed Trade Comm'n) ("The Commission believes that CON laws such as Alaska's can be a barrier to entry to the detriment of health care competition and health care consumers, and that the legislature should

The federal government is not alone in reviewing CON's ineffectiveness, individual states have reviewed their own CON programs. In a 1999 study, the state of Washington's Joint Legislative and Audit Committee found that "CON has not controlled overall health care spending or hospital costs."[171] Iowa's neighbor to the east, Illinois, reviewed its CON program, and "determined CON regulations fail to effectively reduce health care costs, and may increase costs in some cases."[172] Illinois also found that evidence did not support the argument that community hospitals benefit from CON protection.[173] There was no sudden increase in health care costs in states that repealed their CON program compared to states maintaining their CON program.[174]

Although the state of Iowa, to date, has not commissioned a formal study of the effectiveness of the Iowa CON program, no obvious reason exists suggesting Iowa would be an outlier when compared to the results of other states that have studied their respective CON programs. The Mercatus Center at George Mason University has done extensive research on the effect of CON.

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consider their repeal."); *Competition in Healthcare and Certificates of Need, Statement of the Antitrust Division, U.S. Department of Justice, Before the Florida Senate Committee on Health and Human Services Appropriations*, 2 (Fla. 2008) (statement of Joseph M. Miller, Assistant Chief, Litigation I Sec.) ("Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services."); *Competition in Healthcare and Certificates of Need, Before a Joint Session of the Health and Human Services Committee of the State Senate and the CON Special Committee of the State House of Representatives of the General Assembly of the State of Georgia*, 2 (Ga. 2007) (statement of Mark J. Botti, Litigation Sec. I Chief, U.S. Dep't of Justice, Antitrust Division) ("The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat the proper performance of healthcare markets."); DANIEL SHERMAN, FED. TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS iv (1988) (finding "no evidence that CON programs have led to the resource savings they were designed to promote, but rather indicates that reliance on CON review may raise hospital costs"); FED. TRADE COMM'N & U.S. DEP'T JUSTICE, ANTITRUST DIVISION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 22 (2004) (finding that "CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefit"); U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, COMPETITION IN HEALTH CARE AND CERTIFICATES OF NEED: JOINT STATEMENT OF THE ANTITRUST DIVISION OF THE U.S. DEP'T OF JUSTICE AND THE FED. TRADE COMM'N BEFORE THE ILLINOIS TASK FORCE ON HEALTH PLANNING REFORM 1 (2008) ("The Agencies' experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets.").

171. STATE OF WASHINGTON JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE, EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, REPORT 99-1, i (1999).

172. Zeta, *supra* note 65, at 751 (citing AL DOBSON ET AL., LEWIN GROUP, AN EVALUATION OF ILLINOIS' CERTIFICATE OF NEED PROGRAM 16 (2007)).

173. *See* DOBSON ET AL., *supra* note 172, at 28–29. This finding is significant because a common argument used by CON advocates in Iowa is that if CON is eliminated, community hospitals will suffer. *See* Tony Leys, *Hospitals Fight Effort to Loosen Reins on New Health Care Facilities*, DES MOINES REG. (Mar. 1, 2017, 5:01 PM), http://www.desmoinesregister.com/story/news/health/2017/03/01/hospitals-fight-effort-loosen-reins-new-health-care-facilities/98605590 ("The hospital leaders say they want to keep for-profit companies from setting up shop in Iowa and bleeding community hospitals by siphoning off well-paying services.").

174. *See* DOBSON ET AL., *supra* note 172, at 26.

