IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

LEE BIRCHANSKY; FOX EYE SURGERY, LLC; KORVER EAR NOSE AND THROAT, LLC; MICHAEL JENSEN; and MICHAEL DRIESEN; Plaintiffs, v. GERD W. CLABAUGH, in his official capacity as Director of Iowa Department of Public Health and Administrator of the State Board of Health; REBECCA SWIFT, in her official capacity as Administrator of the Health Facilities Council; and ROBERTA CHAMBERS, CONNIE SCHMETT, ROGER THOMAS, BRENDA PERRIN, and HAROLD MILLER in their official capacities as Members of the Health Facilities Council; Defendants.	**No. 4:17-cv-00209-RGE-RAW** **ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT & DENYING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I. INTRODUCTION

Iowa's certificate-of-need (CON) program regulates the development of facilities offering certain types of surgery services. In general, only a facility that has obtained a CON from the Iowa Department of Public Health may offer outpatient surgery services to patients. Plaintiffs are a doctor and two business entities hoping to operate outpatient surgical facilities, as well as two patients hoping to receive outpatient surgery services at those facilities.[1] Iowa's CON program prevents Physician Plaintiffs from operating such facilities without first obtaining a CON.

[1] There are two categories of Plaintiffs: 1) Physician Plaintiffs are Lee Birchansky, Fox Eye Surgery, LLC, and Korver Ear Nose and Throat, LLC; and 2) Patient Plaintiffs are Michael Jensen and Michael Driesen. *See also* Order Den. Defs.' Mot. Dismiss 1 n.1, ECF No. 52.

Plaintiffs allege the disparate treatment of CON-holders and non-CON-holders violates their rights under the Equal Protection and Due Process Clauses of the Fourteenth Amendment. They seek to enjoin Defendants, who administer the CON program, from enforcing the requirement that Physician Plaintiffs obtain a CON before opening outpatient surgical facilities.

The parties have filed cross-motions for summary judgment. Because the Court concludes Iowa's CON program conceivably advances the State of Iowa's legitimate interest in promoting the viability of full-service hospitals, the Court grants Defendants' Motion for Summary Judgment and denies Plaintiffs' Motion for Summary Judgment.

II. BACKGROUND

The Court outlined many relevant facts in its orders pertaining to Defendants' Motion to Dismiss and Defendants' Motion for Reconsideration. *See* Order Den. Defs.' Mot. Dismiss, ECF No. 52; Order Den. Defs.' Mot. Recons., ECF No. 57. With the benefit of a developed evidentiary record, the Court addresses some additional background facts. The parties agree there are no material facts in dispute foreclosing summary judgment. The following facts are either uncontested or, if contested, viewed in the light most favorable to Plaintiffs. *See Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587–88 (1986).

A. History of CON Programs

In the 1970s, "the federal government and private insurance reimbursed health care expenses based on actual cost." Pls.' Statement Undisputed Facts ¶ 4, ECF No. 62-1; *see also* Pls.' App. Supp. Mot. Summ. J. A250–54, ECF No. 62-2 (describing historical development of reimbursement methods); *id.* at A425 (same).[2] This reimbursement model raised

[2] The record contains a July 2004 report, "Improving Health Care: A Dose of Competition: A Report by the Federal Trade Commission and the Department of Justice" (hereinafter "the 2004 FTC–DOJ Report"), which describes the history of CON programs for medical facilities in the

concerns "that reimbursing for actual expenditures (cost-based reimbursement) spurred over-investment by allowing hospitals to recoup all of their expenses, even inefficient expenses." ECF No. 62-1 ¶ 4; Defs.' Resp. Pls.' Statement Undisputed Facts ¶ 4, ECF No. 66-1. These concerns led Congress to pass a federal incentive program in the mid-1970s to encourage states to enact CON programs as a means of preventing inefficient proliferation of facilities. *See* National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 1523, 88 Stat. 2225, 2246–47 (1975), *repealed by* Act of Nov. 14, 1986, Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799; *see also* ECF No. 62-2 at A424 (noting "[m]any CON programs trace their origin" to the National Health Planning and Resources Development Act), A425 ("The system of cost-based reimbursement may have driven the problem that Congress sought to solve."). By 1980, Iowa and forty-eight other states had adopted some form of CON program. *See* Defs.' Statement Undisputed Facts ¶ 4, ECF No. 58-1; ECF No. 62-1 ¶ 5.

In 1983, Congress modified Medicare to reimburse based on estimated prospective costs for services. ECF No. 62-1 ¶ 6; *see* Act of Apr. 20, 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149–63. "Recognizing that the change in reimbursement mechanism no longer justified CON requirements," Congress repealed the federal CON incentive program in 1986. ECF No. 62-1 ¶ 7; ECF No. 66-1 ¶ 7; *see* § 701, 100 Stat. at 3799 (repealing the National Health Planning and Resources Development Act of 1974). In the years since, some states have repealed their CON programs. *See* ECF No. 62-1 ¶ 9. Other states have not; thirty-four states and the District of Columbia "have kept some form of certificate-of-need requirement." *Id.*; *see id.* ¶ 9 n.2 (noting

United States, as well as recent debates over the efficacy of CON programs. Pls.' App. Supp. Mot. Summ. J. A124–484, ECF Nos. 62-2–62-3.

the specific code provisions of the remaining state CON requirements).[3] Iowa's CON program is at issue in this case.

B. Iowa's CON Program

The law establishing Iowa's CON program was passed in 1977 and became effective on July 1, 1978. *See* 1977 Iowa Acts 233 (codified as amended at Iowa Code §§ 135.61–.79). Through designated task forces, the Iowa Department of Public Health has reviewed Iowa's CON program on two occasions, producing reports in 1996 and 2000. *See* Defs.' App. Supp. Mot. Summ. J. at App. P. 12–20, 44–50, ECF No. 58-2.[4] In 1996, an Iowa Department of Public Health task force unanimously recommended the retention of Iowa's CON

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[3] The CON programs in these states are generally similar. Each requires certain health care facilities to receive a CON or functional equivalent before those facilities may offer certain types of services. *See* Ala. Code §§ 22-21-260–278; Alaska Stat. §§ 18.07.031–.111; Ariz. Rev. Stat. Ann. §§ 36-421–434; Ark. Code Ann. §§ 20-8-101–13; Conn. Gen. Stat. §§ 19a-493b, 19a-630–43; Del. Code Ann. tit. 16, §§ 9301–11; D.C. Code §§ 44-401–16; Fla. Stat. §§ 408.031–.045; Ga. Code Ann. §§ 31-6-2, 31-6-40–50; Haw. Rev. Stat. §§ 323D-2, 323D-43–54; 20 Ill. Comp. Stat. 3960/2–19; Iowa Code §§ 135.61–.79; Ky. Rev. Stat. Ann. §§ 216B.010–.130; Me. Stat. tit. 22, §§ 327–50; Md. Code Ann., Health–Gen. §§ 19-114–28; Mass. Gen. Laws ch. 111, §§ 25B–25G; Mich. Comp. Laws §§ 333.22203–.22260; Miss. Code Ann. §§ 41-7-173–209; Mo. Rev. Stat. §§ 197.305–.367; Mont. Code Ann. §§ 50-5-301–10; Neb. Rev. Stat. §§ 71-5803–70; Nev. Rev. Stat. §§ 439A.015, 439A.017, 439A.100; N.J. Stat. Ann. §§ 26:2H-6.1–7.3; N.Y. Pub. Health Law §§ 2800–06; N.C. Gen. Stat. §§ 131E-175–90; Ohio Rev. Code Ann. §§ 3702.51–.62; Okla. Stat. tit. 63, §§ 1-851–58; Or. Rev. Stat. §§ 442.315–.361; 23 R.I. Gen. Laws §§ 23-15-2–7; S.C. Code Ann. §§ 44-7-120–340; Tenn. Code Ann. §§ 68-11-1602–17; Vt. Stat. Ann. tit. 18, §§ 9431–45; Va. Code. Ann. §§ 32.1-102.1–102.10; Wash. Rev. Code §§ 70.38.015–158; W. Va. Code §§ 16-2D-1–20.

[4] The parties agree Iowa's CON program was reviewed in 1996 and 2000. *See* ECF No. 58-1 ¶ 6; Pls.' Resp. Defs.' Statement Undisputed Facts ¶ 6, ECF No. 67-1. The parties dispute whether and when state agencies have conducted other reviews of Iowa's CON program. *See* ECF No. 67-1 ¶ 6 ("Iowa's CON law has been the subject of only two studies."). The 2000 report indicates the CON program was also reviewed by the Governor's Commission on Health Care Costs in 1981, the Governor's Task Force on Long-Term Care in 1985, the Statewide Health Coordinating Council in 1986, a committee convened by the Director of the Iowa Department of Public Health in 1988, and the Elder Care Services Study in 1995. *See* ECF No. 58-2 at App. P. 15. The details and conclusions of the reviews referenced in the 2000 report do not appear in the record. The Court discusses only the uncontested 1996 and 2000 reports.

program with "23 specific modifications to narrow the focus of the process and reduce the number and type of projects which would be reviewed." *Id.* at App. P. 49. In 1997, the Iowa legislature largely adopted the task force's recommendations by passing legislation amending the CON program. *See* 1997 Iowa Acts 132.

The 1997 legislation also directed the Iowa Department of Public Health to "complete a comprehensive review of the certificate of need program and . . . submit a written report of the findings and recommendations as to the continued relevance of the program." *Id.* § 11. The Iowa Department of Public Health established a task force to review Iowa's CON program and produce the requested report. *See* ECF No. 58-2 at App. P. 18. The task force considered presentations from the Iowa Medical Society (a physician advocacy group) and the Association of Iowa Hospitals & Health Systems (a hospital advocacy group), among other parties. *Id.* at App. P. 19; *see id.* at App. P. 24–33, 34–39. The Iowa Medical Society advocated repealing Iowa's CON program and the Association of Iowa Hospitals & Health Systems advocated retaining Iowa's CON program with no changes. *Compare id.* at App. P. 24–33, *with id.* at App. P. 34–39. In 2000, the task force provided its report to the Iowa legislature, recommending Iowa's CON program be retained with no changes. *See id.* at App. P. 12–20. Since 2000, several bills have been introduced in the Iowa legislature to significantly modify or repeal Iowa's CON program. *See* ECF No. 58-1 ¶ 8; ECF No. 58-2 at App. P. 54–61, 62–65, 117–18; Pls.' Resp. Defs.' Statement Undisputed Facts ¶ 8, ECF No. 67-1; *see also* Pls.' App. Supp. Mot. Summ. J. A1414–15, Swift Dep. 304:20–305:2, ECF No. 62-7. None of those bills have become law. *See* Swift Dep. 304:20–305:5, ECF No. 62-7 at A1414–15.

