No. 22-42

IN THE

Supreme Court of the United States

DIPENDRA TIWARI; KISHOR SAPKOTA; GRACE HOME CARE, INC.,
Petitioners,
v.
ADAM MEIER, *ET AL.*,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR *AMICUS CURIAE* AMERICANS FOR PROSPERITY FOUNDATION IN SUPPORT OF PETITIONER

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BRIEF OF *AMICUS CURIAE* AMERICANS FOR PROSPERITY FOUNDATION IN SUPPORT OF PETITIONER

Pursuant to Supreme Court Rule 37.2, Americans for Prosperity Foundation ("AFPF") respectfully submits this *amicus curiae* brief in support of Petitioners.[1]

INTEREST OF *AMICUS CURIAE*

Amicus curiae AFPF is a 501(c)(3) nonprofit organization committed to educating and training Americans to be courageous advocates for the ideas, principles, and policies of a free and open society.

AFPF works toward these goals, in part, by defending the individual rights and economic freedoms that are essential to ensuring all members of society have an equal opportunity to thrive. As part of this mission, it appears as an *amicus curiae* before state and federal courts.

SUMMARY OF ARGUMENT

When "rational" begets absurd, what do you have—a judicial test crying out to be reformed.

The magic of the American legal and economic system is the coupling of broad protection of minority rights with expansive economic opportunity to fulfill whatever needs or desires can be satisfied by a willing seller and a willing buyer—regardless of whether the government agrees the transaction "makes sense."

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[1] All parties have consented to the filing of this *amicus* brief. No counsel for a party authored this brief in whole or in part and no person other than *amicus* or its counsel made any monetary contributions to fund the preparation or submission of this brief.

Over two centuries of experience have proven the rewards of this approach.

Certificate of Need ("CON") laws do the opposite, funneling proposed medical services through a bureaucratic system manipulated by competitors and engineered to preclude competition—even where, as here, no equivalent competition exists, and the proposed service is designed to fulfill unmet needs of a Nepali speaking minority that does not have sufficient numbers to influence the system in its own favor. The Court of Appeals upheld this system under rational basis review.

But, to declare rational the deprivation of health care based on disfavored language or national origin would seem to displace the nation's established solicitude for equal opportunity, replacing it with favoritism toward majority-based protectionism. Stated plainly, if you do not speak one of the "12 other languages, not including English, that are spoken by more residents of Jefferson County than the Nepali language," then, the Hospital Association argues, it "makes little sense from an economic or health planning perspective" to have a home health agency devoted to providing services in your language.[2] Under this theory, the existence of a willing provider capable of serving willing patients is not sufficiently "rational" to avoid depriving minority language speakers of needed health care services in the name of

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[2] Br. of Intervenor Def.-Appellee Kentucky Hosp. Ass'n at 19, *Tiwari v. Meier*, No. 21-5495 (6th Cir. Sept. 13, 2021), ECF No. 24.

protecting incumbents (who admittedly do not provide the service at issue).

The irrationality of Kentucky's CON law is not an outlier but rather a common feature of CON laws in general. An investigative report by Americans for Prosperity Foundation into the true cost of certificate of need laws, *Permission to Care: How Certificate of Need Laws Harm Patients and Stifle Health Care Innovation*, found "CON boards block millions of dollars in investment and artificially limit the supply of health care services, leading to diminished quantity and quality of patient care."[3] Similarly, an analysis by the Mercatus Center concluded that

> [w]hile CON programs were intended to limit the supply of health care services within a state, proponents claim that the limits were necessary to either control costs or increase the amount of charity care being provided. However, 40 years of evidence demonstrate that these programs do not achieve their intended outcomes, but rather decrease the supply

[3] Kevin Schmidt and Thomas Kimbrell, *Permission to Care: How Certificate of Need Laws Harm Patients and Stifle Health Care Innovation*, Americans for Prosperity Foundation, October 2021, https://americansforprosperityfoundation.org/wp-content/uploads/2021/10/Permission-to-Care-AFPF-CON-report-Oct-2021.pdf.