Looking at Iowa specifically, the study found that if CON were repealed that per capita Iowans would spend less and have better access to health care services, without sacrificing quality of care.[175] Specifically, the study found that without CON, Iowans would save $217 per year in total health care costs, the number of hospitals and ambulatory surgery centers (including in rural areas) would increase, and health care quality indicators would improve.[176]

B. IOWA'S CON PROCESS IS UNDULY BURDENSOME, UNPREDICTABLE, AND SUBJECT TO POLITICAL INFLUENCE

The process for obtaining a CON in Iowa is prohibitively expensive, time-consuming, and potentially fruitless for applicants because of the process' built-in unpredictability and exposure to political influence.[177] First, as previously discussed, a CON applicant must include an application fee when submitting their initial application.[178] This fee can be as much as $21,000, which is not a *de minimis* amount for a medical entrepreneur trying to either open, or expand, a health facility.[179]

Second, once the applicant submits an application, the Council evaluates applicants against the list of eighteen criteria, none of which are controlling. As discussed previously, even if the applicant would satisfy all eighteen criteria, the Council cannot grant a CON if it determines certain criteria in section 135.64(2) are met.[180] Moreover, although an applicant can request a preliminary review of the project,[181] once the application is submitted "it is effectively impossible for an applicant to determine in advance whether [the] application for a certificate of need will be granted or denied."[182] Thus, the application and review process can cost applicants up to $21,000 and take up to five months, plus the additional costs of counsel and consultants assisting in the process.[183]

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175. *Certificate-of-Need Laws: Iowa State Profile*, MERCATUS CTR. GEO. MASON UNIV. (2016), https://www.mercatus.org/system/files/iowa_state_profile.pdf.

176. *Id.* The study used mortality rates for pneumonia, heart failure, heart attacks, and post-surgery complications as health care quality indicators. The study found that a 5.7% decrease in post-surgery complications would result if CON was repealed. *Id.* There was also a slight decline in the mortality rates for the other three quality indicators. *Id.*

177. Amended Complaint & Demand for Declaratory and Injunctive Relief, Birchansky v. Clabaugh, Civil Action No. 4:17-cv-209 (S.D. Iowa Sept. 1, 2017) ¶ 154.

178. *See supra* Section II.C.2.

179. *See supra* Section II.C.2.

180. *See supra* Section II.C.2; IOWA CODE §135.64(2) (2017).

181. IOWA CODE § 135.65(2).

182. Amended Complaint, *supra* note 177, ¶ 138.

183. *Id.* ¶ 140; *see also* Kent Hoover, *Doctors Challenge Virginia's Certificate-of-Need Requirement*, BUS. JOURNALS (June 5, 2012, 10:38 AM), https://www.bizjournals.com/bizjournals/washingtonbureau/2012/06/05/doctors-challenge-virginias.html (describing that the CON process in Virginia "took five years—and $175,000 in fees—for Progressive Radiology to obtain a certificate of need simply to add a second MRI at its Virginia location").

Although an applicant's time and monetary investment are substantial, especially given the process' unpredictability, a non-economic factor may have the most negative impact on the process—politics.[184] Iowa's CON program has not been immune from political attention.[185] Stakeholders from across the country "believe that the political process has prevented CON programs from achieving their objectives."[186] Studies confirm that politics may influence the CON process.[187] Researchers at the Center for Studying Health System Change looked at six states with CON laws as a part of their analysis of the effects of politics on CON.[188] The researchers concluded that in five of the six states they studied, "the CON approval process can be highly subjective and tends to be influenced heavily by political relationships rather than policy objectives."[189] According to the study's respondents, factors such as an organization's "clout, organizational size, or overall wealth and resources" influenced CON outcomes more than policy objectives.[190] Although the various departments administering CON programs should be non-partisan, and their primary responsibility should be to review and process CON applications, respondents in the study felt like they were "caught in the competitive crossfire between providers during appeals, public hearings and legislative battles."[191]

184. *See* Parento, *supra* note 160, at 231–32 (exploring the influence politics has on certificate of need).