The Iowa Department of Public Health is responsible for administering Iowa's CON program. Iowa Code § 135.62(1). Defendant Gerd Clabaugh is the Director of the Iowa Department of Public Health. *See* Am. Compl. ¶ 28, ECF No. 32. Defendant Rebecca Swift

is the CON program coordinator. ECF No. 62-1 ¶ 18. As relevant here, Swift handles CON inquiries, interprets the CON statute and administrative rules, and assesses the CON reviewability of proposed facility expansions alongside counsel for the Iowa Department of Public Health. *Id.* ¶ 19. Swift also reviews CON applications and drafts CON decisions. *Id.*; *see* Swift Dep. 39:17–20, ECF No. 62-7 at A1289. Final authority to approve or deny a CON application lies with the Health Facilities Council, a five-member body appointed by the governor of Iowa. Iowa Code §§ 135.62(2), 135.69. Defendants Robert Chambers, Connie Schmett, Roger Thomas, Brenda Perrin, and Harold Miller are members of the Health Facilities Council. *See* ECF No. 32 ¶¶ 34–38.

Plaintiffs' claims challenge Iowa's CON program itself and an exception within the program: the capital expenditure exemption.

1. Iowa's Certificate of Need requirement for outpatient surgical facilities

The "Certificate of Need" requirement is the core of Iowa's CON program; Iowa generally prohibits an entity from establishing a facility offering surgery services unless the entity has received a CON from the Iowa Department of Public Health. Iowa Code Section 135.63(1) prohibits a "new institutional health service or changed institutional health service" from being "offered or developed in this state without prior application to the department for and receipt of a certificate of need." This prohibition involves multiple defined terms. First, "offer" means "that an institutional health facility, health maintenance organization, health care provider, or group of health care providers holds itself out as capable of providing, or as having the means to provide, specified health services." Iowa Code § 135.61(19). Similarly, "develop" means "to undertake those activities which on their completion will result in the offer of a new institutional health

service or the incurring of a financial obligation in relation to the offering of such a service." Iowa Code § 135.61(6).

Next, Iowa Code Section 135.61(18) defines "'[n]ew institutional health service' or 'changed institutional health service'" to include, among other things, "[t]he construction, development or other establishment of a new institutional health facility." An "'[i]nstitutional health facility' means any of the following":

a. A hospital.
b. A health care facility.
c. An organized outpatient health facility.
d. An outpatient surgical facility.
e. A community mental health facility.
f. A birth center.

Iowa Code § 135.61(14). There are two types of institutional health facilities relevant in this case: hospitals and outpatient surgical facilities. As relevant here,

> "Hospital" means a place which is devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care over a period exceeding twenty-four hours of two or more nonrelated individuals suffering from illness, injury, or deformity, or a place which is devoted primarily to the rendering over a period exceeding twenty-four hours of obstetrical or other medical or nursing care for two or more nonrelated individuals.

Iowa Code § 135B.1(3); *see* Iowa Code § 135.61(13). Additionally,

> "Outpatient surgical facility" means 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.

Iowa Code § 135.61(21).[5] The Iowa Department of Public Health determines on a case-by-case basis if a surgical procedure is "ordinarily performed in a private physician's office"; if not, the

[5] The Court notes these statutory definitions are related to but distinct from the terms "full-service hospital" and "outpatient surgery center," used by the parties to describe types of medical facilities based on the services they offer. As used in this Order, "full-service hospital" refers to a facility that offers a range of medical services, including, as relevant here, inpatient surgery services,

surgical procedure must be performed in either a hospital or an outpatient surgical facility. *See* ECF No. 62-1 ¶¶ 67–72; Pls.' App. Supp. Mot. Summ. J. A1044–45, ECF No. 62-6; Swift Dep. 154:21–160:9, ECF No. 62-7 at A1332–38; *see generally* Iowa Admin. Code r. 641-88.2(135) (defining "Major surgical procedure" and "Minor surgical procedure").[6]

Taken together, these provisions generally prohibit an entity from establishing a facility offering outpatient surgeries without first receiving a CON. Such a requirement places Iowa among the twenty-seven states and the District of Columbia that require a CON for outpatient surgery centers. *See* ECF No. 62-1 ¶ 99; ECF No. 66-1 ¶ 99.[7] Iowa's CON requirement for outpatient surgical facilities "was contained in the initial CON law adopted in 1977 and has remained almost verbatim in the law since that time." ECF No. 58-1 ¶ 10; *see* ECF No. 67-1 ¶ 10; *see also* Pls.' App. Supp. Mot. Summ. J. A581–85, ECF No. 62-3 (providing the 2017

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outpatient surgery services, and emergency services. As used in this Order, "outpatient surgery center" refers to a freestanding facility, physically unconnected to a full-service hospital, that offers outpatient surgery services but does not offer inpatient surgery services or emergency services.

[6] The Iowa Department of Public Health has concluded many of the surgical procedures Physician Plaintiffs perform are not "ordinarily performed in a private physician's office." *See* ECF No. 62-1 ¶¶ 67–72, 157, 229.

[7] As with the CON programs in general, the CON requirements for outpatient surgery centers are generally similar. *See* Ala. Code §§ 22-21-260, 22-21-265; Alaska Stat. §§ 18.07.031, 18.07.111; Conn. Gen. Stat. §§ 19a-493b, 19a-630; Del. Code Ann. tit. 16, §§ 9302, 9304; D.C. Code §§ 44-401, 44-406; Ga. Code Ann. §§ 31-6-2, 31-6-40; Haw. Rev. Stat. §§ 323D-2, 323D-43; 20 Ill. Comp. Stat. 3960/3, 3960/5; Iowa Code §§ 135.61, 135.63; Ky. Rev. Stat. Ann. §§ 216B.015, 216B.061; Me. Stat. tit. 22, §§ 328–29; Md. Code Ann., Health–Gen. § 19-125; Mass. Gen. Laws ch. 111, §§ 25B, 25C, 52; Mich. Comp. Laws § 333.22209; Miss. Code Ann. §§ 41-7-173, 41-7-191; Mont. Code Ann. § 50-5-301; Nev. Rev. Stat. § 439A.015; N.J. Stat. Ann. §§ 26:2H-2, 26:2H-7; N.Y. Pub. Health Law §§ 2801, 2801-a; N.C. Gen. Stat. §§ 131E-176, 131E-178; Or. Rev. Stat. §§ 442.015, 442.325; 23 R.I. Gen. Laws §§ 23-15-2, 23-15-4; S.C. Code Ann. §§ 44-7-130, 44-7-160; Tenn. Code Ann. §§ 68-11-1602, 68-11-1607; Vt. Stat. Ann. tit. 18, §§ 9432, 9434; Va. Code. Ann. §§ 32.1-102.1, 32.1-102.3; Wash. Rev. Code §§ 70.38.025, 70.38.105; W. Va. Code §§ 16-2D-2, 162D-8.

version of the CON requirement for outpatient surgical facilities); Pls.' App. Resp. Defs.' Mot. Summ. J. A10, 12, 14, 29–30, ECF No. 67-2 (providing the 1977 enacted and 1979 codified versions of the CON requirement for outpatient surgical facilities).

Iowa's CON program sets out a number of sanctions for offering or developing an institutional health facility in violation of the CON requirement. Among them, Iowa Code Section 135.73(1) allows licensing agencies to deny or change the licenses of any party "constructing a new institutional health facility or an addition to or renovation of an existing institutional health facility without first obtaining a certificate of need." Iowa Code Section 135.73(2)(a) provides for fines for offering "a new institutional health service . . . without review and approval by the council." And Iowa Code Section 135.73(3) authorizes injunctive relief against any "party offering or developing any new institutional health service or changed institutional health service without first obtaining a certificate of need."

2. Capital expenditure exemption

One specific exception to this general framework—the capital expenditure exemption—underlies Plaintiffs' claims. Iowa Code Section 135.61(18) defines "'[n]ew institutional health service' or 'changed institutional health service'" to include certain types of changes to any existing institutional health facility. *See* Iowa Code § 135.61(18)(b)–(m). If an existing institutional health facility changes in one of the ways specified by Iowa Code Section 135.61(18), it is considered a "new institutional health service," subject once again to CON review under Iowa Code Section 135.63(1). Notably, Iowa Code Section 135.61(18)(c) triggers CON review for "[a]ny capital expenditure, lease, or donation by or on behalf of an institutional health facility in excess of one million five hundred thousand dollars within a twelve-month

period."[8] An existing institutional health facility with yearly capital expenditures *under* $1,500,000, however, does not trigger CON review under Iowa Code Section 135.61(18)(c). *See, e.g.*, Swift Dep. 263:5–264:12, ECF No. 62-7 at A1392–93. Thus, hospitals and outpatient surgical facilities already in possession of a CON may expand their facilities without requiring a new CON, provided they stay under the capital expenditure threshold of $1,500,000 and no other provision in Iowa Code Section 135.61(18) is triggered. *See id.*; *cf.* Pls.' App. Supp. Mot. Summ. J. A888, ECF No. 62-5 (noting, in a Health Facilities Council decision denying Iowa Plastic Surgery Center's CON application, "if the facility were granted a certificate of need the potential for expansion of capacity in the future by the applicant could further negatively impact existing facilities"). CON-holders may also build new, off-site facilities in contiguous counties through the same mechanism. *See, e.g.*, Swift Dep. 263:5–264:12, ECF No. 62-7 at A1392–93.