> and availability of health care services by limiting entry and competition.[4]

If diminished care were the goal of diminishing access, then CON laws might be rational. But if, as claimed, diminishing access were intended to improve care, then imposing limitations that drive the opposite result is nothing short of absurd.

ARGUMENT

I. CON LAWS DISCOURAGE ENTREPRENEURS AND INNOVATORS TO THE HARM OF PATIENTS.

Although the details of CON laws vary from state to state, the general dynamics of the approval process and the negative effects on market access are fairly consistent with only minor differences.[5] Americans for Prosperity Foundation released the results of a four-state investigation into the true cost of certificate of need laws *Permission to Care: How Certificate of Need Laws Harm Patients and Stifle Health Care Innovation*, finding the "survey reveals CON boards block millions of dollars in investment and artificially

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[4] Christopher Koopman *et al.*, *Certificate-of-Need Laws: Implications for Kentucky*, Mercatus Center at George Mason University, May 26, 2015, https://www.mercatus.org/publications/regulation/certificate-need-laws-implications-kentucky

[5] *See, e.g.*, *Certificate of Need (CON) State Laws*, National Conference of State Legislatures, (December 20, 2021) https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx ("The structure of CON review and approval varies state to state, but generally a health care facility must seek state approval—through a state health planning agency, department of health or a CON council appointed by the governor or legislature—based on a set of criteria and community need.").

limit the supply of health care services, leading to diminished quantity and quality of patient care." *Permission to Care*, at 1.

A. CON Laws Deprive People of Needed Care.

The four case studies showed that CON laws deprive people of needed care by delaying construction of needed facilities—sometimes for decades, imposing life-threatening restrictions on patients in need, and raising costs while lowering access across-the-board.

For example, a South Carolina case study showed that even though the state identified a need for hospital beds in York County in its 2004–2005 state health plan, legal wrangling over which prospective provider should be granted the CON lasted until 2021. *Permission to Care*, at 18. The facility is anticipated to open in fall of 2022—eighteen years after the original need for expanded facilities was identified….long enough for babies born in the original plan year to reach adulthood.

Such delays can have life and death consequences—sometimes with tragic results. In Virginia, for example, in 2010,

> LewisGale Medical Center in Salem applied for a COPN to construct a neonatal intensive care unit ("NICU") at the facility to treat mothers and infants requiring special life-saving care. Per the DCOPN's recommendation, the State Health Commissioner denied the application. The state subsequently denied a second application for a NICU

> unit at LewisGale, stating both times that NICU services at LewisGale were unnecessary as they are offered at nearby Carilion Clinic in Roanoke.
>
> Then, in 2012, tragedy stuck. A pregnant mother and baby were admitted to LewisGale in urgent need of NICU care but specialized transport to the Carilion Clinic was unavailable. Despite doctors' best efforts, the baby was lost because they were denied the proper equipment to potentially save the child's life.

Permission to Care, at 21.

The negative effects of Virginia's CON laws are not limited to extreme circumstances but are felt in less dramatic ways by a broad range of patients. "A recent study conducted by the Mercatus Center found that without the COPN program, Virginians would spend less annually on health care services per capita. The study also estimated that Virginians would have access to as many as 49 additional hospitals as well as more facilities offering medical imaging services, even in rural areas. Virginians would also enjoy higher quality of care and experience better patient outcomes." *Permission to Care*, at 20.[6]

Such pervasive negative results are not limited to Virginia. The same study also "estimated that without

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[6] Citing Matthew D. Mitchell *et al.*, *Certificate-of-Need Laws: Virginia State Profile*, Mercatus Center at George Mason University, November 11, 2020, https://www.mercatus.org/publications/certificate-need-laws-virginia-0.

