Iowans Need Change: The Case for Repeal of Iowa's Certificate of Need Law

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I. INTRODUCTION

Health care costs are tragically rising, and consumers are paying the price. Additionally, solving the health care cost crisis is not a simple task. Some argue that the nearly 1000 pages of the Patient Protection and Affordable Care Act (Affordable Care Act) did not even scratch the surface of solving the underlying problems in the American health care system and still left many marginalized people without proper access to healthcare.[1] This Note does not purport to solve each and every source of rising health care costs. However, the health care system is riddled with inefficiencies—some of which are easily expendable—and this Note attempts to address one in particular: the Certificate of Need (CON) program.

Iowa's CON law will specifically be addressed. But before delving into the history of CON implementation in Iowa, this Note first provides an overview of the conception of CON laws on a national scale and the problem they were initially intended to solve. A roadmap will then be established for maneuvering the Iowa CON process: the process of attaining a CON, the penalties for not attaining a CON, the process an institutional health facility would go through to determine if the facility required a CON in Iowa, and finally, the current proposed amendments to the CON program.

The effectiveness of CON programs generally will be analyzed—focusing primarily on health care cost, their disloyalty to the outcomes in which they were implemented to address, and whether the benefits thereof derived are worth their shortcomings. The Note will analyze Iowa CON laws specifically and compare the effects of Iowa CON to states that have acted to repeal their programs.

Finally, this Note recommends that Iowa repeal its CON program, while paying close attention to, and simultaneously providing a remedy for, any potential negative effect that may derive from a CON program repeal.

II. BACKGROUND

Prior to discussing the level of effectiveness of CON laws and their unintended consequences, this Part will provide a basic history of the origin of CON laws at the federal level and the history of CON laws particular to their effect in Iowa. Then this Part will provide a comprehensive guide of Iowa's CON program and how a CON is attained. The major questions will then be answered: How does an entity know if a CON must be obtained for a certain project? What factors does the Council consider when determining need in its grant or denial of a CON? And finally, what penalties would an entity incur in Iowa if it were to fail to obtain a required CON?

A. The Implementation of CON Laws: State Invention, Federal Initiative

Controlling the rise in health care costs without sacrificing quality is, and has always

1. *See, e.g.*, Marc Gregory Cain, *The Effects of the Patient Protection and Affordable Care Act on Medicaid: Will Seniors Have More Long-Term Care Options and an Easier Application Process?*, 4 EST. PLAN. & COMMUNITY PROP. L.J. 127, 129 (2011) (analyzing both positive and negative implications of the health reform bill); Joanna V. Theiss, *It May Be Here to Stay, But Is It Working? The Implementation of the Affordable Care Act Through an Analysis of Coverage of HIV Treatment and Prevention*, 12 J. HEALTH & BIOMEDICAL L. 109, 166 (2016) (arguing that even after the Affordable Care Act's passage, the Department of Health and Human Services has not succeeded in making health coverage meaningful, accessible, and affordable).

been, a serious governmental concern. However, over time the "ideal" strategy for striking this balance has changed. In 1946, for example, Congress passed the Hill-Burton Act to "promote the development of community hospitals by providing states with funds for facility construction."[2] This Act provided a financial incentive to states for the formation of modern health care infrastructures.[3] From 1947 to 1971, the Hill-Burton Act was responsible for "$3.7 billion in federal funding and $9.1 billion in matches from state and local governments."[4] This funding created space for nearly half a million beds, spanning a total of 10,748 projects in a variety of health facilities.[5] The idea was inspired by "the '*Roemer Effect*,' i.e., the theory that there is a high correlation between the number of available hospital beds and the use of those beds."[6] However, the governmental financial investment in the health care industry pursuant to this statute proved ineffective—health care costs became highly inflated, in effect making "modern health care" more difficult to access and afford for those to which it was originally intended to help.[7]

In response to the inflating health care costs, the ideal strategy for ensuring the advancement of a quality modern health care system shifted in the early 1960s from the Hill-Burton Act, which prioritized heavy financial investment in the industry, to a cost-controlled marketplace.[8] Since the rising health care costs were attributed to the inefficient, "over-investment in duplicative health care facilities,"[9] Congress enacted a series of legislation in 1974 which provided financial incentives to states implementing processes to control such "over-investment."[10] Thus, the federal government mandated state CON programs—regulatory programs restricting the construction of and investment in institutional health facilities based on market need—pursuant to the National Health Planning and Resources Development Act (NHPRDA).[11] By 1978, 36 states opted into the federal funding initiative and enacted their own statewide CON laws,[12] and by 1982, every state except Louisiana had enacted such programs.[13] However, the effectiveness of CONs

2. Jessica C. Burt, *Certificate of Need (CON) Law Series: Part I – A Controversial History*, 5 HEALTH CAP. TOPICS 1, 1 (2012).

3. Karen Kruse Thomas, *The Hill-Burton Act and Civil Rights: Expanding Hospital Care for Black Southerners, 1939–1960*, 72 J.S. HIST. 823, 823 (2006).

4. *Id.*

5. *Id.*

6. Burt, *supra* note 2.

7. *See infra* Part II.B.

8. *See* Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 ANTITRUST 50, 50–51 (2015) (demonstrating the shift from the Hill-Burton era to the CON cost-containment initiative).

9. *Id.* at 50.

10. *Id.*

11. Richard Cauchi & Ashley Noble, *CON-Certificate of Need State Laws*, NAT'L CONF. ST. LEGISLATURES (Feb. 28 2019), http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx [hereinafter NCSL] (explaining the NHPRDA required the implementation of structures "involving the submission of proposals and obtaining approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices"). Within one year, "20 states had enacted CON laws and by 1978, a total of 36 states had CON laws in place." Burt, *supra* note 2. However, the federal government was not the first entity to identify CON's as a potential solution to the inflated health care costs. Ten years prior to the enactment of NHPRDA, New York enacted its own state law restricting hospital construction. Ohlhausen, *supra* note 8, at 51.

12. NCSL, *supra* note 11.

13. James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225, 1225 (1985).

was quickly called into question,[14] leading Congress to repeal the NHPRDA in 1987. States were then free to control inflation caused by excessive health care investment without any federal financial influence.[15] Today, the CON laws of 36 states plus Puerto Rico, the U.S. Virgin Islands, and the District of Columbia, remain in force.[16]

B. The Implementation of Iowa's CON Law

Iowa implemented its own CON laws in 1977 pursuant to NHPRDA, and the laws—subject to a few amendments—are still in force today.[17] Iowa CON laws carry the purpose of "ensur[ing] that the citizens . . . will receive necessary and adequate institutional health services in an economical manner."[18] In alignment with this goal, it is understood that the State Health Facilities Council (the Council) "avoid[s] unnecessary duplication of institutional services as well as . . . control[s] the costs of administering these services."[19] These goals and expectations shed light on Iowa's CON policy and will be analyzed in later Parts of this Note.

Iowa Code Sections 135.61–83 provide for the implementation of a CON program in Iowa and prescribes the program's basic requirements. Under the Iowa Code, a "new" or "changed" institutional health service[20]—any health service furnished in or through institutional health facilities or health maintenance organizations, including mobile health services—shall not be offered or developed in this state without prior application to the department for, and receipt of, a CON.[21] Pursuant to Iowa Code Sections 135.61–83, the Iowa Department of Public Health (the Department) is responsible for enforcing this program.[22] It does so through a five-member council appointed by the governor and confirmed by the Iowa Senate.[23]

C. The Process of Attaining an Iowa CON

The process of obtaining a CON can be daunting in light of the time required to file all necessary paperwork and await a decision, the cost of hiring an attorney to maneuver the administrative process in the most effective manner, and the risk of a denial by the Council after the plans for an institutional health facility venture are nearly solidified.[24] In

14. David S. Salkever & Thomas W. Bice, *The Impact of Certificate-of Need Controls on Hospital Investment*, 54 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 185, 209 (1976) (finding "that, while CON has controlled expansion in bed supply, it has stimulated other types of investment and, therefore, had little effect on total investment expenditures").

15. Burt, *supra* note 2.

16. NCSL, *supra* note 11.

17. *See* Act of July 1, 1977, ch. 75, § 2, 1977 Iowa Acts 233, 238 (current version at IOWA CODE ANN. § 135.62 (West 2019)) (establishing the Iowa Health Care Facilities Council).

18. Greenwood Manor v. Iowa Dep't of Pub. Health, 641 N.W.2d 823, 831–32 (Iowa 2002).

19. *Id.* at 832.

20. The scope of what specifically classifies as "new" or "changed" under the relevant statute and regulations will be analyzed in depth later. *Infra* Part II.D.1.