C. Procedural History

In June 2017, Plaintiffs filed a six-count complaint seeking to enjoin enforcement of provisions of Iowa's CON program, alleging four claims under the United States Constitution and two claims under the Iowa Constitution. Compl., ECF No. 1. After Defendants moved to dismiss the complaint, ECF No. 26, Plaintiffs filed an amended complaint, ECF No. 32, omitting their claims under the Iowa Constitution and removing some defendants named in the original complaint. Defendants moved to dismiss Plaintiffs' amended complaint for lack of subject matter jurisdiction and failure to state a claim. ECF No. 35. The Court denied in large part Defendants'

[8] The capital expenditure provision has "been modified only to increase the allowable expenditure from the original amount of $150,000 in 1977 to expenditures up to $1.5 million today." ECF No. 58-1 ¶ 12; *see* ECF No. 67-1 ¶ 12; *see also* ECF No. 62-3 at A581 (providing the 2017 version of the capital expenditure exemption limit); ECF No. 67-2 at A11 (providing the 1977 version of the capital expenditure exemption limit).

motion to dismiss, determining Plaintiffs plausibly pleaded that the disparate treatment of CON-holders and non-CON-holders did not conceivably advance a legitimate state interest. ECF No. 52. Defendants moved for reconsideration of the Court's dismissal order in light of an Eighth Circuit decision released after the motion to dismiss was submitted. Defs.' Mot. Recons., ECF No. 54; *see* Defs.' Br. Supp. Mot. Recons. 2–5, ECF No. 54-1; *see also Niang v. Caroll*, 879 F.3d 870 (8th Cir. 2018), *vacated as moot sub nom Niang v. Tomblinson*, No. 17-1428, ___ S.Ct. ___, 2018 WL 1785178 (Oct. 9, 2018). Defendants also proffered several additional state interests they contended warranted dismissal of Plaintiffs' amended complaint. *See* ECF No. 54-1 at 5–12. The Court denied Defendants' motion for reconsideration, determining *Niang*, 879 F.3d 870, which has since been vacated as moot by the Supreme Court, did not modify the rational basis analysis or undermine the legal conclusions of the dismissal order. ECF No. 57. In its reconsideration order, the Court also concluded Plaintiffs' amended complaint adequately countered each of Defendants' newly-proffered interests. *Id.*

Remaining are Counts I, II, and IV of Plaintiffs' Amended Complaint, alleging claims under the Fourteenth Amendment's Equal Protection and Due Process Clauses. *See* ECF No. 32. The parties have filed cross-motions for summary judgment on all counts under Federal Rule of Civil Procedure 56(c). *See* Defs.' Mot. Summ. J., ECF No. 58; Pls.' Mot. Summ. J., ECF No. 62; *see also* ECF No. 58-1; ECF No. 58-2; Defs.' Br. Supp. Mot. Summ. J., ECF No. 61; ECF No. 62-1; Pls.' App. Supp. Mot. Summ. J., ECF Nos. 62-2 to 62-7; Pls.' Br. Supp. Mot. Summ. J., ECF No. 65. The parties each resist the other's motion for summary judgment. Defs.' Br. Resp. Pls.' Mot. Summ. J., ECF No. 66; ECF No. 66-1; Defs.' App. Resp. Pls.' Mot. Summ. J., ECF No. 66-2; Pls.' Resp. Defs.' Mot. Summ. J., ECF No. 67; ECF No. 67-1; ECF No. 67-2. The parties have also filed reply briefs in

support of their motions. Pls.' Reply Br. Supp. Pls.' Mot. Summ. J., ECF No. 68; Defs.' Reply Br. Supp. Defs.' Mot. Summ. J., ECF No. 69.

The motions came before the Court for a hearing on September 7, 2018. Hr'g Mins. Mots. Summ. J., ECF No. 72. Attorneys Joshua House and Darpana Sheth appeared on behalf of Plaintiffs. *Id.* Attorney Jordan Esbrook appeared on behalf of Defendants. *Id.* The parties argued in favor of their motion and in opposition to the other party's motion. *Id.* The Court provides additional facts below as necessary.

III. LEGAL STANDARD

Under Federal Rule of Civil Procedure 56, the Court must grant a party's motion for summary judgment if there are no genuine issues of material fact in dispute and the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322–23 (1986). A genuine issue of material fact exists where the issue "can be resolved only by a finder of fact because [it] may reasonably be resolved in favor of either party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). "On a motion for summary judgment, 'facts must be viewed in the light most favorable to the nonmoving party only if there is a "genuine" dispute as to those facts.'" *Ricci v. DeStefano*, 557 U.S. 557, 586 (2009) (quoting *Scott v. Harris*, 550 U.S. 372, 380 (2007)). "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge." *Anderson*, 477 U.S. at 255. "Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial." *Torgerson v. City of Rochester*, 643 F.3d 1031, 1042–43 (8th Cir. 2011) (quoting *Ricci*, 557 U.S. at 586).

To defeat a motion for summary judgment, the non-moving party "may not rest upon the mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there

is a genuine issue for trial." *Anderson*, 477 U.S. at 248 (omission in original) (quoting a prior version of Fed. R. Civ. P. 56(e)). "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted." *Id.* Furthermore, a court "may consider only the portion of the submitted materials that is admissible or useable at trial." *Moore v. Indehar*, 514 F.3d 756, 758 (8th Cir. 2008) (internal quotation marks omitted).

In general, "the filing of cross motions for summary judgment does not necessarily indicate that there is no dispute as to a material fact, or have the effect of submitting the cause to a plenary determination on the merits." *Wermager v. Cormorant Twp. Bd.*, 716 F.2d 1211, 1214 (8th Cir. 1983); *accord* 10A Charles A. Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2720 (4th ed. 2013 & Supp. 2018). Here, however, the parties' cross motions are mirror images of each other. Neither Plaintiffs nor Defendants contend there is a genuine dispute as to any material fact that would preclude summary judgment. *See* ECF No. 67 at 4; *see generally* ECF Nos. 61, 69. Rather, each side argues the facts contained in the record entitle them to judgment as a matter of law as to each count. Thus, granting summary judgment in favor of one side would necessarily foreclose judgment in favor of the other. Moreover, each side incorporates by reference its affirmative arguments and appendices in its resistance to the other side's motion. *See, e.g.*, ECF No. 66 at 2; ECF No. 67 at 2; ECF No. 67-1 at 1 n.1. Accordingly, this Order considers and addresses the arguments and facts cited in favor and in resistance to each motion.

IV. DISCUSSION

Before the Court are Plaintiffs' claims alleging Iowa's CON program violates Physician Plaintiffs' rights under the Fourteenth Amendment's Equal Protection Clause (Count I), Physician Plaintiffs' rights under the Fourteenth Amendment's Due Process Clause (Count II), and

Patient Plaintiffs' rights under the Fourteenth Amendment's Due Process Clause (Count IV). The Court first considers Counts I and II of Plaintiffs' amended complaint. The parties agree Counts I and II are subject to rational basis scrutiny. *See* ECF No. 65 at 4–20; ECF No. 66 at 1–7. The Court determines Iowa's CON program withstands rational basis scrutiny. Iowa's CON program is justified by promoting the viability of full-service hospitals, a legitimate state interest. Iowa's CON program conceivably advances that interest. Additionally, the Court overrules Plaintiffs' hearsay objections to certain parts of the record and considers those materials as additional support for its conclusions. Because the challenged statute bears a rational relationship to a legitimate state interest, Defendants are entitled to summary judgment as a matter of law with respect to Counts I and II of Plaintiffs' amended complaint.

The Court next considers Count IV of Plaintiffs' amended complaint. Plaintiffs contend Count IV alleges an infringement upon Patient Plaintiffs' fundamental rights, triggering strict scrutiny of Iowa's CON program under the Fourteenth Amendment's Due Process Clause. *See* ECF No. 65 at 20–25. Because Plaintiffs have not shown Iowa's CON program infringes on any of Patient Plaintiffs' fundamental rights, strict scrutiny of Iowa's CON program is not warranted. For the same reasons the Court determines Iowa's CON program satisfies rational basis scrutiny with respect to Counts I and II, Iowa's CON program survives rational basis scrutiny with respect to Count IV, as well. Summary judgment in favor of Defendants is therefore also appropriate as to Count IV.

A. Physician Plaintiffs' Equal Protection and Substantive Due Process Claims (Counts I and II)

At the motion to dismiss stage, the Court concluded Plaintiffs plausibly pleaded Iowa's CON program, in general, and the capital expenditure exemption, in particular, were not conceivably related to advancing any legitimate government interests, including the prioritization

of essential services. *See* ECF No. 52 at 36–40. For the reasons discussed below and in light of the evidentiary record now before it, the Court concludes the promotion of full-service hospitals is a legitimate state interest justifying Iowa's CON program. Iowa's CON program, in general, and the capital expenditure exemption, in particular, rationally further that interest by conceivably insulating full-service hospitals from competition and facilitating full-service hospitals collecting greater revenue from profitable outpatient surgery services. The Court therefore denies Plaintiffs' Motion for Summary Judgment and grants Defendants' Motion for Summary Judgment as to Counts I and II.

1. Rational Basis Scrutiny

Plaintiffs contend Iowa's CON program violates Physician Plaintiffs' rights under the Fourteenth Amendment's Equal Protection and Due Process Clauses. ECF No. 32 ¶¶ 223–46. Under the tiers of scrutiny in Fourteenth Amendment analysis, a statute that does not make a suspect classification or infringe upon a fundamental right must only satisfy rational basis scrutiny. *See City of New Orleans v. Dukes*, 427 U.S. 297, 303 (1976) (per curiam).[9] There are no suspect classifications or fundamental rights at issue in Counts I and II of the complaint, and the parties agree these counts are analyzed under rational basis scrutiny.