its CON program Iowa would have 51 more hospitals, 33 of which would serve rural areas." *Permission to Care* at 7.[7] Likewise, in Michigan, where the state "suffers from a dire shortage of psychiatric care beds, especially for children, adolescents, and the elderly" *Id.* at 10, CON laws have led to the shortfall without commensurate benefit. When asked if a change in the CON standards could result in overabundance of psychiatric care beds, the Chair of the CON Commission responded no, explaining, "especially with psych, [providers] don't want to overbuild because then [they] have a built in [sic] expense and if [they] don't have the patients to fill it, that's not a good situation economically or patient carewise." *Id.*

In other words, CON restrictions are not necessary to balance the supply of psychiatric care beds because providers respond rationally to market-signals and patient needs. Meanwhile, "children across the state, some with severe and dangerous mental health disorders, wait 'stacked up' for days to weeks in emergency rooms for psychiatric care beds to become available." *Id.*

The negative consequences of CON laws are not a mystery to lawmakers, who can be quick to respond when pressure on the health care system becomes too acute to tolerate politically. "At the onset of the [COVID] public health emergency, states with CON laws moved quickly to suspend them, recognizing that

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[7] Citing Matthew D. Mitchell *et al.*, *Certificate-of-Need Laws: Iowa State Profile*, Mercatus Center at George Mason University, November 11, 2020, https://www.mercatus.org/publications/certificate-need-laws-iowa-0.

their CON programs would prevent health care providers from ramping up services to properly respond to the crisis." *Permission to Care* at 3. For example, in "March 2020, [Michigan's] Governor Whitmer issued an executive order that authorized MDHHS to issue emergency CON and skip time-consuming procedural requirements of the application process. The order also allowed the Department of Licensing and Regulatory Affairs to grant waivers for hospitals to open new facilities. Governor Whitmer issued the order because it was apparent CON would prevent or delay necessary care provisions." *Permission to Care* at 11.

CON laws place gratuitous risks on patients by artificially constraining needed health care facilities. Lawmakers, who can be quick to lift such restrictions when politics reward such action, are kidding no one by claiming that it is rational to squeeze providers out of the market through onerous limitations on access.

B. CON Laws Erect Costly Barriers to Entry.

In addition to the express exclusion from the market through denial of CON applications, the application process itself can exert a chill on prospective applicants that acts as a barrier to entry. These barriers may come in the form of a costly application process or the need to overcome opposition from competitors. This is time and money down the drain that could be spent on expanding care.

As the AFPF study found:

> Even without competitor opposition, the CON process can be prohibitive for

> potential providers. It can take months to years and be very costly. In Michigan and South Carolina (excluding the applications tied-up in litigation), the average time to decision for CON applications in AFPF's samples was approximately five months. In all four states, AFPF estimates the average fee per application to be in the thousands of dollars, not including exorbitant costs for the consultants or lawyers often necessary to complete the process. And for providers, who spend tens of thousands of dollars and months navigating red tape just to apply to introduce or expand services, there is no guarantee of approval."

Permission to Care, at 2.

CON applicants in Iowa had to pay an estimated average of $15,774 per CON in application fees. *Permission to Care*, at 5. And, in Virginia, after fighting with the state for two years, a medical provider that received approval from the Virginia Department of Health to build a Surgery Center spent more than 1,000 hours of staff time and in excess of $300,000 in legal and other fees during the Certificate of Public Need process. *Permission to Care*, at 22 (citation omitted).

II. GOVERNMENT BIAS IN FAVOR OF INCUMBENTS CREATES RENT-SEEKING NOT RATIONAL LAWS.

"*Eppur si muove*"

— *Galileo Galilei*

Notwithstanding "considerable evidence," a "rich body of economic scholarship," and a district court opinion that "ably lays out the powerful case against [CON] laws—cataloguing the ill effects they wreak on entrepreneurs and consumers alike and observing how Kentucky's law seemingly 'worsens all problems it purports to fix.'" *Opinion*, App. 18 (citation omitted), the Court of Appeals here felt compelled to uphold Kentucky's CON law because "the question is not whether a law in fact is rational. It's whether a legislator could plausibly think so." *Opinion*, App. 28. This approach leaves rent-seeking incumbent providers as the only rational actors in a CON law environment.