185. *See* Eric Boehm, *Gov. Terry Branstad Pushed Certificate of Need Reform; Iowa Hospitals Killed It*, REASON (Mar. 3, 2017, 9:20 AM), http://reason.com/blog/2017/03/03/gov-terry-branstad-pushed-certificate-of; Chelsea Keenan, *Certificate of Need, Licensing Requirements Could Be Cut in Iowa*, GAZETTE (Feb. 24, 2017), http://www.thegazette.com/subject/news/health/certificate-of-need-licensing-requirements-could-be-cut-in-iowa-20170224; Ed Tibbetts, *Branstad Critical of Certificate of Need Process*, QUAD-CITIES TIMES (Mar. 2, 2016), http://qctimes.com/news/local/government-and-politics/branstad-critical-of-certificate-of-need-process/article_e57d7268-506a-50a3-bbed-e97b7d384a5a.html; Elizabeth Wadas, *Iowa Governor Says Certificate of Need Law is Bad for Business*, WQAD (Mar. 8, 2016, 6:02 PM), http://wqad.com/2016/03/08/iowa-governor-says-certificate-of-need-law-is-bad-for-business.

186. *See* Parento, *supra* note 160, at 231.

187. *See* Thomas Stratmann & Steven Monaghan, *The Effect of Interest Group Pressure on Favorable Regulatory Decisions: The Case of Certificate-of-Need Laws* 5 (Mercatus Center George Mason University, Working Paper), https://www.mercatus.org/system/files/stratmann-interest-group-pressure-wp-mercatus-v1.pdf (suggesting "that there is a statistically significant and positive correlation between CON applicants' contributions to state candidates and the approvals of CON applications for these contributing applicants."); YEE ET AL., *supra* note 152, at 2–3 ("Certificate-of-need programs tend to be influenced heavily by political relationships . . . .").

188. *See* YEE ET AL., *supra* note 152, at 1. States included in the study were Connecticut, Georgia, Illinois, Michigan, South Carolina, and Washington. *Id.*

189. *Id.*

190. *Id.* at 2.

191. *Id.* at 3.

A recent review of interest group spending appears to confirm that medical interest groups have a sizable presence at the Iowa State Capitol.[192] According to data compiled by the *Des Moines Register*, the Iowa Hospital Association spent $265,800 on lobbying during the 2016 fiscal year, making it the second-largest spender overall.[193] The Iowa Hospital Association is not the only medical group that spends money at the Capitol; the Iowa Medical Society reportedly spent $204,759, ranking it as the third-largest spender.[194] The Iowa Medical Society "is the statewide professional association for Iowa allopathic (MD) and osteopathic (DO) physicians . . . represent[ing] 6,200 Iowa physicians, residents and medical students.[195] Although the number of dollars spent by medical interest groups does not draw a direct line to influencing CON decisions, it certainly raises questions and inferences as to the level of influence that medical groups have with state legislators at the State Capitol.

This Note does not assert that the Council's CON decisions are premised on incomplete or bad information, or that the Council denies an exorbitant number of applications,[196] but rather, this Note claims that the CON applications the Council denies are—in large part—influenced by established health care providers and their opportunity to exert political influence throughout the application and review process. The process in Iowa, as currently structured, does not lead to the best economic or health care outcomes for Iowa patients because of the opportunity the statute creates for economic protectionism by health care providers who already hold a CON. Additionally the process limits entrepreneurial, or in some cases, established health care providers ability to compete for the opportunity to provide Iowans quality, low-cost health care services.

C. IOWA'S CON STATUTE IS A FORM OF ECONOMIC PROTECTIONISM

Setting aside the fact that Iowa's CON program does not serve its primary purposes (control health care cost) and is susceptible to political pressure from outside interest groups, yet another glaring flaw exists in the current law. In its current form, the Iowa CON statute violates the Equal Protection Clause of the 14th Amendment of the U.S. Constitution because the law is applied

192. Brianne Pfannenstiel, *Special Interest Groups Spend Big at Iowa Capitol*, DES MOINES REG. (Aug. 26, 2017, 2:43 p.m.), http://www.desmoinesregister.com/story/news/politics/2017/08/24/special-interest-groups-spend-big-iowa-capitol/579725001 ("Broken down by industry, the biggest spenders were those in health care.").

193. *Id.*

194. *Id.*

195. *See Who We Are: About IMS*, IOWA MED. SOC'Y, https://www.iowamedical.org/iowa/Iowa_Public/About/Iowa_Public/About/About_IMS.aspx (last visited July 5, 2018).