The Supreme Court and Eighth Circuit have made clear a statute analyzed under rational basis scrutiny must be upheld so long as it is rationally related to a legitimate state interest. *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993) ("[A] legislative choice is not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or

[9] While the Equal Protection and Substantive Due Process Clauses of the Fourteenth Amendment are conceptually distinct, "[a] rational basis that survives equal protection scrutiny also satisfies substantive due process analysis." *Exec. Air Taxi Corp. v. City of Bismarck*, 518 F.3d 562, 569 (8th Cir. 2008). The Court thus analyzes Counts I and II with the same legal framework.

empirical data."); *accord Barket, Levy & Fine, Inc. v. St. Louis Thermal Energy Corp.*, 21 F.3d 237, 240 (8th Cir. 1994). "A statute is presumed constitutional . . . and '[t]he burden is on the one attacking the legislative arrangement to negat[e] every conceivable basis which might support it.'" *Heller v. Doe ex rel. Doe*, 509 U.S. 312, 320 (1993) (first alteration in original) (quoting *Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356, 364 (1973)). Rational basis scrutiny requires the statute to have "a plausible policy reason for the classification" based on "legislative facts . . . [that] rationally may have been considered to be true by the governmental decisionmaker." *Nordlinger v. Hahn*, 505 U.S. 1, 11 (1992) (internal citations omitted). A court need not parse the relative weight of a statute's conceivable purposes; it is sufficient that there exists one conceivable, legitimate interest served by the statute. *Id.*; *Heller*, 509 U.S. at 320–21.

Although "the relationship of the classification to its goal" cannot be "so attenuated as to render the distinction arbitrary or irrational," *Nordlinger*, 505 U.S. at 11, the state need not "choose between attacking every aspect of a problem or not attacking the problem at all," *United Hosp. v. Thompson*, 383 F.3d 728, 733 (8th Cir. 2004). "[C]ourts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends. A classification does not fail rational-basis review because it 'is not made with mathematical nicety or because in practice it results in some inequality.'" *Heller*, 509 U.S. at 321 (quoting *Dandridge v. Williams*, 397 U.S. 471, 485 (1970)). The classification need only "find some footing in the realities of the subject addressed by the legislation." *Id.* "The assumptions underlying these rationales may be erroneous, but the very fact that they are arguable is sufficient." *Beach Commc'ns*, 508 U.S. at 320 (internal quotation marks omitted). Thus, a statute's "[r]ational distinctions may be made with substantially less than mathematical exactitude."

Minn. Ass'n of Health Care Facilities, Inc. v. Minn. Dep't of Pub. Welfare, 742 F.2d 442, 447–48 (8th Cir. 1984) (quoting *Dukes*, 427 U.S. at 303).

2. Analysis

a. Promotion of full-service hospitals as legitimate state interest

First, the Court concludes Iowa has a legitimate state interest in promoting the viability of full-service hospitals.[10] This interest is fundamentally distinct from naked economic protectionism because it pertains to promoting full-service firms in a market in which such firms conceivably provide distinct public benefits over smaller competitors. *Cf. St. Joseph Abbey v. Castille*, 712 F.3d 215, 222–23 (5th Cir. 2013) (concluding a state statute granting funeral homes an exclusive right to sell caskets was only justified by naked economic protectionism); *Craigmiles v. Giles*, 312 F.3d 220, 224 (6th Cir. 2002) (same); *see also Merrifield v. Lockyer*, 547 F.3d 978, 991 & n.15 (9th Cir. 2008) (concluding a pest control licensing scheme failed to satisfy the rational basis test because "irrational[ly] singling out of three types of vertebrate pests from all other vertebrate animals was designed to favor economically certain constituents at the expense of others"). Two strands of cases are relevant to this conclusion: cases involving full-service firms and cases involving public health.

First, the Eighth Circuit has concluded full-service firms in certain markets conceivably generate ancillary benefits for the public at large. In *Kansas City Taxi*, for instance, the Eighth Circuit affirmed a district court order rejecting a rational basis challenge to a Kansas City, Missouri, ordinance limiting the number of taxicab permits.

[10] Statutory classifications need not strictly align with the categories implicated by an identified state interest. *See Minn. Ass'n of Health Care Facilities, Inc.*, 742 F.2d at 447–48; *see also Dukes*, 427 U.S. at 303. To the extent necessary, the Court concludes "hospital" and "outpatient surgical facility" as defined by Iowa's CON statute conceivably serve as proxies for "full-service hospital" and "outpatient surgery center," respectively.

See Kansas City Taxi Cab Drivers Ass'n, LLC v. City of Kansas City, 742 F.3d 807, 808–09 (8th Cir. 2013). In doing so, the Eighth Circuit endorsed the district court's reasoning that the ordinance conceivably encouraged infrastructure investment and improved the quality of service by insulating full-service taxi companies from competition. *Id.* The Fifth Circuit approved of a similar taxi licensing scheme in Houston, Texas. *Greater Hous. Small Taxicab Co. Owners Ass'n v. City of Houston*, 660 F.3d 235, 238 (5th Cir. 2011). There, the Fifth Circuit noted the Houston ordinance was justified in part by the explanation "full-service taxicab companies" offered "full 24-hour radio dispatch services," "complete on-site repair facilities for their vehicles," "disabled access vehicles," and "more efficient, environmentally friendly taxicabs." *Id.*; *cf. St. Joseph Abbey*, 712 F.3d at 223 (distinguishing "full-service taxi operations" from "mere economic protection of a particular industry"). Because full-service taxicab companies offer such public benefits, protection of full-service taxicab companies is not naked economic protectionism.

Similar reasoning applies to Iowa's interest in full-service hospitals. In particular, promoting the viability of full-service hospitals is connected to significant state interests in public health. The Supreme Court has long held the "power to establish and enforce standards of conduct within its borders relative to the health of everyone there" is "a vital part of a state's police power." *Barsky v. Bd. of Regents of Univ. of N.Y.*, 347 U.S. 442, 449 (1954). The Eighth Circuit has determined even highly specific statutes can be justified by reference to such interests. For example, in *Gallagher v. City of Clayton*, the Eighth Circuit concluded a Clayton, Missouri, ordinance banning outdoor smoking on certain public property was rationally related to public health aims. 699 F.3d 1013 (8th Cir. 2012). The *Gallagher* court specifically noted the city's reliance on "a number of studies, including a 1999 report by the National Cancer Institute that secondhand smoke exposure 'is responsible for the early deaths of approximately 53,000

Americans annually' and the 2006 report of the U.S. Surgeon General that found 'there is no risk-free level of exposure to secondhand smoke.'" *Gallagher*, 699 F.3d at 1019. Although the city "could have engaged in 'rational speculation unsupported by evidence or empirical data' that outdoor secondhand smoke exposure harms health, the [city] went further and relied on reports that 'could . . . reasonably be conceived to be true.'" *Id.* at 1020 (omission in original) (quoting *Beach Commc'ns*, 508 U.S. at 315).

Additionally, the reasoning of *Niang*, although no longer binding, is persuasive. 879 F.3d 870. There, the Eighth Circuit concluded a licensing requirement for hair braiders was rationally related to public health aims. The *Niang* court specifically noted the defendants' submission of "evidence of health risks associated with braiding such as 'hair loss, inflammation, and scalp infection' . . . [and] evidence of scalp conditions that braiders must recognize as unsuitable for braiding." *Niang*, 879 F.3d at 873. The *Niang* court indicated combatting these health risks was related to public health and was therefore unlike illegitimate interests such as "protecting a discrete interest group from economic competition." *Niang*, 879 F.3d at 874 (quoting *Craigmiles*, 312 F.3d at 224).

As the record demonstrates, promoting full-service hospital viability conceivably advances public health in several ways. By virtue of their size, full-service hospitals often possess a wide range of medical professionals, equipment, and facilities. By contrast, outpatient surgery centers—especially single-specialty outpatient surgery centers—are, by their nature, more specialized and possess a narrower range of medical professionals, equipment, and facilities. *See* ECF No. 62-1 ¶ 79; *see also* ECF No. 62-2 at A270 (noting, nationally, "[a]pproximately half of the" facilities offering "surgical procedures on patients who do not require an overnight stay" are single-specialty). Full-service hospitals also offer services that are unavailable at outpatient surgery centers. *See* ECF No. 67-1 ¶¶ 29, 30. For instance, full-service hospitals provide

emergency services. ECF No. 58-2 at App. P. 135; *see also* ECF No. 62-2 at A249–50 (describing range of services offered by hospitals); *id.* at A267 n.103 (noting, nationally, "92 percent of general hospitals had an [emergency department]"); *cf.* ECF No. 58-2 at App. P. 171 (stating Plaintiffs' admission that an outpatient surgical facility does not contain an emergency department). Because they offer inpatient surgery services, full-service hospitals also typically offer long-term hospitalization when necessary. *See* Iowa Code § 135B.1(3). These benefits are particularly important in rural communities, where full-service hospitals are often the only healthcare facilities. *See* ECF No. 58-2 at App. P. 6 (providing Birchansky's testimony before the Health Facilities Council describing "rural critical access hospitals").

The Court finds these benefits more compelling than those identified in the taxicab cases. *Cf. Kansas City Taxi*, 742 F.3d at 808–09; *Greater Hous. Small Taxicab Co.*, 660 F.3d at 238. The healthcare infrastructure facilitated by full-service hospitals directly affects public health by offering emergency services and inpatient surgery services. A state's interest in public health is at least as important as its interest in transportation infrastructure. Furthermore, the differences between full-service hospitals and specialized facilities are more significant than the differences between full-service taxi companies and independent taxi operators. *See Greater Hous. Small Taxicab Co.*, 660 F.3d at 238 (noting benefits offered by full-service taxi companies).