Locking in bias favoring incumbent providers has no rational basis except to motivate and reward rent-seeking by incumbents that profit by the exclusion of competitors. The experience of Iowa's Mercy Medical Center provides an example of how rent-seeking thrives in CON systems.

> [I]n 2017, Mercy Medical Center applied for a radiation therapy program CON. The story of that application shows how incumbent providers leverage the CON process to protect themselves from new competition. At the October 2017 meeting of the SHFC [State Health

Facilities Council], Mercy proposed a $5.7 million acquisition of a linear accelerator and CT simulator to start a radiation therapy program to treat cancer patients. The SHFC denied the application, with one council member explaining the proposal generated "too much controversy."

This "controversy" was manufactured by a competing health care provider, the Wendt Cancer Center, which told the Council: "Mercy's proposed radiation therapy program threatens the continued existence of the Wendt Center … If you approve the proposal, we could be forced to close."

Mercy re-applied in July 2018 backed by "230 letters of support received in 2017 and 2018 from patients and families, health care providers, government and community leaders, and community members; and eight individuals who testified at hearing regarding patient experiences." The Wendt Cancer Center again warned the Council: "The bottom line is this: If you approve Mercy's application … it would threaten the continued viability of the Wendt Cancer Center." This time, the Council approved the application with a 3-1 vote.

Despite the apocalyptic warnings, the Wendt Cancer Center did not close; instead, competition led the Center to

> combine services with Grand River Medical Group and undergo a $2.2 million renovation "focused on the patient experience." The Telegraph Herald noted the "opening follows that of the MercyOne Dubuque Cancer Center, which began accepting patients in June."

Permission to Care, at 5.

While this example eventually reached a happy ending for the prospective competitor and patients, the benefit to incumbents of delaying or excluding competition persistently motivates incumbents to block market entry. And the deck is stacked in their favor. The built-in bias toward incumbents is evident in the nearly ubiquitous conferral of standing on incumbents to oppose new CONS, *Permission to Care*, at 1 ("In nearly every state with CON laws, competing care providers can intervene in the CON process."). Kentucky's CON law is in accord, providing that a competitor may challenge an application. App. 43. There may very well be a good reason to put the fox in charge of guarding the henhouse—and the fox undoubtedly could rationalize such a decision—but such a claim is hardly rational if the goal is to protect the wellbeing of the hens.

"CON laws have failed to produce cost savings, higher quality healthcare, or greater access to care, whether in underserved communities or in underserved areas...the evidence suggests CON laws are ineffective. There is no compelling evidence suggesting that CON laws improve quality or access, inefficiently or otherwise...Evidence also fails to support the claim that CON programs would increase

access to care for the indigent, or in medically underserved areas." *Permission to Care*, at 3.[8]

III. KENTUCKY'S CON LAW IS NOT RATIONAL.

Kentucky's CON law provides an excellent example of a law that has been rationalized by good intentions, but which—like CON laws in general—lacks a rational relationship between intent and reality, with built-in features designed to create the opposite effect of its claimed justification.

A. Rational Basis Requires More Than a Theory of Benefit, But Actual Causation.

Rational basis review is not an exercise in wishful thinking. It requires, of course, rationality—a minimum expectation that prescribed[9] action is likely to result in the desired outcome and the ability to adapt to empirical results if the theoretical world does not mirror the real one. Like Justice Holmes' "page of history" that is "worth a volume of logic", *New York Tr. Co. v. Eisner*, 256 U.S. 345, 349 (1921), a law must bear some semblance to activity that actually takes place in the world and not a flight of fancy. Kentucky's CON law, and CON laws in general, fail on both counts, embedding causative errors within laws that drive the very shortfalls they claim to cure.

