SAS SENATE ANALYSIS SECTION

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Senate Bill 64 (Substitute S-1)
Sponsor: Senator Vern Ehlers
Committee: Health Policy

Date Completed: 3-20-87

RATIONALE

Efforts aimed at gaining some control over rising costs and a rapidly expanding health care industry originated at the state level of government. Arguing that market forces had little effect on restraining rising costs, state governments established a variety of controls designed to achieve a more equitable allocation of health care resources. New York was the first state to respond to these developments by enacting in 1964 a certificate of need program. Community, regional, and statewide needs were factors to be considered in reviewing proposals for new health care services. Ten years later, 27 states had instituted their own programs. Michigan's first experiment with certificate of need resulted in the enactment of Public Act 256 of 1972, which dealt with construction, conversion, or modernization of health facilities. This law required planning agency approval at the local and state levels for hospital projects costing more than $100,000. Also in 1972, the federal Social Security Act (Section 1122) was amended to give states the option of entering into contracts with the U.S. Department of Health, Education, and Welfare to administer more comprehensive capital expenditure reviews. These reviews had the effect in Michigan of broadening the regulatory base to include coverage of all health care institutions receiving Medicare and Medicaid funds. By the middle of the 1970s, all but four states operated either a certificate of need or Section 1122 program, or both.

Federal interest in promoting health care cost containment peaked with the passage of the National Health Planning and Resource Development Act in 1975. Under this law, a system of planning and certificate of need review was established. Michigan's response was the passage of the Michigan Health Planning and Resource Development Act (Public Act 323 of 1978), and the certificate of need component to revisions of the State's Public Health Code (Public Act 368 of 1978) followed in 1978. (The health code revisions repealed Public Act 256 of 1972.) Yet, no formal guidelines were established to govern certificate of need until February 1986 when emergency certificate of need rules were put into place. Permanent rules were adopted in June. Only three states have certificate of need thresholds as low as Michigan's. Some people contend that the threshold is unrealistically low, considering today's costs for most capital projects or equipment purchases. A process that had been established to control medical costs, some people also argue, has become so cumbersome that it now is expensive and time consuming for health facilities to implement, which has delayed the introduction of technical advances in medicine in the State. Some people believe that increasing the threshold of capital expenditures and operating costs requiring certificate of need review would remove lengthy delays for hospitals and health facilities that are trying to keep up with technical advances in medicine, without hurting efforts at medical cost containment.

CONTENT

Senate Bill 64 (S-1) would amend the Public Health Code, as it pertains to certificate of need, to:

- **Increase from $150,000 to $1.5 million the amount that a single project must exceed in order for the code's certificate of need requirements to apply.**
- **Require that under a certificate of need review, preference be given to the health facility that served the greatest number of uninsured and Medicaid patients.**
- **Amend the definition of "change in service" to apply to "clinically-related" health services not offered in the previous year with operating costs that exceed the minimum annual operating costs for the facility.**
- **Set the expenditure minimum for annual operating costs at $306,750 and provide for the adjustment of that amount.**

Capital Expenditure

The code currently prohibits a person from beginning operation of a new health facility making a change in bed capacity, a change in service, or undertaking a capital expenditure for the construction, conversion, addition to or modernization in excess of $150,000 of a health facility, without first obtaining from the Department of Public Health a certificate of need that documents a demonstrated need and grants permission for the proposed project.

In addition to raising to $1.5 million the amount that a capital expenditure must exceed to require a certificate of need, the bill would require that beginning October 1, 1987, the amount be adjusted annually by an amount determined by the State Treasurer to reflect the cumulative annual percentage change in the "Detroit Consumer Price Index". "Detroit Consumer Price Index" would mean the most comprehensive index of consumer prices available for the Detroit area from the Bureau of Labor Statistics of the U.S. Department of Labor.

Change in Service

"Change in service" currently is defined in the code as health services offered in or through a health facility that were not offered on a regular basis in or through that health facility within 12 months prior to the time the service would be offered. Under the bill, the definition would be amended to apply to "clinically related" health services that required annual operating costs in excess of the expenditure minimum for annual operating costs.

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"Expenditure minimum for annual operating costs" would mean $306,750 for the 12-month period beginning October 1, 1986. That amount would be adjusted on October 1, 1987, and annually thereafter, by an amount determined by the State Treasurer to reflect "the cumulative annual percentage change in the "Detroit Consumer Price Index".

Reviews

When conducting concurrent and comparative certificate of need reviews of applications under the Michigan Administrative Code (rules 325.9201-325.9227) for projects designed to meet the service needs of a specific population, the Department and a health systems agency would be required to give preference to the health facility that served the greatest number of uninsured patients and patients who were recipients under the medical assistance program (Medicaid) administered by the Department of Social Services under the Social Welfare Act.

MCL 333.22102 and 333.22113

FISCAL IMPACT

Senate Bill 64 would result in a revenue loss of approximately $140,000 due to the expected reduction in certificate of need (C.O.N.) application fees. In the first year, the bill could also result in an increase in State Medicaid costs of between $0.5 million and $1.5 million. Over three years, the increase in the State portion of Medicaid could be $3 million to $5 million.

The Medicaid cost estimates are based on the following assumptions:

- Capital expansion activities with costs below $1.5 million, which were not carried out previously due to a rejected C.O.N. application, would be carried out upon passage of Senate Bill 64 (S-).
- Health care capital expansion would continue at the 1986 rate for at least three years.
- There would be no significant changes in Medicaid billing policies over the next three years.