Iowa's interests in promoting full-service hospital viability are also more compelling than the interests served by limiting exposure to secondhand smoke. *Cf. Gallagher*, 699 F.3d at 1019–20. Among other reasons, full-service hospitals treat the very sort of health consequences *Gallagher* determined states may address through bans on outdoor smoking. *See id.* Full-service hospitals also treat the sort of hair loss, inflammation, and scalp infection that justified the licensure requirement at issue in *Niang*, 879 F.3d at 873. Thus, the Iowa

legislature could rationally determine the public health would be advanced by supporting the viability of full-service hospitals, even if doing so may also insulate full-service hospitals from economic competition. *See Kansas City Taxi*, 742 F.3d at 808–10; *Gallagher*, 699 F.3d at 1019–20; *see also Niang*, 879 F.3d at 873. For these reasons, the Court concludes Defendants possess a conceivable, legitimate state interest: promoting the viability of full-service hospitals.

b. Iowa's CON program as rationally related means

To survive rational basis scrutiny, Iowa's CON program—including the capital expenditure exemption—must rationally advance Iowa's interest in promoting the viability of full-service hospitals. The Court concludes it does. Iowa's CON program addresses a challenge to the viability of full-service hospitals: the public benefits provided by full-service hospitals are conceivably not financially viable on their own. In most situations, full-service hospitals and their medical professionals may not turn away patients in need of emergency medical care. *See* 42 U.S.C. § 1395dd. Some of those patients are uninsured or otherwise unable to pay for the medical services they receive. The 2004 FTC–DOJ Report indicates "[m]edical treatment for the uninsured is often more expensive than care of the insured, because the uninsured are more likely to delay treatment and receive care in an emergency room." ECF No. 62-2 at A138. "The uninsured . . . often cannot fully pay for the care they receive" and so "[t]he costs of uncompensated treatments for the uninsured are either paid by taxpayers, absorbed by providers, or passed on to the insured." *Id.*; *see also id.* at A255–56, A256 n.43 (describing "providing care to the uninsured" as a pressure on hospitals and noting a 2000 national study indicating "uninsured patients accounted for an average of 4.8 percent of all inpatient discharges, and 10.2 percent of emergency department discharges"). Therefore, emergency departments at full-service hospitals are conceivably less profitable than other departments, creating an economic strain on full-service

hospitals that other types of facilities can avoid. Iowa's CON program, in general, and the capital expenditure exemption, in particular, conceivably address that problem. The Court first addresses how the CON requirement does so before turning to the capital expenditure exemption's effect.

i. CON requirement

It appears undisputed that the CON requirement for outpatient surgical facilities benefits CON-holders by preventing many would-be facilities from competing with incumbents. *See, e.g.*, Swift Dep. 284:11–18, ECF No. 62-7 at A1407 (agreeing "other outpatient surgical facilities could take away profits from a hospital" and the CON requirement protects hospitals against that competition). The program survives rational basis scrutiny if this insulating effect conceivably advances Iowa's interest in promoting the viability of full-service hospitals. Two characteristics of Iowa's CON program conceivably make the CON requirement advance that interest: 1) a substantial number of CON-holders are full-service hospitals; and 2) Iowa's CON program channels profitable outpatient surgeries to facilities associated with CON-holding full-service hospitals. Taken together, these conclusions establish a rational connection between Iowa's CON program and the state's interests.

First, the Iowa legislature could conceivably assume a substantial number of CON-holders are full-service hospitals.[11] To provide surgery services, which all full-service hospitals do, a full-service hospital must have both a hospital license and a CON.

[11] Plaintiffs argue Iowa's CON program does not conceivably advance any interest because Defendants do not collect data on, among other things, "the number of off-campus locations of hospitals that have opened to offer outpatient surgical services since 2000; the number of on-campus locations of hospitals that have opened to offer outpatient surgical services since 2000; or the number of times a healthcare provider has qualified for the in-office exemption." ECF No. 65 at 10 (quoting Swift Aff. ¶ 17, ECF No. 62-4 at A713). Defendants need not produce evidence of the relative number of CON-holders that are full-service hospitals or outpatient surgery centers to satisfy rational basis scrutiny. It is sufficient that the connection between incumbent CON-holders and full-service hospitals "rationally may have been considered to be true by the governmental decisionmaker." *Nordlinger*, 505 U.S. at 11.

See Swift Dep. 150:20–21, 151:3–7, ECF No. 62-7 at A1328–29 (stating "to open a new hospital, you have to have a CON" and, before offering outpatient surgery services, a full-service hospital must "go[ ] through the CON process . . .[and] go[ ] through the course of action [it has] to go through to be licensed"); *see also* ECF No. 62-1 ¶ 66; Swift Dep. 150:8–151:18, ECF No. 62-7 at A1328–29 (noting a full-service hospital with a hospital license may offer outpatient surgery services). Thus, most if not all full-service hospitals are CON-holders. This correlation makes it conceivable that there is a substantial overlap between full-service hospitals and CON-holders, such that the CON requirement affects full-service hospitals in substantial number.

Other intricacies of Iowa's CON program do not negate the significance of this correlation. Such intricacies primarily implicate the means–end fit required by rational basis scrutiny. When fitting the means it employs to the ends it hopes to achieve, Iowa need not narrowly tailor its efforts to solely benefit full-service hospitals because the legislature need not "choose between attacking every aspect of a problem or not attacking the problem at all.'" *United Hosp.*, 383 F.3d at 733. Thus, the CON requirement satisfies rational basis scrutiny even if it benefits full-service hospitals unevenly or benefits other entities as well, so long as full-service hospitals as a whole conceivably benefit. If Iowa's CON program conceivably promotes full-service hospital viability, it is permissible even if some CON-holders are not related to full-service hospitals and some full-service hospitals run off-campus outpatient surgery centers.

The record confirms the CON requirement—including its exceptions—conceivably benefits full-service hospitals, generally. For instance, the record demonstrates full-service hospitals may offer outpatient surgery services at off-campus facilities under the authority of their hospital licenses and without a separate CON. *See* ECF No. 62-1 ¶¶ 100–128; *see also* Swift Dep. 144:18–145:12, ECF No. 62-7 at A1322–23 (noting only five "freestanding"

outpatient surgical facilities unaffiliated with full-service hospitals have received a CON since 2000). This practice does not render the CON requirement irrational. To the contrary, their ability to do so, discussed in greater detail with regard to the capital expenditure exemption below, conceivably promotes full-service hospital viability by permitting full-service hospitals to capture additional revenue from outpatient surgery services. Some facilities offering outpatient surgical services under a hospital license are joint ventures (that is, they are partially owned by non-full-service hospitals). This is also permissibly overbroad. In both instances, the Iowa legislature could conceivably believe the CON requirement supports full-service hospitals even if the CON requirement also benefits other entities.

Full-service hospitals in general benefit financially from operating off-campus facilities like outpatient surgery centers. Consider, as Plaintiffs do, St. Luke's Hospital and Mercy Medical Center, both in Cedar Rapids, Iowa. *See* ECF No. 62-1 ¶¶ 102, 107. St. Luke's Hospital and Mercy Medical Center are full-service hospitals. *See id.*; *see also* ECF No. 62-4 at A770, A847. St Luke's Hospital opened The Surgery Center of Cedar Rapids as an off-campus outpatient surgery center under the $1,500,000 capital expenditure exemption. ECF No. 62-4 at A757–58. St. Luke's Hospital then partially transferred ownership of The Surgery Center of Cedar Rapids under the "seamless transfer" exclusion of Iowa Code Section 135.63(2)(o). *Id.* at A770. The Surgery Center of Cedar Rapids operates as a joint venture LLC, half-owned by St. Luke's Hospital and half-owned by a private physician group, offering outpatient surgical services without its own CON and without its own hospital license. *Id.* at A757–58. Mercy Medical Center operates Hiawatha Outpatient Surgery Center as an off-campus outpatient surgery center; because the estimated cost of Hiawatha Outpatient Surgery Center totaled $1,465,441, a CON was not required. *Id.* at A847. Like their affiliated full-service hospitals, The Surgery Center of Cedar Rapids and Hiawatha Outpatient Surgery Center are insulated from competition by the CON

requirement. However, their finances are, by dint of ownership, intertwined with St. Luke's Hospital and Mercy Medical Center, respectively. Thus, these facilities conceivably promote the viability of their related full-service hospitals. Accordingly, their physical separation does not alter the correlation between full-service hospitals and CON-holders. By the same reasoning, the viability of full-service hospitals conceivably correlates to the viability of CON-holders generally.

Second, Iowa's CON program conceivably promotes full-service hospital viability by channeling profitable surgery services to CON-holding facilities. Specifically, physicians must perform nearly all outpatient surgeries at a facility with a CON. *See* Iowa Code §§ 135.61(14), 135.61(21), 135.63(1).[12] As relevant here, outpatient surgery services are commonly provided in outpatient departments on full-service hospital campuses. *See* ECF No. 62-1 ¶ 63. Off-campus outpatient surgery centers affiliated with full-service hospitals can also provide outpatient surgery services. *Id.* ¶ 74. Both full-service hospitals and outpatient surgery centers charge facility fees for outpatient surgery services. *Id.* ¶ 64, 76. "Hospital facility fees are usually much higher than those of outpatient surgery centers." *Id.* ¶ 65.

Existing CON-holders benefit from these fees. For instance, Mercy Medical Center's hospital facility fee for a cataract surgery is $8,372. *Id.* ¶ 77 (citing Birchansky Aff. ¶ 17, ECF No. 62-4 at A738). The Surgery Center of Cedar Rapids's outpatient surgery center facility fee for a cataract surgery is $3,500. *Id.* (citing Birchansky Aff. ¶ 17, ECF No. 62-4 at A738). Fox Eye would charge outpatient surgery center facility fees for cataract surgeries of $975 for Medicare patients and $1950 for non-Medicare patients. *Id.* (citing Birchansky Aff. ¶ 16,

[12] The Iowa Department of Public Health permits surgeons to continue to perform surgical procedures "ordinarily performed in a private physician's office" in that manner. *See* ECF No. 62-1 ¶¶ 67–72. The Iowa Department of Public Health has determined "no-stitch" cataract surgery must be performed at a facility with a CON. *Id.* ¶ 71.

ECF No. 62-4 at A738). Similarly, hospital facility fees for tympanostomies—an ear tube procedure—range from $2,300 to $4,200. *Id.* ¶ 78 (citing Korver Aff. ¶ 11, ECF No. 62-4 at A722). Hospital facility fees for tonsillectomies range from $4,200 to $4,500. *Id.* (citing Korver Aff. ¶ 11, ECF No. 62-4 at A722). Korver ENT would charge outpatient surgery center facility fees of $1,500 or less for these procedures. *Id.* (citing Korver Aff. ¶ 15, ECF No. 62-4 at A722).[13] Higher fees conceivably indicate Iowa's CON program is accomplishing its objective: maintaining the viability of full-service hospitals. Specifically, the higher facility fees CON-holders (especially full-service hospitals) can charge by virtue of the CON requirement conceivably make them more profitable. Thus, full-service hospitals (and affiliated outpatient surgery centers like The Surgery Center of Cedar Rapids) benefit from the requirement that outpatient surgeries be performed in CON-holding facilities.