21. IOWA CODE ANN. §§ 135.61 (West 2009), 135.62 (West 2019), 135.63 (West 2012).

22. § 135.62.

23. *Certificate of Need*, IOWA DEP'T OF PUB. HEALTH (Feb. 8, 2019), http://idph.iowa.gov/cert-of-need ("The responsibility for providing administrative support for the Council rests with the Iowa Department of Public Health. It is the council's mandate 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.") [hereinafter IDPH Certificate of Need].

24. *See, e.g.*, Birchansky Real Estate, LC v. Iowa Dep't of Pub. Health, No. CV-5619, 2005 WL 6202755

an attempt to address these concerns, this Part presents a comprehensive guide to Iowa's CON process.

1. Determination Proceeding

Although the Iowa Code defines the scope of the CON program generally, there may be a situation in which a party is unsure of the statute's particular applicability. To address this concern, the Department passed Iowa Administrative Code Rule 641-202.3(1), which provides for a determination of reviewability proceeding—a proceeding specifically for the purpose of determining whether a proposed construction or financial investment falls under the scope of Iowa's CON laws.[25] The Department, rather than the Council, conducts this preliminary proceeding, their determination of which is then provided to the Council for a final decision on the matter.[26]

The determination proceeding is available to a sponsor of a project[27] who submits a written request for reviewability.[28] To be considered, the request should include: (1) sufficient details of the proposed project and (2) citations to the sections of the Iowa Code the sponsor relies upon to assert the project is not reviewable.[29] If the Department determines the proposed project to be non-reviewable—to not fall under the scope of Iowa's CON laws—the determination is sent to the Council for final consideration on the matter of reviewability.[30] On the other hand, if the Department determines the project is reviewable, the sponsor's application moves on and serves as the letter of intent for the purpose of the CON application.[31] It is important to note that a determination proceeding is not a prerequisite for a CON application; it is an option available to potential sponsors intended to streamline the CON process and prevent unnecessary hearings down the road. In other words, the determination proceeding helps to ensure most CON applications that go through the extensive CON process are eligible for a CON in the first place.

2. Application Process

Prior to applying for a CON, a letter of intent must be submitted to the Department

(Iowa Dist. Ct. Nov. 16, 2005). Litigation over this specific CON spanned from 2005 until Dr. Birchansky's application for an outpatient surgical facility was finally granted in July of 2017. IOWA DEP'T OF PUB. HEALTH, PROJECTS REVIEWED BY STATE HEALTH FACILITIES COUNCIL: FISCAL YEAR 2018 1, 2 (2018), http://idph.iowa.gov/Portals/1/userfiles/50/FY18%20Projects%20v2.pdf.

25. IOWA ADMIN. CODE r. 641-202.3(1) (2014).

26. IOWA ADMIN. CODE r. 641-202.3(2)(b) (2014).

27. The relevant statutes and regulations are silent as to any limitations on precisely which entity is considered the sponsor of a project. On the CON application form, the sponsor is co-listed with "owner," but it does not seem as though sponsors are exclusively limited to the owners of institutional health facilities. Multiple entities may sponsor an institutional health facility project. For example, Mercy Iowa City and Kindred Healthcare are concurrently sponsoring a new 40-bed inpatient rehabilitation hospital project. The extent of the information about sponsorship provided on the Department's website is that "[p]otential applicants include hospitals, nursing homes, outpatient surgery centers or anyone purchasing medical equipment valued above $1.5 million," and that "[p]rojects proposed by providers are reviewed by department staff and the State Health Facilities Council against the criteria specified in the law." IDPH Certificate of Need, *supra* note 23.

28. IOWA ADMIN. CODE r. 641-202.3(1) (2014).

29. IOWA ADMIN. CODE r. 641-202.3(2) (2014).

30. IOWA ADMIN. CODE r. 641-202.3(2)(b) (2014).

31. IOWA ADMIN. CODE r. 641-202.3(2)(a) (2014). The Note will discuss the CON application *infra* Part II.C.2.

containing a brief description of the proposed project, its location, the estimated cost, and an explanation of how the project will be financed.[32] This letter must be submitted at least 30 days before applying for a CON, before any substantial expenditures are made, and preferably, as soon as the planning stage for the project has begun.[33]

Sixty days after the Department receives the letter of intent, the sponsor may then submit a formal application for their proposed project and pay the applicable fee. Upon the Department's acceptance of the application, a "formal review" of the application begins.[34] Application fees range from $600 to $21,000 based on the total cost of the project.[35] The Council will hear applications that have been submitted to the Department no later than 30 days before the upcoming meeting. The formal review consists of a criteria-based evaluation by the Council determining need for the project in the relevant market and a public hearing in which statements may be made in support or opposition of the project.[36]

3. Notice to Competitors

The purpose of CON programs is to protect pre-existing institutional health facilities, physicians, health care providers, and patients (collectively "affected persons") from suffering the effects of inflation caused by the construction or addition of similar services in the local market. It is therefore important, under the CON model, for affected persons[37]

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32. IOWA CODE ANN. § 135.65(1) (West 2009). If the project is determined reviewable through the Department's determination of reviewability process, the request for non-reviewability rolls over and will be considered the project's letter of intent. IOWA ADMIN. CODE r. 641-202.3(2)(a) (2014). Case law suggests otherwise. The Eighth Circuit held in an uncontested 1997 case that a plaintiff's request for a determination of reviewability did not amount to a letter of intent for the purpose of a CON application, because "[o]nce the Department notified the plaintiff that its proposal was reviewable, the plaintiff was free to change its plans in order to fall outside the CON regulations, or to file a letter of intent and formal application and proceed as planned . . . ." Planned Parenthood of Greater Iowa, Inc. v. Atchison, 126 F.3d 1042, 1047 (8th Cir. 1997). However, Rule 641-202.3(2)(a) was enacted in 2014, to be held effective in 2015, so *Atchison* will most likely not bind future litigation on this matter.

33. IOWA ADMIN. CODE r. 641-202.2(2) (2014).

34. *Atchison*, 126 F.3d at 1044; § 135.65.

35. § 135.63(1). The fee is determined based on the anticipated cost of the project: three-tenths of one percent of the anticipated cost, with a minimum fee of $600 and a maximum fee of $21,000. The Iowa Department of the Treasurer will refund 75% of the application fee if the application is withdrawn within 30 days of submission. Between 30 and 60 days after submission, the Treasurer will refund 50% of the fee. After 60 days, the refund is finally limited to 25% of the fee. *Id.*

36. *Atchison*, 126 F.3d at 1047; § 135.66(3)–(4).

37. Iowa Code Section 135.61 defines "affected persons" as

> [t]he person submitting the application[,] . . . [c]onsumers who would be served by the new institutional health service proposed in the application[,] . . . [e]ach institutional health facility or health maintenance organization which is located in the geographic area which would appropriately be served by the new institutional health service proposed in the application[,] . . . [e]ach institutional health facility or health maintenance organization which, prior to receipt of the application by the department, has formally indicated to the department pursuant to this division an intent to furnish in the future institutional health services similar to the new institutional health service proposed in the application[,] . . . [a]ny other person designated as an affected person by rules of the department[, and] . . . [a]ny payer or third-party payer for health services.

IOWA CODE ANN. § 135.61(1)(a)–(f) (2009). The geographic area which would appropriately be served is defined as "the same county and in Iowa counties contiguous to the county wherein the . . . proposed health care facility will be located." IOWA ADMIN. CODE r. 641-202.1 (2014).

to be notified of a proposed project, and for there to be an opportunity for those entities to provide an objection. Upon acceptance of a CON application, the Department will notify all affected persons a formal review of the application has been initiated.[38] When written notification to consumers, third party payers, and other health service payers proves too difficult, the statute allows the Department to provide general notice through news media.[39] Additionally, the Department provides a list of active applications awaiting review on its website and provides the tentative hearing date.[40] Pursuant to Iowa Code Section 135, the Department is required to give at least ten days' notice of a public hearing to determine the grant or denial of a CON application and provide an opportunity to all affected persons to present testimony to the Council.[41]

4. Decision—Basis for Grant or Denial

The Council considers 18 criteria listed in Iowa Code Section 135.64(1)(a)-(r)[42] and will grant a CON for a proposed project only if it finds the following four factors exist: (1) there are no efficient alternatives to the proposed project already available in the area and it would be impractical to develop such efficient alternatives; (2) "[a]ny existing facilities providing institutional health services similar to those proposed are being used in an appropriate and efficient manner;"[43] (3) if applicable, modernization or sharing arrangements were considered, "and have been implemented to the maximum extent practicable;"[44] and (4) patients will have difficulty obtaining the type of care that would be offered by the proposed new or changed institutional health service if the project were to be denied.[45]

For example, the Council denied a proposed ambulatory plastic surgery center in Davenport, Iowa because the utilization of the excess capacity at existing facilities was a

38. § 135.66(2).