196. A historical review of the Council's decisions demonstrates that, on average, the Council approves more CON applications than it denies. *See Annual Reports*, IOWA DEP'T PUB. HEALTH, https://idph.iowa.gov/cert-of-need/reports (showing the annual statistical breakdown of Iowa's CON program) (last visited July 5, 2018).

unequally, thus benefitting some health care providers at the expense of others. The Fourteenth Amendment requires that no state shall "deny to any person within its jurisdiction the *equal* protection of the laws."[197]

A loophole in the Iowa CON statute leads to the unequal application of the law, resulting in disparate outcomes. Under the Iowa statute, an existing institutional health facility, operating with a CON, does not need to seek permission from the Council if the amount of their project is less than $1.5 million.[198] Whereas if an institutional health facility wants to offer new services, and does not have a CON, the facility must obtain a CON, regardless of expenditure amount, before offering health care services.[199] Additionally, as previously mentioned, the statute allows for existing CON holders to oppose the project at a public hearing.[200]

Dr. Birchansky's situation illustrates the conundrum the Iowa statute creates. Dr. Birchansky was not initially allowed to offer services (eye surgeries) in his outpatient surgery center because he did not have a CON, but because one of Birchansky's competitors in Cedar Rapids already had a CON, they avoided the cost of the burdensome CON process and opened a new outpatient surgery center like the one Dr. Birchansky originally proposed.[201] Arguably Dr. Birchansky was denied, in part, following a public hearing in which the competitor, who later opened an outpatient surgery center themselves, opposed his project.[202] Thus, an existing CON holder may oppose a project and claim that it is not needed, but then later develop and open a facility like the one it opposed without going through the CON process, provided the facility costs less than $1.5 million. This situation leaves one wondering, what purpose does CON serve if health care providers—who already have a CON—can circumvent the process altogether by spending less than $1.5 million on a project? In addition, besides avoiding the CON process if they navigate the statute correctly, the statute allows existing CON holders the opportunity to significantly influence who their competitors are.

197. U.S. CONST. amend. XIV § 1 (emphasis added).

198. *See* IOWA CODE § 135.61(18)(c)–(j) (2017); *supra* Section II.C. (explaining that Iowa's CON statute allows current CON holders to make capital expenditures under $1.5 million without going through the CON process).

199. IOWA CODE § 135.61(18)(c)–(j).

200. *See supra* Section II.C.2.

201. *Mercy's Hiawatha Medical Park Celebrates Opening*, MERCY CEDAR RAPIDS (July 21, 2017), https://www.mercycare.org/news/2017/mercys-hiawatha-medical-park-celebrates-opening. Given that Mercy had opposed Birchansky's application to open an outpatient surgery center, the comments from their CEO that there was "demand" for outpatient surgery center makes one wonder what the motives were for blocking Birchansky's application. Tim Charles, Mercy's CEO stated that, "We are responding to significant demand for conveniently located and more accessible care . . . . [t]here's been a push for many years to provide more treatment on an outpatient basis." *Id.*

202. *Id.*

In its current form, the Iowa CON program is an example of "naked economic protectionism."[203] Naked economic protectionism is "a term used to describe a law enacted with the sole purpose of shielding a particular group from economic competition."[204] As previously discussed, the statute's primary purpose, when originally enacted, was to control health care cost,[205] but over the last 40 years[206] the primary purpose of the CON statute has shifted from a cost containment mechanism to a government shield that certain health care providers can hide behind in the face of potential competition.[207]

This Note argues that the Iowa CON statute's loophole allowing existing CON holders to circumvent the CON application and review process violates the Equal Protection Clause of the 14th Amendment of the U.S. Constitution. When a party claims an Equal Protection violation based on a statute that does not impact a fundamental right, courts typically look to the rational basis test to weigh the statute's validity.[208] The rational basis test is "focused on a single underlying evil: The distribution of resources or opportunities to one group rather than another solely on the ground that those favored have exercised the raw political power to obtain what they want."[209]

A statute survives the rational basis test if

> there is a plausible policy reason for the [statute], the legislative facts on which the [statute] is apparently based rationally may have been considered to be true by the governmental decisionmaker, and the relationship of the [statute] to its goal is not so attenuated as to render the distinction arbitrary or irrational.[210]