Full-service hospitals in rural communities may especially benefit from the requirement. Birchansky testified before the Health Facilities Council that, by performing surgeries in "small rural hospitals," he has "prevented several of them from failing." ECF No. 58-2 at App. P. 6. Birchansky noted his surgeries have supported Marengo Hospital, Anamosa Hospital, Maquoketa Hospital, DeWitt Hospital, and Manchester Hospital. *Id.* at App. P. 6–7. Birchansky notes Marengo Hospital, Anamosa Hospital and Maquoketa hospital were all "nearly bankrupt" when he started offering his services. *Id.* By virtue of his involvement, those facilities "are all now thriving and expanding." *Id.* at App. P. 6. Birchansky notes Anamosa Hospital and Maquoketa Hospital became profitable enough to build new facilities. *Id.* at App. P. 6–7.

[13] The record does not contain detailed analysis of the current financial state of full-service hospitals in general or of St. Luke's Hospital and Mercy Medical Center in particular. It does, however, contain some indication St. Luke's Hospital and Mercy Medical Center have been recently profitable. Fox Eye's 2007 CON application includes a summary of St. Luke's Hospital's and Mercy Medical Center's tax returns from 2004, 2005, and 2006. *See* ECF No. 62-5 at A940–42.

Through this lens, the relationship between facilities and services is apparent. Full-service hospitals remain viable in part because they offer a range of services, some profitable and some unprofitable. The higher fees charged by full-service hospitals suggest the CON requirement has prevented new entrants from "cherry-picking" profitable surgeries away from full-service hospitals and their affiliated facilities. *See* ECF No. 62-2 at A272–73 (noting the view that ambulatory surgery centers "are eroding the outpatient market share of hospitals that hospitals depend upon"), A426 (noting the view "CON regulation also can address cherry picking, preventing firms from, for example, converting cancer 'medical practices to medical care facilities [that] divert well-insured patients [from] local hospital cancer programs'" (alterations in original)). The 2004 FTC–DOJ Report describes this effect as cross subsidization, "the practice of charging supracompetitive prices to some payors or for some services and using the surpluses to subsidize other payors or other clinical services." *Id.* at A284. Defendants need not offer evidence on this effect, so long as the effect "rationally may have been considered to be true by the governmental decisionmaker." *Nordlinger*, 505 U.S. at 11; *cf.* ECF No. 62-1 ¶ 53 (noting "[t]he Department testified that it has no evidence that the CON requirement allows hospitals to cross-subsidize essential services"). In short, if full-service hospitals can be spared competition on profitable services, they are more likely to remain profitable overall. In light of the record, the legislature could conceivably determine full-service hospitals benefit from cross-subsidization.

These features make it conceivable that Iowa's CON program promotes the viability of full-service hospitals. *See Kansas City Taxi*, 742 F.3d at 808–09 (concluding limitations on new taxicabs conceivably promoted full-service taxi company investments in infrastructure). Thus, the Court concludes Iowa's CON program in general withstands rational basis scrutiny. The Court next addresses the effect of one exception to Iowa's CON program.

ii. Capital expenditure exemption

Plaintiffs contend "the various loopholes in the CON requirement"—specifically, the capital expenditure exemption—undermine any cross-subsidization rationale for Iowa's CON program. ECF No. 65 at 14. The Court finds the same rationale supporting Iowa's CON program generally justifies the capital expenditure exemption. Iowa's CON program channels outpatient surgery services to facilities with CONs, allowing those facilities to collect facility fees. By similar reasoning, allowing a CON-holder to expand and develop new facilities allows it to perform more surgeries and reap more profit.

A CON-holder may charge a facility fee for outpatient surgery services. *See* ECF No. 62-1 ¶¶ 64–65, 76. The capital expenditure exemption allows a CON-holder to offer more outpatient surgery services, either by expanding its existing facilities or by building new off-campus facilities. *See* Swift Dep. 263:5–264:12, ECF No. 62-7 at A1392–93; *see also* ECF No. 62-1 ¶¶ 100–128 (describing The Surgery Center of Cedar Rapids and Hiawatha Outpatient Surgery Center). As discussed above, an outpatient surgery center run by a full-service hospital CON-holder conceivably puts money in the full-service hospital's coffers. *See, e.g.*, ECF No. 62-1 ¶¶ 77–78 (comparing facility fees for Mercy Medical Center and The Surgery Center of Cedar Rapids with facility fees for Fox Eye Surgery and Korver ENT); *id.* ¶¶ 102, 104, 107, 126 (noting St. Luke's Hospital's joint ownership of The Surgery Center of Cedar Rapids and Mercy Medical Center's ownership of Hiawatha Outpatient Surgery Center). Permitting CON-holders to expand existing facilities or build new facilities conceivably amplifies this effect by permitting CON-holders to capture additional profit from more outpatient surgery services. Full-service hospitals are CON-holders, and so the capital expenditure exemption conceivably promotes full-service hospital viability.

Nor does the capital expenditure exemption undermine the cross-subsidization rationale supporting Iowa's CON program. Because the capital expenditure exemption permits the sort of expansion Iowa's CON program generally forbids, the precise contours of the capital expenditure exemption warrant attention. Importantly, Iowa's current capital expenditure exemption has a limit: $1,500,000. Iowa Code § 135.61(18)(c). The existence of this limit conceivably curtails the ability of CON-holders to expand their facilities. *Cf.* ECF No. 62-4 at A847 (determining Mercy Medical Center's $1,465,441 Hiawatha Outpatient Surgery Center was not subject to CON review because it was under the $1,500,000 capital expenditure exemption limit). In doing so, this limit conceivably prevents CON-holders from expanding enough to jeopardize the viability of other CON-holders. In other words, if the CON requirement prevents non-CON-holders from siphoning profits from CON-holders, then the limit on the capital expenditure exemption prevents, at least to some extent, other CON-holders from doing the same.

The Iowa legislature set the capital expenditure exemption limit at a value conceivably likely to accomplish this goal. The ability of CON-holders to siphon profits from other CON-holders is rationally curtailed so long as the capital expenditure exemption limit imposes a conceivably meaningful limitation on the types of projects CON-holders can pursue. The legislature might have concluded the capital expenditure exemption limit curtails CON-holder expansion by reference to the projected costs of other CON proposals. *See Beach Commc'ns*, 508 U.S. at 315 (noting "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature" and reasoning a "legislative choice . . . may be based on rational speculation"). Historical data on outpatient surgical facility CON application proposals is therefore instructive.

Iowa's CON program was enacted in 1977 with a capital expenditure exemption limit of $150,000. Between 1978 and 1982, the single outpatient surgical facility CON

proposal—Surgery Center Des Moines's $775,000 proposal in 1980—projected costs in excess of $150,000, not adjusted for inflation. *See* ECF No. 62-4 at A776.

In 1982, the Iowa legislature increased the capital expenditure exemption limit from $150,000 to $600,000. 1982 Iowa Acts 334, § 1(c). Between 1982 and 1991, three out of the four outpatient surgical facility CON proposals projected costs at or in excess of the capital expenditure limit of $600,000. *See* ECF No. 62-4 at A776. Those proposals were: Ambulatory Surgical of Des Moines's $600,000 proposal in 1984; Iowa Surgery Center, Inc.'s $696,500 proposal in 1984; and University of Osteopathic Medicine and Health Sciences' $1,202,778 proposal in 1984. *Id.*

In 1991, the Iowa legislature increased the capital expenditure exemption limit from $600,000 to $800,000. 1991 Iowa Acts 454, § 1(18)(c). Between 1991 and 1997, five of the nine outpatient surgical facility CON proposals projected costs in excess of the capital expenditure limit of $800,000. ECF No. 62-4 at A776–77. Those proposals were: Mercy Hospital Medical Center's $7,400,000 proposal in fiscal year 1992; Ottumwa Surgicenter, Inc.'s $825,000 proposal in fiscal year 1993; Mississippi Medical Plaza's $2,734,000 proposal in September 1993; Mississippi Medical Plaza's $2,150,000 proposal in May 1994; and Fox Eye Outpatient Laser and Surgery Center's $1,263,087 proposal in fiscal year 1996. *Id.*

Finally, in 1997, the Iowa legislature increased the capital expenditure exemption limit from $800,000 to $1,500,000. 1997 Iowa Acts 133, § 2(c). Between 1997 and 2018, six of the twenty-five total outpatient surgical facility CON proposals projected costs in excess of the capital expenditure limit of $1,500,000, not adjusted for inflation. *See* ECF No. 62-4 at A777–79. The proposals projecting costs in excess of $1,500,000 during this period were: NE Iowa Regional Surgery Center's $2,839,815 proposal in fiscal year 1998; West Des Moines Surgery Center, LC's $3,485,836 proposal in fiscal year 2000; Steindler Orthopedic

Clinic PLC's $2,288,500 proposal in fiscal year 2002; Mason City Ambulatory Surgery Center's $2,640,330 proposal in fiscal year 2004; Mercy North Ambulatory Surgery Center's $2,441,260 proposal in fiscal year 2004; and Mercy Hospital's $9,382,037 proposal in fiscal year 2007. *Id.* Five proposals during this period were projected to cost nothing. *Id.*

It is therefore conceivable the capital expenditure exemption limit cabins yearly incumbent expansion. Between 1978 and 2018, fifteen of the thirty-four outpatient surgical facility CON proposals projected to cost anything exceeded the relevant capital expenditure limit. During the period in which the capital expenditure exemption limit has been $1,500,000, the twenty outpatient surgical facility CON proposals projected to cost anything averaged a projected cost of $1,447,871. The six proposals with a projected cost exceeding $1,500,000 averaged a projected cost of $3,846,296. Outpatient surgical facility CON proposals commonly project costs above the capital expenditure exemption limit. If a CON-holder wanted to expand in the same way, it, too, would have to receive a new CON. Iowa Code § 135.61(18)(c). Thus, the capital expenditure exemption limit conceivably prevents some CON-holder expansion. Therefore, the capital expenditure exemption does not negate the benefits conceivably conferred by the CON requirement. Accordingly, the exemption also survives rational basis scrutiny.

c. Newspaper articles, websites, pleading allegations, academic studies, and other state experiences

Finally, the Court addresses additional materials supporting the conclusion Iowa's CON program is rationally related to Iowa's interest in promoting the viability of full-service hospitals. Plaintiffs object to some of Defendants' proffered evidence as impermissible hearsay evidence. *See* ECF No. 67-1 ¶¶ 4, 11, 16, 18, 20–23, 28–30, 32–33. The Court overrules these objections as discussed below. Even so, the Court notes these materials provide only additional support for its

conclusions discussed above; even if the Court did not consider these materials, its conclusions would remain the same.