39. *Id.*

40. *See, e.g.*, IOWA DEP'T PUB. HEALTH, Applications for CON Currently on File Waiting Review – 8/30/2018, Idph.iowa.gov/policy-and-workforce-services/cert-of-need (follow "List of current applications" PDF hyperlink to see the updated document) (last visited Feb. 9, 2019).

41. § 135.66(4).

42. For example, the Council considers these factors, among others, when determining need for a proposed project:

> The contribution of the . . . service in meeting the needs of the medically underserved . . . the extent to which medically underserved residents in the applicant's service area are likely to have access to the proposed institutional health service[, t]he relationship of the proposed institutional health services to the long-range development plan, if any, of the person providing or proposing the services[, t]he need of the population . . . to be served by the proposed institutional health services for those services[,] . . . [t]he availability of alternative, less costly, or more effective methods of providing the proposed institutional health services . . . the probable impact of the proposal on the costs of and charges for providing health services by the . . . new institutional health service . . . [t]he appropriate and efficient use or prospective use of the proposed institutional health service, and of any existing similar services . . . [, t]he appropriate and nondiscriminatory utilization of existing and available health care providers.

IOWA CODE ANN. § 135.64(1)(a)–(r) (West 2009). There are additional criteria that apply only to specific types of proposed projects. *Id.*

43. *Id.* at § 135.64(1)(b).

44. § 135.64(1)(c).

45. Birchansky Real Estate, L.C. v. Iowa Dep't of Pub. Health, 737 N.W.2d 134, 140 (Iowa 2007).

more appropriate alternative, the existing facilities would lose about five to ten cases per year from the applicant, the project was not "new" or "changed," and patients would not experience problems obtaining care with the denial of this project.[46]

5. Penalties

A party is subject to temporary or permanent restraint from offering or developing a new or changed institutional health facility if the party does not first obtain a CON.[47] When a party acts in violation of Iowa's CON program, Section 135.71 first requires the party be denied its respective licensure or change in licensure,[48] and is also subject to certain penalties to be determined based on the category of violation.[49] The Iowa Legislature has divided violations of Iowa's CON laws into two categories—class I and class II violations—but has relinquished power to the Department to "adopt rules setting forth the violations by classification, the criteria for the classification of any violation not [provided by Section 135.73], and procedures for implementing [Section 135.73]."[50]

Section 135.73 defines a class I violation as those in which a party offers a new or changed institutional health facility without first being approved by the Council. For a class I violation, the party is subject to a penalty of $300 per each day the violation occurs.[51]

Class II violations occur when a party receives approval by the Council for a project but violates the terms of the approved application.[52] For example, imagine a proposed project was approved by the Council based on the understanding the construction of the ambulatory surgical center would cost $1.2 million, yet amidst construction, the actual cost of the project turns out to exceed the approved amount. The sponsor of the project must then file a request with the Department to re-review the project under the new circumstances.[53] If the sponsor does not file a request for re-review of the project, the party has committed a class II violation.

The Department may seek injunctive relief and impose a penalty of $500 for each day of a class II violation.[54] However, if there is a showing of good faith compliance with the Department's request to immediately cease and desist from any further violations, the Department has the discretion to reduce, alter, or waive a class II penalty.[55]

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46. App. of Iowa Plastic Surgery Center, LC, Iowa Dept. of Public Health, State Health Facilities Council (Apr. 15, 2008).

47. IOWA CODE ANN. § 135.73(3) (West 2009).

48. § 135.73(1).

49. § 135.73(2).

50. § 135.73. Hearings to determine under which class a violation falls are conducted pursuant to 641 Iowa Admin. Code 173, the Department's procedural rules for contested cases. IOWA ADMIN. CODE r. 641-202.15.

51. § 135.73(2)(a).

52. IOWA CODE ANN. § 135.73(2)(b) (West 1991).

53. IOWA ADMIN. CODE r. 641-202.14(1)–(2).

> An increase in the actual cost of the project over and above that originally approved shall automatically generate a rereview by the council if the increase exceeds the originally approved amount by: a. Fifteen percent for projects up to $999,999.99; b. Twelve percent for projects from $1,000,000.00 to $4,999,999.99; c. Eight percent for projects $5,000,000.00 and over. An increase in the approved cost that falls below the above percentages shall be reported to the department.

IOWA ADMIN. CODE r. 641-202.14(2). "Requests shall be made in writing and filed with the department." IOWA ADMIN. CODE r. 641-202.14(1).

54. § 135.73(2)(b).

55. *Id.*

D. Falling Under the Scope of Iowa's CON Law

Proposed projects' sponsors must consider the costs associated with the CON process, and the time budgeted for its administration. However, obtaining a CON is not required for every institutional health facility. This Part addresses that inquiry: who is required to obtain a CON in Iowa, and who may wish to incur the costs to obtain one—whether or not it is required of them by law.

1. Who Needs a CON?

New or changed institutional health services are required to obtain a CON by the Department before developing or offering services in Iowa.[56] Institutional health services are services provided at an institutional health facility, which is

> without regard to whether the facilities referred to are publicly or privately owned or are organized for profit or not or whether the facilities are part of or sponsored by a health maintenance organization: [a] hospital[, a] health care facility[, a]n organized outpatient health facility[, a]n outpatient surgical facility[, a] community mental health facility[, and a] birth center.[57]

Each of these facilities is specifically defined in Iowa Code Section 135.[58] It can be tricky, however, to determine if a specific health facility's venture falls under one of these definitions. For example, an "outpatient surgical facility" is

> a facility which as its *primary function* provides, through an organized medical staff and on an outpatient basis to patients who are generally ambulatory, surgical procedures *not ordinarily performed* in a private physician's office, but not requiring twenty-four hour hospitalization, and which is neither a part of a hospital nor the private office of a health care provider who there engages in the lawful practice of surgery.[59]

There are no statutory definitions or examples for procedures "not ordinarily performed in a private physician's office," so one must look elsewhere to determine if the Iowa Code would classify a potential health care facility's venture as an outpatient surgical facility, and thus require a CON.[60]

There are 16 situations in which an institutional health service is new or changed—and thus requires a CON.[61] A few of which are: when there is a complete construction of an institutional health facility, a capital expenditure in excess of $1.5 million within a 12-month period, an expenditure in excess of $500,000 for health services not offered on a regular basis for the past 12 months, or an acquisition of replacement equipment with a

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56. § 135.63(1).

57. IOWA CODE ANN. § 135.61(14) (West 1991).

58. § 135.61.

59. § 135.61(21) (emphasis added).

60. The problem with looking elsewhere is that agency decisions can be unpredictably ad hoc. Agency determinations are not bound by precedent quite like judicial decisions, so Council decisions may turn more on industry standards and the quality of advocacy rather than clear and pre-established standards. *See, e.g.*, Int'l Union v. NLRB, 802 F.2d 969, 974 (7th Cir. 1986) ("[This board is] not bound by *stare decisis* . . . [but] can jettison its precedents only if it has 'adequately explicated the basis of its [new] interpretation.'").

61. § 135.61(18)(a)–(m).

value in excess of $1.5 million.[62]

2. Who Wants a CON?

There are situations in which a party whose project is otherwise non-reviewable (or in other words, does not require a CON in Iowa) desires a CON. For the sake of demonstration, the following is a real example arising out of proceedings beginning in 2003.[63] Iowa Plastic Surgery, LC (IPS), out of Davenport, filed a request for non-reviewability in April 2003 for a proposed addition to an American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) accredited operating room to be constructed within its already-existing private physician facilities.[64] Originally, the Department determined reviewability over the project—Iowa Plastic Surgery would need a CON for this new operating room.[65] The Department reasoned that the request for an operating room implied their procedures were not ordinarily performed in a private physician's office (which therefore places IPS under the scope of the CON statute)[66] absent an operating room. However, in June of that same year, the Department considered additional information about the practice and decided, in fact, no CON was required.[67]

Despite the fact IPS did not require a CON, it reapplied for one five years later. Why would an entity go through the procedural trouble? IPS wanted to widen its customer base by providing reconstructive procedures, the financial feasibility of which was dependent on the ability to accept insurance payments.[68] In order to accept insurance payments for these procedures, Medicare certification as an ambulatory surgical center is required.[69] However, desiring a CON in order to classify itself as an ambulatory surgical center was not sufficient to obtain one in this case, because the Council determined nothing about their

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62. The 16 situations in which an institutional health service is new or changed—and thus requires a CON—are provided in Section 135.61(18)(a)–(m). Exclusions to the rule are promulgated in Section 135.63(2)–(3). One of the enumerated exclusions to the CON process is a "change in ownership, licensure, organizational structure, or designation of the type of institutional health facility [as long as] the health services offered [] are unchanged." IOWA CODE ANN. § 135.63(2)(*o*) (West 2019). In 2007, the Iowa Supreme Court held the Department's requirement that the change be "seamless" is "wholly unjustifiable" because the statute does not expressly or impliedly involve a temporal aspect. Birchansky Real Estate, L.C. v. Iowa Dep't of Pub. Health, 737 N.W.2d 134, 139 (Iowa 2007). However, during the course of the appeal in *Birchansky*, the Iowa legislature amended Section 135.63(2)(o) to include the language "simultaneously," which, for all intents and purposes, is a temporal aspect and can be reasonably interpreted by the Department as requiring a "seamless" transition of ownership to fall under the exclusion. *See* § 135.63(2)(o).