Courts using the rational basis test have been deferential to legislatures by holding "that, if a law neither burdens a fundamental right nor targets a suspect class, we will uphold the legislative classification so long as it bears a rational relation to some legitimate end."[211] When applying this analytical framework to the Iowa CON statute in question, this Note argues that the loophole in the law fails rational basis because it targets a suspect class (non-

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203. Robert M. Ahlander, *Undressing Naked Economic Protectionism, Rational Basis Review, and Fourteenth Amendment Equal Protection*, 2017 BYU L. REV. 167, 168.

204. *Id.*

205. *See supra* Section II.C.1.

206. *See supra* Section II.C.1 & Part III.

207. *See* YEE ET AL., *supra* note 152, at 4.

208. *See* Heller v. Doe, 509 U.S. 312, 320 (1993) (applying the rational basis test in response to an Equal Protection claim); *see also* Hughes v. City of Cedar Rapids, 840 F.3d 987, 996 (8th Cir. 2016) ("When no fundamental right or suspect class is at issue, a challenged law must pass the rational basis test." (citing Reno v. Flores, 507 U.S. 292, 301 (1993))).

209. Order Re: Defendants' Motion to Dismiss at 27, Birchansky v. Clabaugh, No. 4:17-cv-00209-RGE-RAW (S.D. Iowa Feb. 12, 2018) (pdf on file with author) (quoting Cass R. Sunstein, *Naked Preferences & the Constitution*, 84 COLUM. L. REV. 1689, 1689 (2014)).

210. Nordlinger v. Hahn, 505 U.S. 1, 11 (1992) (citations omitted).

211. Romer v. Evans, 517 U.S. 620, 631 (1996).

CON holders), and does not have a relation to a legitimate end, because data and evidence prove that CON does not control health care cost, but instead simply results in naked economic protectionism.

Although Iowa CON defenders may claim that the statute's original purpose (to control health care cost) is clear and should control, the rational basis test allows plaintiffs challenging a law to "negate a seemingly plausible basis for the law by adducing evidence of [the law's] irrationality."[212] Plaintiffs challenging Iowa's statute can meet this hurdle. The data, reports, and experiences that states have had with CON over the last 40 years is compelling evidence,[213] and enough evidence to "negate [the] seemingly plausible basis"[214] that the Iowa Legislature may have had in 1977. Unfortunately, the Iowa Legislature continues to maintain the program under the guise that CON controls cost, which data shows is not true, and thus is an irrational basis for the loophole in the law to exist.

Because a plaintiff challenging the Iowa CON statute under a rational basis test can share data and facts that sufficiently "negate a seemingly plausible basis for the law"[215] the court's analysis under the rational basis test shifts. The question before the court becomes whether the statute's only remaining rational purpose—naked economic protectionism—is a legitimate purpose that should survive the rational basis test? The circuit courts have grappled with this question, and a circuit split currently exists on whether economic protectionism is a legitimate state purpose.[216] The Fifth, Sixth, and Ninth Circuits have held that naked economic protectionism is not a legitimate purpose, whereas the Second and Tenth circuits have concluded that economic protectionism is a legitimate state interest.[217] If the Eighth

212. St. Joseph Abbey v. Castille, 712 F.3d 215, 223 (5th Cir. 2013) (explaining that plaintiffs can use evidence to negate a statute's rationality, and the government has no burden to establish a rational basis for the statute). It is also important to note though that one should not assume the law's rationality. *See* Butts v. Nichols, 381 F. Supp. 573, 579 (S.D. Iowa 1974) ("Recent Supreme Court cases have made it quite apparent that simply discerning any legislative reason, however plausible, will not serve to satisfy the rational basis requirement." (citing U.S. Dep't of Agric. v. Moreno, 413 U.S. 528 (1973); Weber v. Aetna Casualty & Surety Co., 406 U.S. 164 (1972); Reed v. Reed, 404 U.S. 71 (1971))).