Supporting Argument

The threshold increase would enable hospitals to make capital improvements without first obtaining a certificate of need if the improvements cost less than $1.5 million and would not raise hospital operating costs by more than $306,750 a year. If a project exceeded either the capital expenditure threshold or operating cost threshold, then that project would have to undergo a certificate of need review. The impact of raising these thresholds would have an important but not a dramatic impact on the number of hospital projects subject to review. A review of certificate of need applications submitted between October 2, 1986, and December 31, 1986, showed that 62 hospital reviews were completed for a total project cost of approximately $90.2 million. If the thresholds were increased, as proposed in the bill, 42 projects still would have been reviewed with a total project cost of nearly $75 million. This would amount to 67.7% of the 1986 reviews and 83.1% of the total project dollars. Despite opponents' claims that the proposed limit would raise thresholds too high, thereby allowing more projects to be implemented without being reviewed, these statistics show that probably most of the future projects still would come under a review.

Response: These statistics don't account for projects that never were submitted because of the current threshold limit, and for any new technologies that will be introduced in the future. Therefore, it is difficult to use current data to predict future costs resulting from increasing the threshold.

Supporting Argument

Only three other states have thresholds as low as Michigan's: Delaware, Rhode Island, and Vermont. All three states have substantially fewer hospitals, and have fewer reviews to do each year. The remainder of the states have higher thresholds, no certificate of need program, or are phasing out existing programs. The national average for the capital expenditure threshold is $700,000. Thus, raising the thresholds in Michigan would not be breaking new ground, but reducing regulatory control that is hindering the competitive environment emerging in the health care industry.

Supporting Arguments

Small hospitals in the State have been undergoing severe financial hardships in recent years. Raising the certificate of need thresholds alone wouldn't make small hospitals financially viable, but would help. Increasing thresholds would save smaller hospitals significant amounts of funds in compliance costs since getting a certificate of need through the process can be expensive. The application alone can run 150-200 pages, take many hours to complete, and cost about $15,000 in consulting fees. In addition, local hearings must be held. In some cases, a certificate of need costs about $30,000 to complete and get through the review process. Therefore, a process that is supposed to help control medical costs can actually help raise administrative health care costs. The bill, by raising the thresholds, would reduce the number of applications that have to be reviewed and aid hospitals in controlling costs.

Supporting Argument

Certificate of need reviews, by law, are to be completed within 180 days. In 1983 and 1984, however, the average review took 238 days. Some reviews have taken up to two years or longer. Thus, the certificate of need process means delays. The process delays project implementation by seven to eight months, or longer. An increase in the threshold would help remove certain projects from the review and assist in providing a community with a needed health service in a more timely manner.

Response: The Department of Public Health has noted that the project review time has been reduced from 127 to 118 days. Appeals lengthen this time period.

Supporting Argument

The dilemma of health care progress versus regulation was clearly illustrated last year when hospitals in the State were trying to gain permission to obtain lithotripters, which are used in a procedure in which shock waves destroy kidney stones. This is a painless method of getting rid of kidney stones without costly surgery. While there were 3,000 people in the State who qualified for the procedure a year ago, not a single unit had been approved for use. Since then, three hospitals have been approved for lithotripters, but two of the largest research hospitals in the State (the University of Michigan and Henry Ford hospitals) were denied approval (although a court subsequently ordered that they had to be granted a certificate of need). Since each unit costs $2 million, applications would still have to undergo certificate of need review under the bill. Nevertheless, this situation demonstrates how the C.O.N. process can have the effect of withholding an important treatment from Michigan residents. The certificate of need process was implemented in the 1970s to control costs, but it has become a cumbersome regulatory process that has slowed technological advances.

MORE

Supporting Argument

Thresholds in other states range from $300,000 to $1.5 million. Under the current threshold, a certificate of need is required for most major equipment in hospitals and in some ambulatory facilities. Planning policies applied to certificate of need reviews, and the application process have caused delays in obtaining and replacing equipment.

Opposing Argument

Admittedly, a review of the threshold levels may be needed, especially since Michigan's levels are low and are even lower than the national average of $700,000. Yet, this bill presents a piecemeal approach to dealing with the entire certificate of need issue. A work group has been established by the State Department of Public Health and the Office of Health and Medical Affairs with a focus on strengthening and streamlining the certificate of need system. This work group consists of representatives of purchasers, providers, business, labor, consumers, and government agencies. It is expected that the work group will report its findings to the Legislature by July. Changing any part of the certificate of need process until the entire issue has been examined and the work group issues its report would be premature.

Opposing Argument

Despite of efforts to control health care costs, health care has become a very burdensome cost of doing business in Michigan. In order for the State to retain a competitive economic status, these expenses must be brought under control. Any increase of the certificate of need threshold for capital expenditures must be carefully analyzed and made part of a comprehensive solution.

Opposing Argument

The bill would require that under a certificate of need review, the Department and a "health systems agency" give preference to the health facility that served the greatest number of uninsured and Medicaid patients. Such health systems agencies were authorized under the National Health Planning and Resources Development Act, which has since been repealed, and Public Act 323 of 1978, which still is in effect. As a result, there are no Federal funds for these agencies and no State funds have been appropriated to maintain the agencies, which now must rely on local funding. Currently, there are only two such agencies operating in the State. While the exact status of these agencies is not clear, the bill's proponents need to clarify how this provision would be implemented.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.