In analyzing a summary judgment motion, a "court may consider only the portion of the submitted materials that is admissible or useable at trial." *Moore v. Indehar*, 514 F.3d 756, 758 (8th Cir. 2008) (internal quotation marks omitted); *see also Jones v. McNeese*, 746 F.3d 887, 894–95 (8th Cir. 2014). Absent a recognized exception, hearsay is inadmissible evidence. *See* Fed. R. Evid. 802. Hearsay is an out-of-court statement offered to prove the truth of the matter asserted. Fed. R. Evid. 801; *see ZW USA, Inc. v. PWD Sys., LLC*, 889 F.3d 441, 449 n.7 (8th Cir. 2018) (concluding website printouts describing products as "one-pull" were properly considered on summary judgment as they were "not offered to prove the fact that [plaintiff]'s competitors' bags can actually be dispensed with one pull" but instead were "offered to show the fact that certain of [plaintiff]'s competitors use the phrase 'one-pull' to describe their products").

Plaintiffs specifically note Paragraphs 18, 21, 23, 28, 32, and 33 of Defendants' Statement of Undisputed Facts rely on information from newspaper articles; Paragraphs 4 and 11 are unauthenticated websites; and Paragraphs 16 and 20 cite academic studies. ECF No. 67 at 10–11 n.7 (citing ECF No. 58-1). Defendants respond they do not offer the challenged materials for the truth of the matter asserted. ECF No. 69 at 4. Defendants contend the materials are not being used to prove their contents, but rather "to show that these topics have been the subject of study and reporting and that issues surrounding the efficacy of CON programs are being legitimately debated in the public realm." *Id.*

The Court finds the objected-to materials are being offered for a non-hearsay purpose. Defendants do not offer the challenged materials to prove Iowa's CON program, in fact, has the effects the materials describe. Instead, they offer the materials to show the legislature might rationally think those effects to be true. *See Minnesota v. Clover Leaf Creamery*, 449 U.S. 456,

464 (1981) (determining rational basis scrutiny is satisfied where the justification for a statute "is at least debatable"). In the rational basis setting, Defendants do not bear any burden of proof. *See Gallagher*, 699 F.3d at 1020. Any conceivable justification, including those independently identified by a district court, can support a statute. *See Kansas City Taxi*, 742 F.3d at 809 (rejecting argument that a district court cannot offer separate justifications for the statute). Justifications contained in the record may support a statute, even if those justifications are out-of-court statements. The Court therefore concludes Defendants offer these materials for a non-hearsay purpose, and so considers the materials.

These materials provide further support for the Court's conclusions described above. First, these materials provide additional support for the conclusion full-service hospitals benefit the public health of Iowans. Some news articles indicate surgery at an outpatient surgery center is more dangerous than surgery at a full-service hospital. *See* ECF No. 58-2 at App. P. 107–08. Other materials indicate full-service hospitals offer ancillary benefits. For example, the Iowa Hospital Association indicates full-service hospitals offer "charity care and free and reduced-cost services like immunizations, health screenings, and counseling." ECF No. 58-2 at App. P. 123; *cf.* ECF No. 67-1 ¶ 28 (objecting to Defendants' characterization that hospitals "provid[e] millions in charity care, subsidized health services, and community benefit programs and producing jobs and economic growth" as hearsay). These materials further support the conclusion Iowa has a legitimate interest in promoting the viability of full-service hospitals.

Second, these materials provide additional support for the CON requirement. Some studies suggest the unregulated growth of outpatient surgery centers may harm full-service hospitals by competing away profitable services. *See* ECF No. 58-2 at App. P. 103–06, 126. For instance, the 2004 FTC–DOJ Report (a study that Plaintiffs include in their appendix without objection) notes "[full-service h]ospital panelists [surveyed for the report] see cross subsidies not as a theory, but

as a fact of life." ECF No. 62-2 at A284. Specifically, the 2004 FTC–DOJ Report indicates a panelist described:

> [If we] take away those profitable services and leave the hospital, the community hospital, with just the unprofitable services, one of two things is going to happen. Either services will be diminished to the community in a way that is not transparent, in a way that they cannot see that happening, or costs will be shifted back to other payors, and business and labor and consumers end up absorbing them, once again, not in a transparent way where they can see what's happening.

Id. The 2004 FTC–DOJ Report also notes cross-subsidies might facilitate charity care: "[s]everal panelists noted that in some communities, hospitals make substantial profits on one group and use those funds to provide charity care to the balance of the community." *Id.* at A285. The 2004 FTC–DOJ Report indicates "cross subsidies require either the exercise of market power by a non-profit-maximizing firm, or a non-profit-maximizing firm that receives supracompetitive profits on some services in a market with barriers to entry." *Id.* These materials further support the conclusion Iowa's CON program conceivably promotes the viability of full-service hospitals.

Moreover, reports from other states further highlight the connection between the interest in promoting full-service hospitals and Iowa's CON program. The parties agree twenty-seven states and the District of Columbia require a CON to construct an outpatient surgery center. *See* ECF No. 62-1 ¶ 99; ECF No. 66-1 ¶ 99. The fact CON programs continue in so many states does not, on its own, make Iowa's CON program constitutional. Even so, the wide retention of such programs buttresses the Court's conclusion that the CON requirement conceivably serves some legitimate state interest.

By the same token, similar capital expenditure thresholds in other states support Iowa's capital expenditure exemption. Iowa's capital expenditure exemption limit of $1,500,000 lies within the range of other state's thresholds. For instance, Alabama has a capital expenditure threshold of $4,000,000, adjusted annually for inflation. Ala. Code § 22-21-263(a)(2).

Connecticut has a capital expenditure threshold of $2,000,000. Conn. Gen. Stat. § 17b-353(a). Kentucky has a capital expenditure threshold set by administrative rule. Ky. Rev. Stat. Ann. §§ 216B.015(7), (8), 216B.130; *see* 900 Ky. Admin. Regs. 6:030 (setting capital expenditure threshold of $2,913,541). Massachusetts has a capital expenditure threshold of $7,500,000. Mass. Gen. Laws ch. 111 § 25B. Maine permits a hospital to develop an outpatient surgery site without a CON provided it does so under a $10,000,000 capital expenditure threshold. Me. Stat. tit. 22 § 329(3); *see also* ECF No. 58-2 at App. P. 2. Missouri has a capital expenditure threshold of $600,000. Mo. Rev. Stat. § 197.305(3), (6). Nevada permits a hospital to develop an outpatient surgery site without a CON provided it does so under a $2,000,000 capital expenditure threshold and in certain areas of the state. Nev. Rev. Stat. § 439A.100(1); *see also* ECF No. 58-2 at App. P. 3. Vermont permits a hospital to develop an outpatient surgery site without a CON provided it does so under a $3,000,000 capital expenditure threshold. Vt. Stat. Ann. tit. 18, § 9434(b)(1); *see also* Vt. Stat. Ann. tit. 18, § 9434(a)(1) (exempting non-hospital capital expenditures under $1,500,000 from review); ECF No. 58-2 at App. P. 3. These threshold levels further support the reasonableness of the capital expenditure limit in Iowa's CON program, even if other states' exemptions apply to both new and existing facilities.

3. Conclusion

Iowa has a legitimate interest in promoting the public health of Iowans. To promote public health, Iowa has an interest in promoting the viability of full-service hospitals, which offer a range of services typically unavailable at other types of medical facilities. Iowa's CON program conceivably advances Iowa's interest in promoting the viability of full-service hospitals. Specifically, Iowa's CON program prevents non-CON-holders from competing with CON-holders, some of which are full-service hospitals. Because Iowa's CON program

channels profitable surgery services to CON-holders, it is conceivable full-service hospitals are more profitable as a result. Furthermore, the capital expenditure exemption permits full-service hospitals and other CON-holders to further capitalize on this effect through new and expanded facilities. Finally, because the capital expenditure exemption has a limit conceivably likely to prevent unbridled expansion by CON-holders, the capital expenditure exemption does not negate the effect of the CON requirement. Studies, news articles, and experiences in other states—all properly considered in this analysis—support these conclusions. Accordingly, Plaintiffs' have not met their burden to show Iowa's CON program is not rationally related to a legitimate state interest. The Court grants summary judgment in Defendants' favor as to Counts I and II.

B. Patient Plaintiffs' Substantive Due Process Claim (Count IV)

Plaintiffs contend Iowa's CON program violates Patient Plaintiffs' fundamental rights under the Fourteenth Amendment's Due Process Clause. ECF No. 32 ¶¶ 252–66. Plaintiffs argue Patient Plaintiffs possess a substantive due process right to medical treatment, and allege infringement of that right subjects Iowa's CON program to strict scrutiny. ECF No. 65 at 21–24. Plaintiffs urge Iowa's CON program must be held unconstitutional under strict scrutiny even if Iowa's CON program satisfies rational basis scrutiny. The Court concludes Patient Plaintiffs' substantive due process claim does not implicate a fundamental right triggering strict scrutiny. Rather, rational basis scrutiny applies to Patient Plaintiffs' substantive due process claim.

Plaintiffs assert a fundamental right unenumerated in the Constitution. In analyzing whether strict scrutiny applies to an unenumerated right, a court must determine whether the asserted right falls within "those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997) (internal quotation marks and citations omitted). "As such rights are

not set forth in the language of the Constitution, the Supreme Court has cautioned against expanding the substantive rights protected by the Due Process Clause 'because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended.'" *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 702 (D.C. Cir. 2007) (en banc) (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992)). A court must therefore consider "a careful description of the asserted right, for [t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field." *Reno v. Flores*, 507 U.S. 292, 302 (1993) (alteration in original) (internal quotation marks omitted).