213. *See supra* Section III.A.

214. *See St. Joseph Abbey*, 712 F.3d at 223.

215. *See id.*

216. *See* David Bernstein, *Do Laws that Embody 'Naked Economic Protectionism' Violate the Equal Protection Clause?*, WASH. POST (Sept. 14, 2015), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/09/14/do-laws-that-embody-naked-economic-protectionism-violate-the-equal-protection-clause ("[A] split among the federal appellate courts has developed over whether courts are obligated to uphold laws for which the court is unable to find any public-spirited rationale, laws that instead seem to embody naked economic protectionism favoring an incumbent professional group seeking to stifle upstart competitors.").

217. *Compare St. Joseph Abbey*, 712 F.3d at 222–23, *and* Craigmiles v. Giles, 312 F.3d 220, 224 (6th Cir. 2002) (holding that protecting discrete interest groups from economic competition is not a legitimate government interest), *and* Merrifield v. Lockyer, 547 F.3d 978, 991 n.15 (9th Cir. 2008) ("[M]ere economic protectionism for the sake of economic protectionism is irrational with respect

Circuit applies the majority rule and holds that economic protectionism is not a legitimate state interest, the loophole in the Iowa CON statute would likely fail the rational basis test. At least one judge in the Southern District of Iowa has suggested that the Eighth Circuit would likely follow the Fifth Circuit because "[t]he Eighth Circuit's extensive quotation of the Fifth Circuit's conceptual framework suggests an agreement with the Fifth Circuit's determination [that] naked economic protectionism, stripped of any other legitimate government purpose, does not constitute a legitimate state interest for the purposes of a rational basis analysis."[218]

This Note does not analyze whether or not economic protectionism is a legitimate state interest, as a number of authors have previously considered this question.[219] This Note explains that the Iowa CON statute is an example of a statute that may have been enacted with the aspirational aim of controlling health care costs, but instead of accomplishing that goal, the statute has resulted in naked economic protectionism for certain Iowa health care providers. As time and research has shown, CONs do not control health care costs.[220] Instead CONs primarily serve to protect entrenched health care service providers market share on health care services across the state. Thus, this Note argues that the primary purpose for the Iowa CON statute has shifted from controlling health care cost for Iowans (a legitimate state interest), to simply becoming a form of naked economic protectionism (a non-legitimate state interest) for certain existing Iowa health care providers. The Iowa Legislature needs to address this significant problem, and this Note offers two solutions for their consideration.

IV. SOLUTION

The Iowa Legislature has a few straight-forward options to address the fact that the Iowa CON statute likely does not control cost,[221] and instead acts as a government shield from competition for certain health care providers.[222]

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to determining if a classification survives rational basis review."), *with* Sensational Smiles, LLC v. Mullen, 793 F.3d 281, 286 (2d Cir. 2015) ("[E]conomic favoritism is rational for purposes of our review of state action under the Fourteenth Amendment"), *and* Powers v. Harris, 379 F.3d 1208, 1221 (10th Cir. 2004) ("[A]bsent a violation of a specific constitutional provision or other federal law, intrastate economic protectionism constitutes a legitimate state interest.").

218. Birchansky v. Clabaugh, No. 4:17-cv-00209-RGE-RAW, at 26 (S.D. Iowa Feb. 12, 2018).

219. *See, e.g.*, Timothy Sandefur, *Is Economic Exclusion a Legitimate State Interest? Four Recent Cases Test the Boundaries*, 14 WM. & MARY BILL OF RIGHTS J. 1023 (2006); Roger V. Abbot, Note, *Is Economic Protectionism a Legitimate Governmental Interest Under Rational Basis Review?*, 62 CATH. U. L. REV. 475 (2013); Elizabeth Trafton, Comment, *The Fifth Circuit Lays Economic Protectionism to Rest in* St. Joseph Abbey, 55 B.C. L. REV. 141 (2014).

220. *See supra* Section III.A.

221. The author acknowledges that no empirical research or study has been done specifically on the effect of CON in the state of Iowa, thus, besides otherwise stated, any reference to cost increases or decreases are in a general sense and inferred from other states experiences with CON.