63. App. of Iowa Plastic Surgery Center, LC, at *1 (IOWA DEP'T OF PUB. HEALTH, June 19, 2007). This decision is stored in the Department's archive.

64. *Id.*

65. Letter from Barb Nervig to Ben Van Raalte, Certificate of Need Program, IOWA DEP'T OF PUB. HEALTH (Mar. 3, 2003).

66. The Iowa Code provides the following definition for "outpatient surgical facility":

> a facility which as its primary function provides, through an organized medical staff and on an outpatient basis to patients who are generally ambulatory, surgical procedures *not ordinarily performed in a private physician's office*, but not requiring twenty-four hour hospitalization, and which is neither a part of a hospital nor the private office of a health care provider who there engages in the lawful practice of surgery.

IOWA CODE ANN. § 135.61(21) (2009) (emphasis added).

67. App. of Iowa Plastic Surgery Center, LC, at *1 (IOWA DEP'T OF PUB. HEALTH, June 19, 2007).

68. App. of Iowa Plastic Surgery Center, LC, at *1–2 (IOWA DEP'T OF PUB. HEALTH, Apr. 15, 2008).

69. *Id.*

services had changed, only the desire to extend their customer base by seeking Medicare certification. The Council denied IPS's CON application, because the services rendered at IPS did not fall within the scope of the CON statute.[70]

E. Current Proposed Amendments

The scope of the Iowa CON program may be changing. There were two pending bills in the Iowa Legislature 2018 General Assembly intended to achieve that end. Iowa House File 2263, spear-headed by Representative Rob Taylor, suggests the program be restricted by increasing the threshold amount for various institutional health facility expenditures, thus requiring a CON in fewer situations.[71] The bill also no longer requires outpatient surgical facilities located in a county with a population over 30,000 that are offered, developed, and owned by a group of health care providers to obtain a CON.[72] The second bill relating to CON reform, Iowa Senate File 2021, proposed the complete repeal of the CON process.[73] Unfortunately, Senate File 2021 died in the subcommittee stage.[74]

III. ANALYSIS

In light of the administrative intricacies and hurdles discussed in the previous Part, one may wonder if CON programs deliver the promised results. This Part will analyze the effectiveness of CON laws, their loyalty to the outcomes in which they were implemented to address, and whether the benefits of CON laws are worth their shortcomings. This Analysis has the ultimate goal of demonstrating whether Iowa would be better off with or without its CON program.

A. CON Goals and Intended Outcomes

As stated in Part II, CON laws were originally, and still are, intended to rein in health care costs for consumers, insurers, and institutional health facilities by restricting market entrance.[75] By doing so, CON regulation should, in theory, (1) produce a sufficient supply of institutional health care services; (2) increase access to health care, especially to rural areas; (3) increase quality of health care; (4) expand access to health care to indigent consumers; (5) diversify the available institutional health care facilities by introducing and encouraging construction of hospital alternatives; and (6) generally restrain health care costs.[76] A less competitive market would allow institutional health facilities to charge higher up-front rates, which would raise profits and encourage reinvestment in quality

70. *Id.*

71. The bill increases the threshold amount applicable to new or changed institutional health services that must be met to be subject to the certificate of need process from $1.5 million to $5 million for certain acquisitions, capital expenditures, leases, and donations. H.F. 2263, 85th Gen. Assemb., Reg. Sess. (Iowa 2018).

72. H.F. 2263 (Iowa 2018).

73. S.F. 2021, 87th Gen. Assemb., Reg. Sess. (Iowa 2018). This bill was proposed by Iowa Senator Brad Zaun out of Polk County.

74. *Iowa Senate Bill 2021*, LEGISCAN, https://legiscan.com/IA/text/SF2021/id/1677647 (last visited Feb. 4, 2019).

75. *See supra* Part II.A.

76. Matthew D. Mitchell, *Certificate-of-Need Laws: Are They Achieving Their Goals?*, MERCATUS ON POLICY, 1–2 (Apr. 2017), https://www.mercatus.org/system/files/mercatus-mitchell-con-qa-mop-v1.pdf [hereinafter Mitchell, *Achieving Their Goals*].

assurance (such as investing in a state-of-the-art MRI machine) and cross-subsidization (subsidizing the cost of servicing consumers who cannot afford the market rate, thus making health care more accessible to indigent consumers).[77] However, instead of being praised for these theoretical effects, CON regulations have been subject to severe criticism over the years.[78]

B. Disloyalty to Goals and Intended Outcomes

In the age of cost-plus reimbursement,[79] CON regulations were strategically designed to combat the wasteful spending of hospitals.[80] Under the cost-plus reimbursement system, hospitals "were [reimbursed retroactively by the federal government for] whatever they spent."[81] Cost-plus reimbursement gave no external incentive to health care facilities to engage in efficient spending habits, because no matter the cost of the services offered, the facility would be reimbursed.[82] This practice of excessive spending resulted in deadweight loss, which occurs when marginal cost exceeds marginal benefit.[83] In response to these inefficiently high health care costs resulting from unchecked hospital spending, CON regulations were designed to move the market to a more efficient outcome by restricting the supply of institutional health services.[84]

Today, however, with cost-plus reimbursement being a distant memory,[85] constraining the supply of institutionalized health services no longer aids in reaching its original goals, but rather, creates substantial costs for consumers, taxpayers, and insurers.[86]

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77. Cross-subsidization has been described as "a cornerstone of the American hospital industry." However, scholars question its effectiveness in the health care industry. Dwayne A. Banks et al., *Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation*, 9 HEALTH MATRIX 1, 10 (1999).

78. *See, e.g.*, Mark J. Botti, Chief, Litigation I Section, U.S. Dep't Justice, Antitrust Division, Address Before a Joint Session of Georgia General Assembly Committees: Competition in Healthcare and Certificates of Need (Feb. 23, 2007), https://www.justice.gov/atr/competition-healthcare-and-certificates-need ("They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation."); Malia Blom, *'Certificate of Need' Laws are Certifiably Unnecessary*, THE HILL (Nov. 27, 2017, 1:00 PM), https://thehill.com/opinion/healthcare/361971-certificate-of-need-laws-are-certifiably-unnecessary (giving criticism of Certificate of Need laws).

79. For an overview of "cost-plus reimbursement" systems, see Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 96–97 (2011).

80. *See* Matthew D. Mitchell, *Do Certificate-of-Need Laws Limit Spending?* 9 (Mercatus Ctr. Geo. Mason U., Working Paper, 2016), https://www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v3.pdf (describing the practice of overinvestment in certain inputs with little regard to cost-control) [hereinafter Mitchell, *Limit Spending*]. *See also id.* Figure 2, Panel A, at 8 (demonstrating the economic waste produced under the cost-plus system when hospitals externalized costs).

81. Mitchell, *Limit Spending*, *supra* note 80, at 9.

82. *Id.*

83. *Id.*

84. *Id.*

85. Cost-plus retroactive reimbursement was replaced by Medicare's Prospective Payment System in 1983 under Public Law 98-21. *Id.* at 10; Stuart Guterman & Allen Dobson, *Impact of the Medicare Prospective Payment System for Hospitals*, 7 HEALTH CARE FIN. REV. 97, 97 (1986). Some argue that the shift from retroactive to prospective reimbursement left no reason for the existence of CON regulations at all. Mitchell, *Limit Spending, supra* note 80, at 9.

86. *See infra* Parts III.B.1–3.