The Court begins with a "careful description of the asserted right." *Id.* Plaintiffs claim a fundamental right in "the right to seek approved medical care from a demonstrably competent provider." ECF No. 65 at 21–22. Yet, both Plaintiffs' amended complaint and the record show Patient Plaintiffs can already seek (and have already received) approved medical care from demonstrably competent providers—including from Physician Plaintiffs. *See* ECF No. 32 ¶¶ 44(c), 46, 49, 51, 57, 226; Jensen Aff. ¶¶ 4, 7–9, ECF No. 62-4 at A715; Driesen Aff. ¶¶ 7–11, ECF No. 62-4 at A718–19; Korver Aff. ¶¶ 27, 28, ECF No. 62-4 at A724; Birchansky Aff. ¶¶ 64–70, ECF No. 62-4 at A745. Instead, the record reveals the crux of Patient Plaintiffs' asserted right is their desire to receive specific treatment (eye and sinus outpatient surgeries) from specific providers (Birchansky and Korver) at specific facilities (Fox Eye and Korver ENT outpatient surgical facilities). *See* ECF No. 32 ¶¶ 208, 215; Jensen Aff. ¶ 12, ECF No. 62-4 at A716 ("I want to receive future cataract or other eye surgeries from Dr. Birchansky at Fox Eye Surgery's outpatient surgery center."); Driesen Aff. ¶ 12, ECF No. 62-4 at A719 ("I want to receive future outpatient surgeries for my sinus condition from Dr. Korver at Korver ENT's proposed surgery center.").

No court has recognized a fundamental right to receive specific treatment from a specific provider at a specific facility. To the contrary, it appears that every court to consider the issue has rejected the argument that access to a specific treatment or specific provider—let alone at a specific facility—is a fundamental right protected by the Constitution. *See generally Abigail All.*, 495 F.3d at 710 & n.18 (collecting cases and noting with approval "other courts have rejected arguments that the Constitution provides an affirmative right of access to particular medical treatments reasonably prohibited by the Government" and "[n]o circuit court has acceded to an affirmative access claim"). For instance, the D.C. Circuit has determined "a right to procure and use experimental drugs" is not "deeply rooted in our Nation's history and traditions." *Id.* at 711. The Ninth Circuit has held "substantive due process rights do not extend to the choice of type of treatment or of a particular health care provider." *Nat'l Ass'n for Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043, 1050 (9th Cir. 2000). And the Seventh Circuit has concluded "most federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider." *Mitchell v. Clayton*, 995 F.2d 772, 775 (7th Cir. 1993). These cases are highly persuasive, and the Court relies on their reasoning.

Plaintiffs attempt to distinguish such cases, arguing Patient Plaintiffs' asserted right is fundamental because here "the legislature has already approved both the treatments and the providers." ECF No. 65 at 24. "The only reason that Patient-Plaintiffs cannot seek treatment at Dr. Birchansky's or the other Physician-Plaintiffs' facilities is that those facilities do not enjoy the most-favored facility status that Iowa bestows on hospitals and incumbent surgery centers." *Id.* Plaintiffs argue strict scrutiny is appropriate because these facility restrictions are "not a 'reasonabl[e] prohibit[ion].'" *Id.* (alteration in original)

(quoting *Nat'l Ass'n for Advancement of Psychoanalysis*, 228 F.3d at 1050). Because Plaintiffs fail to show that their desire to receive treatment at a facility of their choice is a fundamental right, their argument is unavailing.

Even if, as Plaintiffs assert, access to approved treatment by an approved provider is a fundamental right (a conclusion the Court does not reach), Plaintiffs do not establish how that right encompasses receiving such treatment at specific facilities. *Cf. Nat'l Ass'n for Advancement of Psychoanalysis*, 228 F.3d at 1050–51 (applying rational basis scrutiny to treatment and provider restrictions). First, many of the cases Plaintiffs cite address different rights than those Plaintiffs assert. In arguing for "a fundamental right to seek approved medical treatment," Plaintiffs rely on the Iowa Supreme Court's decision in *State of Iowa ex rel. Iowa Department of Health v. Van Wyk*, 320 N.W.2d 599 (Iowa 1982). ECF No. 65 at 22. Plaintiffs quote *Van Wyk* for the proposition "[a]s a matter of privacy persons enjoy a fundamental right to seek or reject medical treatment generally." *Id.* (quoting *Van Wyk*, 320 N.W.2d at 606). This statement does not guarantee any right to "seek or reject medical treatment" at any particular facility. *Van Wyk*, 320 N.W.2d at 606. The next line of *Van Wyk* makes clear: "It does not follow, however, that there is a fundamental right to select a particular treatment or medication." *Id.* Thus, like the D.C., Ninth, and Seventh Circuits, the Iowa Supreme Court has not recognized a fundamental right to specific medical treatments—or, by extension, a right to specific treatments from specific providers at specific facilities. *Compare Van Wyk,* 320 N.W.2d at 606, *with Abigail All.*, 495 F.3d at 711, *Nat'l Ass'n for Advancement of Psychoanalysis*, 228 F.3d at 1050, *and Mitchell*, 995 F.2d at 775. Nor have these cases reasoned an individual possesses a fundamental right to receive approved treatments from approved providers at the location of their choice.

Plaintiffs also address a number of cases pertaining to refusing medical treatment. ECF No. 65 at 23; *see Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."); *Jordan v. District of Columbia*, 161 F. Supp. 3d 45, 54 n.6 (D.D.C. 2016) (reasoning "the right to be free from unwanted antipsychotic medication, the right to be free from bodily restraint and to avoid unnecessary confinement for medical treatment, and a parent's right to seek and follow medical advice—are each protected by the substantive component of the Fourteenth Amendment's Due Process Clause"), *aff'd*, 686 F. App'x 3 (D.C. Cir. 2017). Such cases are distinguishable on the basis they involve individuals' bodily integrity, not at issue in this case. *See also Abigail All.*, 495 F.3d at 711 n.19 ("[A] tradition protecting individual *freedom* from life-saving, but forced, medical treatment does not evidence a constitutional tradition of providing affirmative *access* to a potentially harmful, and even fatal, commercial good."). None of these cases support an affirmative right to access specific treatments, specific providers, or specific facilities—in pursuit of approved treatments or otherwise.

Finally, Plaintiffs cite two cases that suggest effective deprivation of treatment might warrant strict scrutiny. The first is a 1980 Southern District of Texas case holding unconstitutional a number of Texas statutes regulating acupuncture services on the grounds the statutes effectively deprived patients of their right to seek acupuncture treatment. ECF No. 65 at 22–23; *see Andrews v. Ballard*, 498 F. Supp. 1038, 1048–51, 1057 (S.D. Tex. 1980). The second—the dissenting opinion from the D.C. Circuit's en banc ruling in *Abigail Alliance*—would also subject a state action to strict scrutiny when a plaintiff is effectively denied access to a treatment. *See Abigail All.*, 495 F.3d at 716–17 (Rogers, J., dissenting). Even under the reasoning in these two cases, facility restrictions like Iowa's CON program would be implicated only

when such restrictions amount to an effective deprivation of access to treatment. Patient Plaintiffs have not alleged or shown deprivation of access to medical treatment. *Cf.* ECF No. 32 ¶¶ 44(c), 46, 49, 51, 57; Jensen Aff. ¶¶ 4, 7–9, ECF No. 62-4 at A715; Driesen Aff. ¶¶ 7–11, ECF No. 62-4 at A718–19; Korver Aff. ¶¶ 27, 28, ECF No. 62-4 at A724; Birchansky Aff. ¶¶ 64–70, ECF No. 62-4 at A745. Patient Plaintiffs concede they "may currently obtain the very same surgeries from the very same providers so long as they do so at a hospital." ECF No. 65 at 24. Patient Plaintiffs have only shown it is likely they will have to pay more for the treatment they desire. That is a cognizable injury. *See* ECF No. 52 at 18. It does not implicate a fundamental right.

Accordingly, the Court concludes Patient Plaintiffs' asserted right does not implicate "those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Glucksberg*, 521 U.S. at 720–21 (internal quotation marks and citations omitted). Rational basis scrutiny therefore applies. *See Abigail All.*, 495 F.3d at 712 (analyzing challenged limitations on experimental drugs under rational basis scrutiny); *Nat'l Ass'n for Advancement of Psychoanalysis*, 228 F.3d at 1050–51 (analyzing the challenged licensing scheme under rational basis scrutiny); *see also Dukes*, 427 U.S. at 303 (reasoning where a fundamental right or suspect classification is not at issue, rational basis scrutiny applies). Because rational basis scrutiny applies, the analysis of Patient Plaintiffs' substantive due process claim tracks the analysis of Physician Plaintiffs' substantive due process and equal protection claims. As discussed above, the Court concludes Iowa's CON program survives rational basis scrutiny. Thus, the Court determines Defendants are also entitled to summary judgment as to Count IV of the complaint.

V. CONCLUSION

Iowa has a legitimate interest in promoting full-service hospitals, even to the detriment of their would-be competitors. Iowa's CON program—including the capital expenditure exemption—conceivably advances that interest by channeling profitable surgery services to facilities like full-service hospitals. Thus, Iowa's CON program is rationally related to a legitimate state interest. Physician Plaintiffs' equal protection and substantive due process claims therefore fail. Because Patient Plaintiffs' fundamental rights are not implicated by Iowa's CON program, their claims fail on the same grounds.

IT IS ORDERED that Defendants' Motion for Summary Judgment, ECF No. 58, is **GRANTED**.

IT IS FURTHER ORDERED that Plaintiffs' Motion for Summary Judgment, ECF No. 62, is **DENIED**.

The Clerk of Court is directed to enter judgment in favor of Defendants. The parties are responsible for their own costs.

IT IS SO ORDERED.

Dated this 17th day of October, 2018.

REBECCA GOODGAME EBINGER
UNITED STATES DISTRICT JUDGE