222. *See supra* Section III.B.

This Note proposes two possible solutions in response to the existing Iowa CON program: (1) fully repeal the Iowa CON statute and program; or (2) amend the statute significantly to eliminate the CON requirements for a number of institutional health facilities and address the loophole that gives rise to economic protectionism. This Note asserts that the first solution—full repeal—should be a mechanism that any state legislature across the country, within a state that currently has CON, should employ. In comparison, the second solution this Note proposes—statutory amendment—is crafted and proposed specifically in response to the loophole in Iowa's CON statute. This Part of the Note addresses both of those potential solutions.

A. FULL REPEAL

The most effective solution to the problems that the Iowa CON regime imposes on health care service providers is simple: a full repeal of the statute. This Note proposes that the Iowa Legislature should join the 14 states that have repealed their CON programs.[223] As previously discussed, studies indicate that no decrease in patients' access to health care services or quality of care results following CON's repeal.[224] In fact, following repeal access and quality typically increase, while the per capita cost of health care decreases.[225] Not only would Iowa join a number of states that have repealed CON, Iowa would join several states that are considering, or making significant steps towards, repeal of their CON statutes.[226] Additionally, the legislature can look to states that have fully repealed CON and be comfortable knowing that the health care market will not collapse without CON. Full repeal will not only result in lower health care cost, but will likely lead to increased investment throughout the state by health care providers who do not hold a CON and were wary of investing previously due to the burdensome, expensive, and unpredictable CON process.

By repealing the CON Statute, the Iowa Legislature's action would not run counter to any policy objectives that the prior legislature aimed for when it enacted the original CON statute. As discussed, the Iowa CON statute was put in place to control cost and develop the Iowa health care market in an

223. Cauchi & Noble, *supra* note 90.

224. *See supra* Section III.A.

225. *See* DOBSON ET AL., *supra* note 172, at 26.

226. Alexandra Glorioso, *Florida Legislators Focus on Hospital Costs, Competition*, NAPLES DAILY NEWS (Mar. 19, 2017, 12:01 PM), http://www.naplesnews.com/story/news/politics/2017/03/17/lawmakers-work-florida-hospital-regulation-deal/99252714; Jeff Moore, *Senate Republicans introduce multiple Certificate of Need reform, repeal bills*, N. ST. J. (Mar. 25, 2017), https://nsjonline.com/article/2017/03/senate-republicans-intriduce-con-reform; Mark Taylor, *States Scrutinizing Certificate of Need Programs*, HFMA (Feb. 18, 2017), https://www.hfma.org/Content.aspx?id=52833 ("In the last legislative session, two dozen states introduced some CON reforms—some more drastic than others. North and South Carolina have pushed to reform or repeal their laws and Tennessee has made efforts in that direction, as well.").

economical manner.[227] Although repeal of the statute seems counter-intuitive to achieving the statute's policy goal, if the legislature is truly interested in controlling health care cost, repealing this unduly burdensome regulation on the health care market would be a positive step towards expanding access to, and decreasing the cost of, health care for Iowans. On February 3, 2018, Senator Brad Zaun introduced a bill in the Iowa Senate which would repeal the Iowa CON program in its entirety,[228] but notably, similar bills making changes to the CON program have been introduced before—but only to fall on deaf ears. Senator Zaun's bill subsequently did not receive a vote in committee, thus it died during the 2018 legislative session.

B. AMENDING THE IOWA CON STATUTE

This Note proposes a second, likely more realistic, solution for the Iowa Legislature. Because the Iowa health care industry is one of the largest influencers at the State Capitol in Des Moines,[229] full repeal of the statute is likely unobtainable. At a minimum, the legislature should address the loophole in the CON statute that amounts to a form of naked economic protectionism.[230] The legislature should treat all institutional health care providers equally, regardless of whether the provider currently has a CON or not. Thus, this Note recommends that the Iowa Legislature amend the statute to eliminate the $1.5 million threshold exception that currently applies to institutional health care facilities that already hold a CON.[231] An alternative to completely eliminating the threshold would be to potentially lower the amount triggering the exception, thus the legislature could make it difficult in practice for any existing institutional health care provider to make a capital expenditure without going through the CON process.

