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SFA BILL ANALYSIS

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Senate Bill 1436 (Substitute S-1 as reported)
Sponsor: Senator John J. H. Schwarz, M.D.
Committee: Health Policy

CONTENT

The bill would amend the Public Health Code to do the following:

-- Transfer the administration of the certificate of need (CON) program from the Department of Community Health (DCH) to the Department of Consumer and Industry Services (DCIS).
-- Increase from $2 million to $2.5 million the capital expenditure threshold at which a health facility must obtain a CON before improving, constructing, or replacing a clinical service area; and increase the threshold from $3 million to $5 million for a nonclinical service area.
-- Remove from CON requirements magnetic resonance imager (MRI) services, and certain psychiatric program services.
-- Revise, and add, certain reporting requirements for the DCIS; and require the DCIS each year to review the CON application process.
-- Allow an applicant to file a single, consolidated CON application under certain conditions.
-- Require, and prescribe procedures for, the licensure of a lithotripter (a unit that uses shock waves to pulverize kidney stones).
-- Require the DCIS to review requirements for the licensure of ambulance and aircraft transport vehicles.
-- Require the CON Commission, by January 1, 2004, to include in all CON review standards a requirement that each applicant participate in Title 19 of the Social Security Act (Medicaid).

MCL 333.22201 et al. Legislative Analyst: George Towne

FISCAL IMPACT

The fiscal impact is indeterminate. For FY 2002-03, the CON program is appropriated at $222,900 GF/GP ($944,000 Gross). Although the bill would require the DCIS to perform some additional duties relating to the administration of the program, it appears that sufficient dollars are available within the current appropriation to cover any additional costs.

Quantifying the impact of removing CON requirements on selected, currently covered clinical services, as proposed in this bill, is difficult. Arguments have been made in support of both sides of the issue (continuation of the CON process or removal/restructure of the CON process), all in the name of providing access to quality health care.

The CON program is a mechanism to control costs and improve the quality of health care by regulating the supply of health care services. The premise of the CON program is based on an extrapolation of Roemer's Law (a hospital bed built is a hospital bed filled -- and billed), which suggests that an increase in the supply of health care services will lead to an increase in the use of health care, independent of need.

It has been well established that the presence of third party insurance coverage has expanded the demand for health care services and made consumers insensitive to price. As a result, health care providers compete for patients on the basis of the types of services and amenities they offer, rather than their ability to provide the consumer with bargain health care. One

concern raised about the removal of CON requirements for certain covered clinical services is that it would lead to excess capacity of expensive, high-technology services. An increase in capacity of these types of services, without a corresponding increase in need, could lead to a number of situations, all detrimental to health care costs and quality, such as: higher total and per-unit costs; an increase in the receipt of unnecessary health care services; decreased volume per facility/provider; and underused facilities.

On the other hand, in situations in which there are currently shortages in service capacity, removing CON requirements could result in improved access to care for some. However, this would not likely be a very efficient or effective mechanism for improving access to care. Without CON requirements, health care providers could offer services based on whether they believe a service will be profitable, not based on whether a community is in need of the particular service. Areas with a high concentration of insured individuals, such as suburban areas, could see an increase in the availability of high-technology services, potentially to the point of excess capacity. Access to care for other areas that have lower total population and/or a high proportion of publicly insured or uninsured individuals, such as rural and urban areas, would not likely be improved.

Complicating these issues is a provision in the bill that would require all CON applicants to participate in the Medicaid program. Currently, all hospitals in Michigan participate in Medicaid and would not be affected by this provision. However, a significant number of other types of providers, such as ambulatory surgical centers (ASCs) and even a number of nursing homes, do not participate in Medicaid. Medicaid reimbursement rates are often substantially lower than private insurance reimbursement rates and once providers agree to accept Medicaid, they cannot deny care to Medicaid beneficiaries in favor of persons with private insurance. If providers believe that participating in Medicaid would not be a profitable business decision, this provision of the bill could lead to a reduction in service capacity and potentially to a lack of access to care. For example, if ASCs, which are predominately not Medicaid providers, found that in order to establish new sites or to undertake extensive capital expenditures on existing sites, they had to become Medicaid providers, there could be a reduction in the number of ASC facilities. The effect of this would be that services now provided in ASCs would have to be provided in a more costly setting (inpatient hospital) and/or service capacity would be reduced in areas where the ASCs had been located.

Date Completed: 11-8-02 Fiscal Analyst: Dana Patterson

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