More than rational intent is needed before a law may have a rational basis—the law itself must be

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[8] Citing *Reforming America's Healthcare System Through Choice and Competition*. Joint Report by the U.S. Department of Health and Human Services, U.S. Department of the Treasury, and U.S. Department of Labor, December 3, 2018.

[9] Or proscribed action in the case of CON laws.

consistent with that intent. One would not deem a plumbing system intended to carry fresh water to all homes in a neighborhood to be rational if the pipes stopped short of the exterior walls for some homes and did not allow the supply to be connected to the interior plumbing. Nor could such an approach be made rational by focusing solely on the intent to deliver water to all homes. Intent alone cannot render an approach rational. When water supply is stopped before it becomes useful one must question the rationality of any designer who proclaims the system to work—works to do what exactly? And, as the case is with CON laws, if purposeful exclusion of piping to some homes from the overall plumbing system may be rationalized by claiming excluded homes actually benefit from their neighbors' monopoly on running water, that would flip its purpose on its head.

Thus, even if the Constitution "does not require" Kentucky "to draw the perfect line" or "even to draw a line superior to some other line it might have drawn," *Armour v. City of Indianapolis*, 566 U.S. 673, 685 (2012), it must, like plumbing that carries clean water to the desired endpoint, draw a line that a minimum goes from "here" to "there."

The Court of Appeals acknowledged "Certificate-of-need laws teeter on the edge of rationality." *Opinion*, App. 27. When a law, like the Kentucky CON law, deprives individuals of their ability to work and the public of services necessary to life and health, the inverse relationship between a law's professed goal and its logical and demonstrated outcome is not rationality but injury. And when such a mismatch disproportionately benefits a limited set of incumbents, then injury becomes injustice.

B. The State Health Plan's Irrational Basis Cannot be Cured by Applying Algebra.

"Garbage in, garbage out"[10]

The Kentucky CON law has many flaws and the parties have largely focused on how the law creates results that are contrary to declared intent. But these negative outcomes are not just artifacts or minor variance from a "perfect" solution. They are systemic outcomes of the law's design. A simple examination of the law's structure is sufficient to explain why the law cannot ever work to create sufficient access to health care in any Kentucky county that does not have a consistently expanding population and a demographic make-up that mirrors the majority.

Appellees argue that the State Health Plan, "is based on the annual calculated need for home health services in each county."[11] But this assertion rests on irrational assumptions and thus cannot provide a rational basis for the law.

The text of the Plan states:

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[10] *Garbage in, garbage out,* Wikipedia, available at: https://en.wikipedia.org/wiki/Garbage_in,_garbage_out ('In computer science, garbage in, garbage out (GIGO) is the concept that flawed, or nonsense (garbage) input data produces nonsense output. Rubbish in, rubbish out (RIRO) is an alternate wording. The principle applies to all logical argumentation: sound arguments can lead to unsound conclusions if their premises are flawed.").

[11] Brief of Intervenor Defendant-Appellee Kentucky Hospital Association at 13, *Tiwari v. Meier*, No. 21-5495 (6th Cir. Sept. 13, 2021), ECF No. 24.

> The need for home health services is determined on a county-by-county basis by applying target rates estimating the number of individuals per 1,000 population expected to require home health services.[12]

This seems to make sense, giving the impression that calculated "need" reflects specific county characteristics. But that impression is an illusion driven by imbedded bias in the "target rates." How are the "target rates" determined? The text continues:

> Age cohort target rates are calculated for the plan year and are based on the average number of unduplicated patients served statewide in each age cohort for the most recent two (2) calendar years in the Kentucky Annual Home Health Services Report.[13]

At this step, the target rates are based on patients "served." This is not a measure of patients who want or need a service but only a headcount of people who have already received a service. As such, it undercounts, by definition, potential patients who were not served.