1. The Cost of Restricted Access

CON regulations restrict access to *all* consumers.[87] Restricting the supply of institutional health services, which is the purpose of CON regulations, "means that all patients—even those who pay out of pocket . . . have less access to valuable medical services."[88] For example, CON laws are correlated with fewer hospital beds,[89] MRI machines,[90] CT scanners,[91] optical colonoscopy offerings,[92] and ambulatory surgical centers.[93] Additionally, "CON programs are associated with fewer hospitals overall, but also with fewer rural hospitals, rural hospital substitutes, and rural hospice care."[94] Rural and indigent consumers are especially negatively affected by these laws, specifically threatening Goal 6,[95] because CON regulations are correlated with increased prices and a reduction in supply, making health care more unaffordable for those with little resources and a visit with the doctor more difficult to obtain.[96] Restricted access means that patients are driving further and waiting longer for their health care services.[97]

So how did the legislatures and administrative officials incorrectly believe CON laws would increase health care access to indigent consumers? They mistakenly relied on the hospitals to cross-subsidize, to internalize the profits gained from their market control, and cover the cost of services to those that cannot pay.[98] A study conducted by Thomas Stratmann and Jacob W. Russ concluded CON programs do not induce cross-subsidization.[99] However, since their study lacked measures of hospital profitability, "[their] data do not allow us to make conclusions about whether this is because supply restrictions have not increased hospital profits, or because indigent care provision is not sufficiently enforced by the states that have these provisions."[100]

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87. Mitchell, *Limit Spending*, *supra* note 80, at 13 ("CON regulations restrict the ability of everybody to access medical services such as psychiatric care (regulated by CON procedures in 26 states), neonatal intensive care (regulated by 23 states), and MRI scans (regulated by 16 states).").

88. *Id.* To combat this and ensure access to health care services in low-income areas, some states have implemented an inverse market restriction measure in their CON programs. In Michigan, for example, "non-rural hospitals that wish to close a facility and build a new one must build within a 2-mile radius of the existing facility unless they undergo a formal CON review assessing the impact of the hospital closure on the community." Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?*, 4 NAT'L INST. HEALTH CARE REFORM 1, 6 (2011), https://web.archive.org/web/20180820194110/http:/nihcr.org/wp-content/uploads/2015/03/NIHCR_Research_Brief_No._4.pdf.

89. Thomas Stratmann & Jacob W. Russ, *Do Certificate-of-Need Laws Increase Indigent Care?* 10–11 (Mercatus Ctr. Geo. Mason U., Working Paper No. 14–20, 2014), https://www.mercatus.org/system/files/Stratmann-Certificate-of-Need.pdf.

90. *Id.* at 11.

91. *Id.* at 11–12.

92. *Id.* at 13.

93. Mitchell, *Achieving Their Goals*, *supra* note 76, tbl.1, at 6.

94. *Id.*

95. *See supra* Part II.A.

96. *See* Stratmann & Russ, *supra* note 89, at 16–17.

97. Mitchell, *Achieving Their Goals*, *supra* note 76, tbl.1, at 6 ("Residents of CON states must drive further to obtain care than residents of non-CON states.").

98. *See* Stratmann & Russ, *supra* note 89, at 3 (concluding that despite the intended incentives provided by the cross-subsidization hypothesis, "[t]he effect of CON programs on indigent care shows no clear pattern using either direct or indirect measures of indigent care").

99. *Id.* at 18. *See also* Frakt, *supra* note 79, at 90 (finding that when "cost shifting [or cross-subsidizing] . . . has occurred, [it is] usually at a relatively low rate").

100. Stratmann & Russ, *supra* note 89, at 18. Some states have, in turn, implemented charity requirements

2. The Cost of Mistakes

Second, CON regulations do not increase the quality of available health care services, but rather lower quality, and thus indirectly raise costs.[101] For example, George Mason University's Mercatus Center, a non-profit think-tank, found the "mortality rates for pneumonia, heart failure, and heart attacks, as well as patient deaths from serious complications after surgery" in hospitals that are subject to CON laws is statistically significantly higher than those that are not.[102]

While it is true that "providers performing higher volumes of procedures have better patient outcomes, particularly for more complex procedures," because limiting the number of institutional health facilities funnels patients into a handful of facilities where the physicians are more practiced,[103] this volume/outcome argument does not consider *all* of the effects of competition on health care quality.[104] The effects are better demonstrated by directly analyzing how changes in CON laws affect health outcomes overall. In fact, repealing or narrowing CON laws may, in some instances, actually improve the quality of care.[105]

3. The Increase of Per-Unit Cost

Third, although CON laws may reduce total health care expenditures, they have caused higher per-unit cost for health care services.[106] Similar to the idea that the cost-plus system of reimbursement encouraged hospitals to externalize their costs and spend irresponsibly, the x-efficiency theory[107] of economics furthers "when firms are protected from competition, they will have higher, not lower, production costs because

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to their CON programs. *Id.* at 14. Iowa is one of such states. *Id.* at n.12. However, "[t]he estimated effect of charity care requirements is positive, but is never statistically significant." *Id.* at 14. For example,

> one empirical study of the relationship between competition and charity care found a "complete lack of support for the 'cross-subsidization hypothesis': that hospitals use increased market power to fund more charity care or, stated in the negative, that increased competition will harm patients who rely on charity care.

Joint Statement of the FTC and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250, at *17 (Jan. 11, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf [hereinafter FTC Antitrust Joint Statement]. Note that there are scholars with opposing views. *See, e.g.*, Ellen S. Campbell & Gary M. Fournier, *Certificate-of-Need Deregulation and Indigent Hospital Care*, 18 J. HEALTH POL., POL'Y & L. 905, 906, 923 (1993) (concluding that despite CON laws' failure to contain health care costs, CON deregulation would decrease the incentive for hospitals to provide indigent care).

101. Mitchell, *Achieving Their Goals*, *supra* note 76, at 3.

102. *Certificate-of-Need Laws: Iowa State Profile*, GEO. MASON U. MERCATUS CTR., https://www.mercatus.org/system/files/iowa_state_profile.pdf (last visited Sept. 14, 2019) [hereinafter Iowa State Profile].

103. FTC Antitrust Joint Statement, *supra* note 100, at 14.

104. *Id.* at 14–15.

105. *Id.* at 15.

106. Mitchell, *Limit Spending*, *supra* note 80, at 7.

107. *X-Efficiency*, INVESTOPEDIA, https://www.investopedia.com/terms/x/x-efficiency.asp (last updated Feb. 21, 2018) (defining x-efficiency as "the degree of efficiency maintained by individuals and firms under conditions of imperfect competition"); HARVEY LEIBENSTEIN, GENERAL X-EFFICIENCY THEORY AND ECONOMIC DEVELOPMENT 17–18 (Oxford Univ. Press, Inc. 1978).

administrators will tend to be less disciplined about cost minimization."[108] So, whether or not we are faced with a cost-plus retroactive reimbursement process or a prospective reimbursement process like today, the simple fact CON regulations protect preexisting institutional health facilities from others entering the market will decrease their incentive to lower their internal costs as they will be able to charge what they want regardless.[109]

Interestingly, this increase in spending associated with CON laws does not correlate with the stringency of the various states' programs as one may otherwise expect.[110] So, perhaps, it could be the mere presence of CON regulations, the artificial supply restriction *generally*, that increases spending. For an example of this effect, consider another way in which the health care industry limits competition: hospital consolidation—or hospital mergers and acquisitions. Research shows when hospitals merge—especially in a highly concentrated market similar to markets created by CON regulations—those hospitals can increase health care prices by 20% or more.[111] As a result, consumers absorb those costs "in the form of higher premiums, lower benefits and lower wages."[112]

Restricting supply, based on a classic supply-and-demand economic model, may decrease total expenditures.[113] This decrease in expenditures naturally follows the decrease in supply; e.g., as a coal mine depletes its resources and as time passes, less coal will be purchased overall. However, the public receives a more direct benefit from a decrease in per-unit cost rather than a decrease in total health care expenditures, because it means quality health care is more affordable and accessible to consumers.[114] Health care in the United States, like coal (assuming we live in a world where there are no coal substitutes), is generally inelastic.[115] In other words, no matter the price, we still need to heat our homes and treat our pneumonia. Demand for the product or service will not simply bend to meet the restricted supply curve. So, although restricting supply may decrease total health care

108. Mitchell, *Limit Spending*, *supra* note 80, at 16.

109. *See* Harvey Leibenstein, *Allocative Efficiency vs. "X-Efficiency,"* 56 AM. ECON. REV. 392, 406–07 (1966) ("The importance of motivation and its association with degree of effort and search arises because the relation between inputs and outputs is *not* a determinate one."). *See also* Patrick A. Rivers et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11 (2010) (finding that CON programs do not only fail to minimize costs, but may actually increase them).