The legislature can also amend the statute to (somewhat) eliminate the potential for undue political influence with the Health Facility Council's decisions. One step that the legislature should consider is to expand the number of members on the Iowa Health Facilities Council. Expanding the number of individuals on the Council from five to seven or nine limits the concentration of influence that each Council member has. Expanding the number of members on the Council will likely result in a limited increase in cost; and in exchange the increase members will result, at a minimum, in better optics for the CON process in Iowa. An expanded board could potentially limit the amount of influence any one member or interested party could exercise.

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227. *See supra* notes 151–52 and accompanying text.

228. S.F. 2021, 87th Gen. Assemb. (Iowa 2017).

229. *See supra* notes 192–94 and accompanying text.

230. *See supra* Section III.C.

231. To accomplish my amendment, I would strike from Iowa Code § 135.61(18), subpart's C, G, H, I, and J.

A narrower amendment that the legislature should consider is a change in the application fee structure for the CON process.[232] Currently the application fee is "equivalent to three-tenths of 1 percent of the anticipated cost of the project."[233] In its current form, the application fee is non-refundable if an applicant's CON is denied. Given the inherent unpredictability in the system, and the significant amount of the application fee, up to $21,000, the Iowa Legislature should amend the statute to allow for the refund of the fee if the Council denies the applicant a CON. This amendment, although likely *de minimis* in nature, will be an incentive for medical entrepreneurs to pursue investment in Iowa and know that if their application is denied they can recover some cost that they have incurred.[234]

This Note also encourages the Iowa Legislature to consider House File 422, legislation that Representative Rob Taylor introduced in the 2017 legislative session.[235] The proposed legislation failed to pass a three-member panel of Republicans in 2017, but should be reconsidered.[236] Taylor's original bill would have eliminated CON requirements for all institutional health facilities in Iowa except nursing homes and assisted living facilities, under an amended version of the bill, new hospitals would need to obtain a CON, but the bill "would have exempted doctor-owned clinics from having to seek permits to buy equipment costing more than $1.5 million."[237] Although this Note recommends the adoption of the Bill in its original form, and recommends against the inclusion of the $1.5 million exemption for existing CON holders, any conversation aimed towards limiting the scope of CON in Iowa will surely benefit Iowa medical entrepreneurs and patients.

V. CONCLUSION

In its current form—and in any form—the Iowa CON statute does not achieve its primary purpose of controlling health care access and ensuring efficient access to health care for Iowans. The federal repeal of the NHPRDA, the mountain of research and literature, and the federal governments repeated statements and studies concluding that CON does not work, should incentive the Iowa Legislature to repeal the statute. As this Note points out, unfortunately the political pressure that legislators feel from the influence of

232. *See supra* notes 113–17 and accompanying text.

233. IOWA ADMIN. CODE r. 641-202.4(2) (2017); *see supra* note 114 and accompanying text.

234. Applicants will undoubtedly incur a number of expenses outside of the application fee, so providing relief in this manner does not mean that applicants are off the hook for all expenses associated with the process.

235. H.F. 422, 87th Gen. Assemb. (Iowa 2017).

236. Joyce Russell, *GOP Bill to Help Entrepreneurial Physicians Stalls*, IOWA PUB. RADIO (Mar. 1, 2017), http://iowapublicradio.org/post/gop-bill-help-entrepreneurial-physicians-stalls#stream ("Hospital executives say if the bill is passed, they would lose income from those profitable services that helps pay the bills for full-service 24-7 medical care.").

237. *See* Pfannenstiel, *supra* note 192 (describing the proposed bill and subsequent amendments made by Rep. Taylor).

the Iowa Hospital Association and other medical interest group blurs their vision, but they should look through the smoke and mirrors and see the facts. At the end of the day, "Patients lose, but hospitals (at least the ones lucky enough to already have access to the market) benefit from CON laws."[238]

238. Boehm, *supra* note 185.