A patient can only be served if the desired service is available. In simple terms: a person cannot use a service that does not exist. Like the neighborhood plumbing plan described above, households that receive no clean water even though they want it can hardly contribute to a rational measure of the

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[12] *Id.* citing State Health Plan, R. 84-3, Page ID #1938.
[13] *Id.*

aggregate water needs of the neighborhood—especially when it is the plumbing plan itself and not individual choices that precluded water usage.

Thus, at the first step the statewide usage bakes in existing gaps in service—including shortfalls created by the CON system itself. If in previous periods no CON was issued, then no services were developed, and no services were provided in the past two years, leading to an input of zero patients "served" being fed into the measure of "need" for following year.

Similarly, even if a service is generally available statewide, a patient can only use the service if it is accessible. If the prospective patient cannot reach the desired service because it's too far away, too expensive, or the patient is excluded for a host of other reasons, then that unsatisfied need is not "served".[14] Finally, available services, even if financially and geographically accessible, may not be delivered due to nuanced mismatches between the service and the need—such as whether the services are provided in a language the patient understands. If the cost/benefit trade-off of accessing the service is insufficient, then those needs would be unserved as well. This leakage on the frontend makes the initial summation of patients served systemically depressed and biased against communities where the negative feedback

[14] Mixing utilities metaphors slightly: in the television show *Green Acres*, the Douglas's telephone line only ran as far as the pole outside their house, requiring Mr. Douglas to climb to the top of the pole to reach the handset. If he had been physically unable to climb the height of a telephone pole, then the Douglas's lack of usage would not accurately represent their need for phone service and accordingly would misinform any calculation of customers serviced.

loop is most severe. It is not unreasonable to assume that the undercount would be aggravated in age cohorts that can be expected to struggle accessing services they need.

These systemic errors are then aggregated into "unduplicated patients served statewide" to set the aggregate target rates, washing away any severe mismatches from small communities in the great pool of statewide numbers. Once useful county-level data has been obscured, statewide aggregate numbers are used to set target rates based on headcount.

> Age cohort rates are applied to the plan year county population projections to determine expected need for home health services.[15]

There is no apparent consideration of diversity across counties—just raw projected headcount application. Counties in which certain services are needed due to lifestyle, demographics, ambient factors such as weather or air quality, etc. are assigned an artificially constrained "expected need," because all that matters to the calculation is headcount.

On the other hand, counties—especially those with projected population growth—lacking in similar health challenges are assigned an inflated calculation of "expected need."

> The number of additional patient services needed in a county is then determined by subtracting the average number of unduplicated patients served

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[15] *Supra* note 6.

> in the county for the most recent two (2) calendar years, as reported in the Kentucky Annual Home Health Services Report, from projected need.[16]

The difference between these two numbers is used to determine whether a CON would be consistent with the State Health Plan.

The Court of Appeals characterized the process of "calculating need" as "compar[ing] the forecasted demands of the population to the number of people already receiving the service." *Opinion*, App. 5. This characterization lends a patina of rationality to the process. But a cursory review of this calculation of "need" exposes fatal flaws.

It is not necessary to know anything about the specifics of any county to recognize that systematically undercounting need at the state-aggregated level and then applying depressed aggregate rates to county population regardless of individual circumstances would result in driving CON approvals toward healthy high-growth counties and away from counties that need services most.

This approach is decoupled from what it alleges to establish: need. It is, in fact, quite silly to tell a prospective patient that because the state denied him access to services last year, he does not need access to services next year, and thus the state is justified in imposing the status quo (which will, in turn, ensure that when the calculation is done next year, it will start with the same faulty premise). Applying algebra in the face of irrational assumptions does not produce

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[16] *Id.*

a rational outcome. Thus, when the Court of Appeals asserted that "Kentucky's Health Plan requires new entrants to show that at least 250 patients need the service while it requires existing companies to show that at least 125 patients need the expanded service" *Id.*, it did not mean that 250 or 125 human beings have an identifiable need; it meant that the algebraic function employing irrational assumptions cranked out a number that the statute labels "need".[17] This mismatch between real need and the output of an algebraic function is not based in reason but in blind application of math.