110. *See* James Bailey, *Can Health Spending Be Reined in Through Supply Constraints?: An Evaluation of Certificate-of-Need Laws* 25–27 (Geo. Mason U. Mercatus Ctr., Working Paper, 2016), https://www.mercatus.org/system/files/Bailey-CON-v1.pdf (finding that broader CON laws do not have stronger effects); *see also* Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL., POL'Y & L. 455, 473–74 (1998) (finding stringency of CON laws to have a statistically insignificant effect on cost-constraint).

111. MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 1–2 (Robert Wood Johnson Foundation, The Synthesis Project 2012), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

112. *Id.* at 1.

113. Mitchell, *Limit Spending*, *supra* note 8080, at 5.

114. *Id.*

115. Bailey, *supra* note 110, at 14–15 ("CON laws will only reduce total spending if demand is elastic" and "[b]ecause health care is generally estimated to be quite inelastic, the baseline model means we should generally expect CON to lead to increases in spending."). Bailey also notes the effect that insurance coverage has on the inelasticity of health care: "Adding insurance to the model makes it even more likely that patient demand will be inelastic and that CON will result in increased spending on the regulated service." *Id.* at 15. For example, "[t]he Affordable Care Act, together with older state health-insurance regulations, limits the ability of insurers to [refuse to pay the higher prices], making an increase in spending more likely." *Id.* at 16.

expenditures,[116] it has the opposite effect on per-unit cost when the demand is inelastic, as it is for many regulated health care services.[117]

Demand for health care services becomes more or less elastic depending on who is making the consumer decisions.[118] Many times, the decision-maker is the insurance company. In other words, the insurance company decides which services to cover and where to cover them.[119] In this case, the patient-consumer is less likely to consider per-unit cost when picking a certain health care producer. Demand for health care services is therefore more inelastic, and thus, restricting supply through means such as a CON program increases per-unit cost.[120] However, when a patient is not insured—or otherwise underinsured—the decision as to where and whether to seek health care services can be heavily driven by cost and quality variables. Demand for health care in this situation is elastic, where per-unit cost is more likely to reflect the true supply and demand economic model.[121] Note, however, through legislation such as the Affordable Care Act and other initiatives driven to get more patients insured, patients are less likely to be the decision-makers in the health care market.[122] So in addressing the rising per-unit cost of health care, it is more accurate to assume that demand is generally inelastic and therefore restricting supply increases per-unit cost.

Another aspect of the supply-and-demand economic model as it relates to supply restriction is the concept of "rent-seeking." Existing institutional health facilities' profits gained resulting from the restricted market is known as "economic rent," because it comes at the cost of consumers and denied applicants.[123] Economic rent can be worth a substantial amount of money; that is the nature of a monopoly.[124] Because of its substantial value, institutional health facilities may be willing to invest their already scarce resources in

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116. Arguments against this assertion exist. For example, Mitchell argues that "because total expenditures . . . are equal to the price per unit multiplied by the number of units sold [and] [b]ecause the supply restriction raises the price per unit but lowers the number of units sold," supply restriction has an "ambiguous effect on total expenditures." Mitchell, *Limit Spending*, *supra* note 8080, at 7. Mitchell also notes the effect of health care demand's inelasticity on total expenditures:

> a supply restriction would be more likely to increase total expenditures when demand was less elastic. Because the third-party-payer problem tends to cause the effective demand curve to be less elastic than it otherwise would be, this model suggests that CON is likely to increase rather than decrease total expenditures.

Id. at 13–14. It should be noted that studies have shown CON reduces spending on certain areas, such as acute care (seeing a reduction of five percent thanks to CON regulations), but does not reduce overall health expenditures. *Id.* at 8.

117. Mitchell, *Achieving Their Goals*, *supra* note 76, at n.46.

118. *See* Thomas E. Getzen, *Health Care Is an Individual Necessity and a National Luxury: Applying Multilevel Decision Models to the Analysis of Health Care Expenditures*, 19 J. HEALTH ECON. 259, 259, 267 (2000) (arguing that elasticity varies depending on the level of analysis—whether the decisions are made at an individual level or a group level such as with private insurance companies).

119. *See id.* at 267 (explaining that "[w]ith insurance, it is the average income of the group, and the fraction that the group is collectively willing to spend on medical care, that determines the health care budget, not the income of the particular patient being treated").

120. *See* Bailey, *supra* note 110, at 13–15.

121. *Id.*

122. *Id.* at 16.

123. Mitchell, *Limit Spending*, *supra* note 80, at 19.

124. Consider why inventors are willing to spend so much time and money upfront in the development of inventions—because they are guaranteed the profit associated with the patent monopoly.

seeking market control—a phenomenon referred to as "rent seeking."[125] Sometimes, they invest more resources than the rent is even worth or engage in illegal means during their pursuit.[126] This results in higher costs, lower quality, and less innovation than the business development encouraged by a more competitive market.[127]

C. Are There Any Benefits to CON Regulations?

There is one problem associated with competition between hospitals and hospital alternatives that CON regulations correct: economists refer to the phenomena as "cream-skimming."[128] When unregulated hospital alternatives are introduced into the market, facilities such as ambulatory surgical centers "[are able to] accept only the more profitable, less complicated, and well-insured patients while hospitals will be left to treat the less profitable, more complicated, and uninsured patients."[129] This problem is especially detrimental to rural hospitals, which already rely on a less-concentrated consumer base.[130] The fear is that facilities such as ambulatory surgical centers, if allowed to freely enter the market (in the absence of CON laws), will prompt hospital closures.[131]

Thomas Stratmann and Christopher Koopman tested this theory in 2016. They predicted because CON programs intend to reduce the influx of ambulatory surgical centers, they would find a higher number of hospitals in states with CON laws.[132] To the contrary, the study found there were, in fact, 30% fewer hospitals per capita—both in rural and urban areas—in states with CON programs in place.[133] That being said, cream-skimming may be directly correlated with a higher number of hospitals, but the threat of competitive advantage for hospital alternatives may still need consideration when determining a replacement for CON programs.

IV. RECOMMENDATION

As the foregoing analysis suggests, CON programs did not turn out as originally hoped. Congress discovered this fact just 13 years after it enacted the NHPRDA and responded with a swift repeal of the federal mandate.[134] Since then, 14 states have incrementally followed suit. This Part suggests that Iowa should join the 14 pioneering

125. Mitchell, *Limit Spending*, *supra* note 80, at 19–20.

126. *Id.* For example, "[t]hey will lobby, donate to political action committees, and alter their business models to satisfy political preferences." *Id.* at 19 "[A]ccording to federal prosecutors, former HealthSouth CEO Richard Scrushy paid former Alabama Governor Don Siegelman more than $500,000 for a seat on the state's certificate-of-need board. Both men were convicted of bribery (among other crimes) in June 2006." *Id.* at 19–20.

127. *Id.* at 20.

128. Thomas Stratmann & Christopher Koopman, *Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals* 3–4 (Geo. Mason U. Mercatus Ctr., Working Paper, 2016), https://www.mercatus.org/system/files/Stratmann-Rural-Health-Care-v1.pdf.

129. *Id.* at 4.

130. *Id.* at 9.

131. *Id.* at 18.

132. *Id.*

133. Stratmann & Koopman, *supra* note 128, at 16–17. The question as to whether the decrease in hospitals is directly caused by the influx of hospital substitutes—such as ASCs—into the market goes unanswered. However, the study proceeds to conclude that CON laws also decrease the number of per capita ASCs as well—by about 14%. *Id.* at 17.

134. NCSL, *supra* note 11.

states by repealing its own CON law, because its effects are inconsistent with the Iowa CON program's intended goals,[135] and CON laws are generally not cost-effective; they do not provide sufficient benefits to justify the cost to consumers. Iowa's CON law carries the purpose of "ensur[ing] that the citizens . . . will receive necessary and adequate institutional health services in an economical manner."[136] Since these two goals are negatively impacted by Iowa's CON law, the Iowa Legislature should completely repeal the Iowa CON program. Any negative effects of a CON repeal on the health service market in Iowa can be addressed by other, less anti-competitive and administratively burdensome, means. This Part will address such negative effects like the competitive advantage of hospital alternatives, the inequitable distribution of financial burden for Medicare-reimbursed service provisions, or the potential for health care companies to engage in non-risk-based spending in an unrestricted market.

A. Iowa's CON Law Negatively Affects the Adequacy of Institutional Health Services

In alignment with the legislature's goal of ensuring "[Iowans] will receive necessary and adequate institutional health services in an economical manner,"[137] Iowa should repeal its CON program, which, as previously demonstrated, is linked to lower access to and lower quality of healthcare.[138] This is especially true in the event there are less burdensome alternatives which are more likely to increase access and quality of health care to Iowans.

B. Iowa's CON Law Negatively Affects the Economic Provision of Health Services

In alignment with Iowa's goal of ensuring health services in an economical manner, the Iowa Supreme Court has said that the Council should "avoid unnecessary duplication of institutional services as well as to control the costs of administering these services."[139] However, as this Note discusses throughout the previous Analysis, CON regulations, no matter how lenient or restrictive, do not control costs.[140]

Specifically, the Mercatus Center compiled an Iowa state profile regarding its CON laws,[141] which estimates total healthcare spending in Iowa could drop by $217 per capita, and rural hospital access could increase from 89 to 127.1 hospitals, if CON laws were to be repealed.[142] When more hospitals are located in rural areas, there are lower transportation costs for consumers, shorter wait times (because less consumers are funneled into urban hospitals), and the development has been found to both directly and indirectly contribute significantly to the economy of rural communities.[143]

Besides the economic costs CON laws have on the state, there are other procedural

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135. In addition to the literature cited within this Note regarding the nation-wide purpose of CON programs, see IOWA CODE ANN. § 135.76 for evidence of the Iowa CON program's intended goals by way of internal oversight mechanisms.

136. Greenwood Manor v. Iowa Dep't of Pub. Health, 641 N.W.2d 823, 831–32 (Iowa 2002).

137. *Id.* (citing 1977 Iowa Acts ch. 75, preamble).

138. *See supra* Part III.B.1 & Part III.B.2.

139. *Greenwood Manor*, 641 N.W.2d at 832.

140. Bailey, *supra* note 110, at 25–27.

141. Note that the Iowa profile relies on existing data of the costs of CON laws in other states. *See* Iowa State Profile, *supra* note 102.

142. *Id.*

143. Richard E. Doelker, Jr. & Bonnie C. Bedics, *Impact of Rural Hospital Closings on the Community*, 34 SOC. WORK 541, 541 (1989).

costs that the repeal of Sections 135.61–83 would eliminate. Parties investing in a proposed institutional health service or facility project[144] do not want to be governed or regulated by the Iowa CON laws and regulations based simply on the burdensome requirements and the timely, unpredictable procedural process which carries both legal fees and opportunity cost.[145] The administrative process itself can cost applicants up to $21,000,[146] a cost many applicants may then externalize through their pricing structure. Additionally, there are costs associated with the ad hoc nature of Council decisions; the outcome of which is highly dependent on third party opposition or political motives which can be difficult to predict—resulting in compounding legal fees throughout the application and reapplication processes.[147] Finally, it is arguable that the costs incurred during the administrative process—e.g., attorneys' fees, filing fees, cost of reapplication upon denial,[148] opportunity cost of a delayed project, etc.—are not worth the administrative hurdles since roughly 90% of all applications are approved by the Council anyway.[149] Yet these costs may nonetheless act as an artificial barrier to projects that would otherwise bring quality health care services to Iowans in need.

C. The CON Program's Natural Replacement

The CON process is intended to act as a controlled barrier to entry for the health service industry. However, even when accounting for the data determining the simple existence of a CON process raises per-unit costs, there are other, more competitive alternatives serving the CON's purpose of controlling entrance into the market, and thus, keeping hospitals from extreme market vulnerability. In fact, the inherent nature of the

144. This excludes sponsors of projects for existing facilities that already reap the benefits of the restricted market, such as an already existing hospital that simply desires an additional MRI machine. *See Iowa Certificate of Need: Ending Iowa's CON Laws That Limit Medical Options and Enrich Established Businesses*, INST. FOR JUST., https://ij.org/case/iowa-certificate-need/ (last visited Feb. 9, 2019) (arguing that, through loopholes, Iowa's CON law only benefits established businesses).

145. *See id.* (describing a case where an applicant seeking approval for an outpatient surgical facility needed to apply four times before finally being granted a certificate of need). Litigation over this specific certificate of need spanned from 2005 until 2017, when Dr. Birchansky was finally granted a CON for his outpatient surgical facility. *See* Birchansky Real Estate, LC v. Iowa Dep't of Pub. Health, No. CV 5619, 2005 WL 6202755 (Iowa Dist. Ct. Nov. 16, 2005); IOWA DEP'T OF PUB. HEALTH, PROJECTS REVIEWED BY STATE HEALTH FACILITIES COUNCIL, FISCAL YEAR 2018, http://idph.iowa.gov/Portals/1/userfiles/50/FY18%20Projects%20v2.pdf.

146. IOWA CODE ANN. § 135.63(1) (West 2012).

147. Yee et al., *supra* note 88, at 2 ("Certificate-of-need programs tend to be influenced heavily by political relationships, such as a provider's clout, organizational size, or overall wealth and resources, rather than policy objectives, according to many respondents. In five of the six states studied—all except Michigan—respondents indicated the approval process can be highly subjective and that CON authorities often interpret regulations or standards quite broadly."). One case in Virginia cost a radiology group "more than $175,000 in lawyers' and other fees [to obtain a CON for an MRI machine]." Lisa Schencker, *State Certificate-of-Need Laws Weather Persistent Attacks*, MOD. HEALTHCARE (Jan. 23, 2016, 12:00 AM), https://www.modernhealthcare.com/article/20160123/MAGAZINE/301239964.

148. Note that from 2008 to 2018, only five of the denied applications reapplied, three of which were denied for a second time. *See* IOWA DEP'T PUB. HEALTH, *Reports*, http://idph.iowa.gov/cert-of-need/reports (last visited Feb. 9, 2019) (providing records online through fiscal year 2017). Pre-2017 records are available by request to the Department.

149. This percentage determination comes from looking at the Council's reports from 2008 to 2018, dividing the sum of all applications denied (minus those which reapplied and were subsequently approved) by all applications considered. *Id.*

market for institutional health facilities itself would serve the same purpose as a CON program. In other words, the high cost of initial investment required to construct or change an institutional health facility—such as the high construction costs and high costs of state-of-the-art equipment—serves as its own barrier to entry. At the end of the day, the health service industry is business-driven and investors and directors will assess their own risk before entering a market. Companies can, and already do, assess the market need for their facilities and services without the help of the CON process.[150]

Of course, there is a risk health care companies may enter the market whether or not there is a need. Entering the market regardless of need is called non-risk-based spending, and occurs when supplier-induced rather than consumer-induced demand (or moral hazard) causes overspending in the health service industry, and thus creates economic waste.[151] For example, "[p]erhaps there is no real need for a new hospital or MRI machine in a city, but once it exists, doctors will find a way to talk patients into using it."[152] Insurance companies, however, may not be similarly persuaded, as they make decisions based on cost and risk, rather than out of fear and trust. Insurance companies, which are typically the entity making consumer decisions, will logically refuse to cover the cost of wasteful services.[153] In those cases, when patients then become the consumer and are responsible for footing the bill, patients will make consumer choice decisions reflecting the classic supply and demand model: when the cost of an unnecessary MRI scan is high and the need for a scan is low, the doctor will be less convincing. Again, a competitive economic market will reduce waste and will drive the supply curve to meet demand at the equilibrium.

D. Addressing the Threat of a Hospital Shutdown

The public is disadvantaged when hospitals close their doors because they cannot compete with the inherently less-costly hospital alternatives. There are certain services that are unavailable, by law, in a non-hospital-based setting. The public thus loses access to those services in the event of a shutdown. So, the data suggesting hospitals are vulnerable to shutdown when they are in unregulated competition with less-costly hospital alternatives[154] should not be ignored. In order to propose a complete repeal of CON laws, which currently serve as the hospitals' main defense to this phenomenon, there must be some assurance these inherent disadvantages are addressed and hospitals are placed in more direct competition.

This Note proposes, after acknowledging the hospitals' disadvantage in the market and propose whatever the reason hospitals are disadvantaged without market protection,

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150. For information regarding how existing companies determine market need, see Timothy S. Schoenecker & Arnold C. Cooper, *The Role of Firm Resources and Organizational Attributes in Determining Entry Timing: A Cross-Industry Study*, 19 STRATEGIC MGMT. J. 1127, 1128 (1998) (providing research regarding entry timing and use of resources of existing firms breaking into new industries).