Garbage in, garbage out.

C. Kentucky is Not Alone in Limiting Market Entry on an Irrational Basis.

The irrationality built into Kentucky's calculation of need is not an isolated example of bad numbers driving bad outcomes under cover of an allegedly analytical approach.

In Michigan, for example, "the state . . . requires providers applying to add new beds to submit a form certifying the [Certificate of Need] Commission has

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[17] This error of definition is in addition to systemic skewing that allows incumbents to expand based on the lower 125 need threshold. The lower hurdle for incumbents not only drives CON approvals toward communities that already have incumbent service providers and away from those that do not, but also diverts opportunity to serve expanding populations to incumbent providers before prospective new providers can apply. The cycle of feeding healthy expanding populations into incumbent providers while excluding currently underserved communities from accessing otherwise prospective providers is a feature of the calculation.

projected a need for those beds in the provider's area of operation, or else the application will not be accepted." *Permission to Care* at 11. But such projections of "need" have been demonstrated to be wildly inaccurate.

In 2019, the "Commission projected a need for approximately 3,000 additional nursing home beds in the state." *Permission to Care*, at 9. As a result, CON applications to add beds or construct new nursing homes estimated at over $630 million in new health care investment came flowing in. *Id*. The Commission abruptly changed the estimate—reducing it by ten-fold. *Id*. Four-fifths of the CON applications were denied or withdrawn. *Id*.

A reversal of this magnitude is not just an "oh never mind…" aberration from an otherwise rational scheme. Whether the initial projection or the revised projection—if either—better represented actual need, it can hardly be said that such dramatic swings, resulting in 80% of CON applications coming to naught, represents a rational approach. If the system were designed to fail, it could hardly do worse.

It is also worth noting that Michigan received its data for nursing homes directly from incumbent providers[18]. The Kentucky State Health Plan, similarly, relies on utilization numbers provided by

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[18] *Permission to Care*, at 12 ("A CON Commission meeting transcript tells the story. The projected bed need for nursing homes was higher than the Commission expected. Why? Because the data submitted by incumbent providers in previous years, on which prior bed need projections were based, was inaccurate. An executive with the Health Care Association of Michigan admitted, '[D]ata was missed. It is much better data today.'").

incumbent providers to the Cabinet for Health and Family Services through online surveys. In Michigan, it turned out the incumbents had been submitting bad data which artificially lowered bed need calculations (and protected them from competition). There is nothing to prevent a similar error in Kentucky

D. Madness Cannot Be Made Rational.

> "The definition of insanity is doing the same thing over and over and expecting different results."
>
> — *Attributed to Albert Einstein, Benjamin Franklin, Mark Twain, and possibly others.*

The Opinion noted that "Certificate-of-need laws teeter on the edge of rationality." *Opinion*, App. 27. But as shown above, at least under Kentucky's statute, the CON system is designed to fail underserved counties by locking in shortages and perpetuating them *ad infinitum*. Such an approach could only be rationalized by redefining "need" to mean "if you don't have it, then you don't need it." And, voila, the problem is solved. But such a definition does not (and cannot) lead to different outcomes, it just applies different labels.

CONCLUSION

The abundance of evidence is clear: CON laws hurt the availability of quality health care services, harming patients and entrepreneurs alike. They accomplish nothing except insulating existing and market-dominant providers from competition. Not only is this basis irrational, but it also creates the *opposite* result of what legislator's claim their "rational" basis is. If anything should ever fail the rational basis test, it is this.

The Court should grant a writ of certiorari to clarify that to the extent rational basis review has any place in our constitutional system it precludes irrational results such as demonstrated deprivation of medical care and senseless barriers to entry into medical services.

Respectfully submitted,

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