151. Bailey, *supra* note 110, at 30.

152. *Id.*

153. This is assuming, of course, that the insurance company makes decisions to maximize profitability.

154. This is the phenomenon of "cream-skimming." *Supra* Part III.C. Qualities such as high overhead costs (especially in urban hospitals) and a higher likelihood of servicing indigent consumers through avenues like emergency care services (which are not offered in hospital alternatives) are unique to hospitals and thus put them at a competitive disadvantage. *See* Elizabeth L. Munnich & Stephen T. Parente, *Procedures Take Less Time at Ambulatory Surgical Centers, Keeping Costs Down and Ability to Meet Demand Up*, 33 HEALTH AFF. 764, 767 (2014) (discussing factors that contribute to the low-cost nature of ambulatory surgical centers).

entities in competition must be placed equally at a disadvantage, or the state must ensure each are advantaged uniformly; thus, a competitive market results.[155] That is not to say, however, that markets should be completely unconstrained. An evenly-regulated yet competitive market should still maintain direct competition while the consumers are assured quality and affordability.[156] Safety licensing regulations, for example, assure quality services and facilities without acting as a barrier to the market.[157] Entities are free to enter the health care market based on their independent judgment of need (which we can assure will be exercised to appease the interests of creditors), and with the understanding certain quality standards must be met to remain in operation. So, instead of correcting a market disadvantage (cream-skimming) with the grant of a non-competitive monopoly, Iowa should address the precise nature of the disadvantage directly.

Another disadvantage inherent in hospital alternatives is hospitals, particularly non-profit hospitals, are unevenly carrying the financial burden of providing Medicare-reimbursed services.[158] More than 70% of the private hospitals in the United States are nonprofits "and [are] therefore expected to provide a 'community benefit' in exchange for tax relief. One key component of this community benefit is charity care for indigent patients. For-profit firms do not face a similar community-benefit standard."[159] Providing services to the uninsured, Medicare, and Medicaid patients usually results in a large revenue loss; hospitals (and particularly nonprofit hospitals) usually carry the burden.[160]

To combat this, hospitals engage in what is known as "payer mix," where, in order to cover the costs of servicing the uninsured, Medicare, and Medicaid patients, the hospital must be able to accept enough profitable, insured patients.[161] This process is directly undercut by cream-skimming hospital alternatives because they accept the profitable,

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155. Consider, for the sake of comparison, the impact of cream-skimming of ride-sharing services—such as Uber and Lyft—on the taxi market. *See, e.g.*, James B. Speta, *Southwest Airlines, MCI, and Now Uber: Lessons for Managing Competitive Entry into Taxi Markets*, 43 TRANSP. L.J. 101, 115–16 (2016). Taxis were singularly carrying the market burden, because they were subject to common carrier regulations—such as requiring licensees and taxicabs "to respond to dispatch requests . . . in underserved areas"—whereas ride-sharing services were not. *Id.* at 104, 108 (suggesting that the unregulated ride-sharing services cream-skim valuable customers from the regulated taxi market). This comparison between the effect ride-sharing has on the taxi market and the effect hospital alternatives have on the hospital market is not direct, however. Taxi services and ride-sharing are (for the most part) direct market substitutes, whereas hospital alternatives cannot provide every service that hospitals are able to provide. *Id.* at 130; *see, e.g.*, IOWA ADMIN. CODE r. 441-78.26 (providing restrictions on certain services furnished by ambulatory surgical centers). So, although some authors may be in favor of ride-sharing services as accomplishing a more-efficient market alternative, and thus benefitting the public despite putting taxi companies out of business, hospital shutdowns leave patients with little to no access to those services that hospital alternatives cannot safely provide.

156. *See supra* Parts III.B.3., III.C.

157. This is true as long as the safety licenses are required by all institutional health facilities. *See* Speta, *supr*a note 155, at 121–24 ("In setting safety regulations, maintaining competitive equality between services is important, for safety regulations are costly and can create barriers to entry or tilt the playing field.").

158. For an example of how fixed-price payers such as Medicare affect a facility's profit target, see WILLIAM O. CLEVERLEY & JAMES O. CLEVERLEY, ESSENTIALS OF HEALTH CARE FINANCE 389 (Jones & Bartlett ed., 8th ed. 2018).

159. Drew Calvert, *Who Bears the Cost of the Uninsured? Nonprofit Hospitals.*, KELLOGGINSIGHT (June 22, 2015), https://insight.kellogg.northwestern.edu/article/who-bears-the-cost-of-the-uninsured-nonprofit-hospitals.

160. CLEVERLEY & CLEVERLEY, *supra* note 158, at 155–56. Hospitals typically recover less than five percent of their costs for the uninsured. Ten percent of all Americans are uninsured, even after the enactment of the Affordable Care Act.

161. *Id.* at 155.

privately insured patients, leaving the hospitals to bear the cost of uninsured, Medicare, and Medicaid patients.[162] To combat this effect of cream-skimming and give hospitals a chance at fair competition with hospital alternatives, the hospital alternatives must also be required to bear the cost of unprofitable patients. Although hospital alternatives cannot be forced to accept Medicare and Medicaid-insured patients, once they do, they can be subject to requirements that a certain percentage of their patients be covered by Medicare and Medicaid. For those entities that do not accept Medicare and Medicaid, tax incentives can be offered to entities to encourage them to enter the market and be regulated thereunder.

These regulations may seem heavy-handed on private healthcare entities that have not necessarily agreed to provide a community benefit. However, once the regulations are clearly established, private entities will include foreseeable costs in their financial statements and business plans. Creditors will be on notice for such foreseeable costs, and it will itself serve as a natural barrier to entry. If a health facility cannot find a way to maintain profitability without providing a certain percentage of services to the indigent, creditors will be apprehensive about making the initial investment, and the market will be open to those able to make this happen.

E. Rejecting H.F. 2263 and Abandoning the Iowa CON Program Completely

There are three imminent options to deal with Iowa's CON program: (1) leave it as it stands, (2) limit its scope by passing Iowa House File 2263, or (3) eliminate the program completely by enacting legislation similar to Iowa Senate File 2021. This Note recommends Iowa pass legislation similar to Senate File 2021[163] to eliminate Iowa's CON program—following the 14 pioneering states—to realign its health care regulations to suit a post-NHPRDA world.

Per the previous analysis, the CON program should not be left intact; it does not serve the goals it was intended to reach, and the inefficiencies inherent in this type of barrier to entry have proven costly. It is clear Iowa must do *something* to address the cost of its health care inefficiencies; it is not clear, however, that simply restricting the CON program through means such as Iowa House File 2263 will be enough.[164] Remember, states with more restrictive CON laws do not necessarily have higher health care costs than those with minimal CON laws; it is the mere presence of CON regulations, the artificial supply restriction *generally*, which increases spending.[165]

Therefore, the best way to address this costly program is to eliminate it altogether by enacting legislation similar to Iowa Senate File 2021. The bill, upon enactment, would have effectively removed the current requirements imposed on institutional health facility projects, and allow natural barriers to entry—such as high investment risk—rather than a five-member Council, determine which projects should be allowed to enter the market for certain institutional health services. This would reduce administrative costs, encourage

162. *Supra* Part II.C.3; Stratmann & Koopman, *supra* note 128, at 18.

163. The bill was introduced on January 1, 2019, and died while in the subcommittee stage on January 24, 2019. LEGISCAN, *supra* note 74.

164. *See supra* note 71 and accompanying text.

165. *See supra* note 110 and accompanying text. This is why, despite the Council approving roughly 90% of all applications anyway, the small amount of restriction that the Council does impose on the market should still have an effect on health care costs, since CON stringency does not have a statistically significant effect on cost-constraint. *See* Bailey, *supra* note 110, at 26–29 (analyzing the scope of a CON program's effect on cost-containment).

investors of institutional health facilities to do their own due diligence in determining market need, and reduce the amount of economic waste associated with unnecessarily restricted markets.

Although this Note suggests repeal is the best option, it should not be passed in isolation. A completely unregulated market carries with it the threat of hospital shutdown. To give hospitals a chance at fair competition with hospital alternatives, the hospital alternatives must also be required to bear the cost of unprofitable patients per the recommendation proposed in the previous subpart.

V. CONCLUSION

As long as health care costs are crippling and many Iowans are left unable to access health care services, the state is not ensuring "the citizens of this state will receive necessary and adequate institutional health services in an economical manner."[166] Redrafting an entire health care initiative is no small feat, but smaller steps—like repealing an outdated and ineffective administrative process with marginal utility—can be taken in the meantime to reduce sources of inefficiencies and waste. The health care industry is in desperate need of some assistance; repealing Iowa's CON program is the next step.

166. Greenwood Manor v. Iowa Dep't of Pub. Health, 641 N.W.2d 823, 831–32 (Iowa 2002) https://www.idph.iowa.gov/Portals/1/Files/BRFSS/2016BRFSSAnnualReport.pdf.