HEALTH FINANCE COMMISSION

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**October 2, 2003**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 431**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Greg Server; Sen. Beverly Gard; Sen. Sue Landske; Sen. Connie Lawson; Sen. Billie Breaux; Sen. Vi Simpson; Sen. Timothy Skinner; Rep.Charlie Brown, Vice-Chairperson; Rep. David Orentlicher; Rep. John Day; Rep. Craig Fry; Rep. Scott Reske; Rep. Vaneta Becker; Rep. Robert Behning; Rep. Timothy Brown; Rep. Mary Kay Budak; Rep. David Frizzell.**

Members Absent: **Sen. Gary Dillon; Sen. Marvin Riegsecker; Sen. Connie Sipes; Rep. Brian Hasler; Rep.Carolene Mays; Rep. Peggy Welch; Rep. Donald Lehe.**

Chairperson Sen. Patricia Miller called the fourth meeting of the Health Finance Commission to order at 10:10 A.M.

Niche Providers

Rep. Crawford, HB 1697-2003

Rep. Crawford discussed HB 1697-2003 (Attachment A) which was intended to limit physicians' potential to divert high-paying procedures from public and community hospitals. He commented that it had been his hope to hold hearings on the issue and provide a forum for debate. Instead,

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

the Hospital Association and other parties asked him to hold the bill to allow them to establish a working dialogue among the interested parties.

Rep. Crawford discussed the interrelationship of education and healthcare with the economic infrastructure. To illustrate his point, he mentioned that Daimler-Chrysler pays more for employee health care benefits in Indiana than in other states and just weeks ago the company closed a major plant in Indianapolis. The state needs to retain current business as well as attract new businesses. Rep. Crawford commented that if the cost to do business is not controlled, how can we hope to energize Indiana?

Rep. Crawford noted that the practice of skimming high revenue business lines of general acute care community hospitals places the financial survival of the general hospitals at risk. The high revenue procedures provide the funding for much of the safety net indigent care that is provided by the general community hospitals. He added that this is not just a social issue, it is intertwined with the whole economic status of the state since the practice also results in an oversupply of services and excessive capitalization. Rep. Crawford suggested that maybe Certificate of Need is the answer to this problem.

Zach Cattell, Indiana State Department of Health

Mr. Cattell reviewed the definitions of hospitals and ambulatory surgery centers used by the State Department of Health (ISDH) for licensure purposes. He also outlined the administrative process for a new facility license, the type of information required, and the timing of surveys that the Department would conduct. Mr. Cattell noted that under the current rules, multiple buildings may be included under one type of license, or one building may have multiple types of licenses such as a hospital with a long-term care or rehabilitation license. He added that the Department does not have a separate definition for a specialty hospital.

Rep. Tim Brown asked if the Department surveyed or had a process to approve new types of services and if ISDH monitored quality? Mr. Cattell responded that the Department did not monitor quality in the sense of requiring certain numbers of procedures or defined required outcomes.

At the Commission's request, Sen. Miller asked Mr. Cattell to continue with the Department's comments on the concept of reimplementing a Certificate of Need (CON) Program. Mr. Cattell defined the Certificate of Need program as a tool intended to maximize the use of resources dedicated to: (1) the construction of new facilities; (2) the purchase of new technologies; and (3) the implementation of new services expected to generate new cost to the health care system. The ISDH position on CON as it was previously implemented is that the process did not work due to insufficient resources dedicated to the process and a general lack of will to institute an effective, efficient system. The Department did not have the resources necessary to refute or prove "need"; they were required to review assessments, but couldn't prove the validity of the assessments, and the exemptions that were allowed were problematic. If reinstituted, the Department believes that CON would require significant resources and effort by the Department. There could be no exceptions from the established process, and the Department would ask for considerable direction and definition from the Legislature on the areas to be addressed.

Discussion followed regarding the potential impact on the Department of a moratorium, possible CON fees, and how standards might be set.

Michael Mirro, MD, Indiana Chapter, American College of Cardiology

Dr. Mirro began his remarks with a review of the development of heart hospitals in Marion

County. He stated that Indiana has a disproportionately high incidence of death due to heart disease and stroke making cardiology services a high demand product in Indiana. At the same time, the reimbursement for services, in general, is declining. In response to declining revenues, Indiana physicians are coalescing into small groups to pool resources in order to expand their revenues and gain more control over their practice environment. Increasingly, physicians view general hospitals as more difficult environments in which to practice due to rigorous regulatory requirements and competition for resources within the hospital.

Dr. Mirro explained that specialty hospitals are not a new concept. By specializing, a hospital can provide focused, high quality, efficient care; Riley Children's Hospital is a good example. However, Dr. Mirro stated that Indianapolis does not need four heart specialty hospitals. The not-for-profit hospitals are competing against each other, making enormous capital investments in duplicated infrastructure that may already be obsolete. Dr. Mirro explained that technological advances that allow earlier diagnosis will have therapeutic solutions that will not require the surgical procedures that are so profitable today. Cardiovascular treatment advances, such as coated-stents, revascularization, and other nonsurgical approaches will be performed on an outpatient basis.

Dr. Mirro then discussed the lack of good quality outcome data. He commented that purchasers of care must have access to information that is accurate, scientific, and fair to providers. Rep. Tim Brown observed that if purchasers used such outcome data, and reimbursements were linked to quality outcomes, the lower quality specialty institutions would fail. Dr. Mirro responded that government payers and a lack of outcome information create the nonmarket forces that allow lesser quality institutions to exist.

In response to questions regarding possible solutions, Dr. Mirro suggested that specialty hospitals be required to accept Medicaid and Medicare patients, operate under defined quality standards, and provide full service emergency departments (i.e., specialty hospitals should be required to participate in the community safety net). He thought those requirements would sort out the profit-motivated from the service-motivated providers.

Kenyon Kopecky, MD, Indiana Radiology Society

Dr. Kopecky discussed the problem of physician ownership with regard to medical imaging technologies. He stated that the cost of medical imaging is increasing at a faster rate than average health care costs even though the cost per exam is flat. The disproportionate increase is due to increased utilization. Dr. Kopecky cited studies that demonstrated that physicians with ownership interest in the technology order more procedures per patient than physicians with no ownership interest. (See Attachment B.) This practice inflates the cost of medical imaging to the health care system. Patients who cannot pay are referred to the community hospital while the hospital loses referrals for paying patients.

Dr. Kopecky suggested that Indiana should not allow referrals for medical imaging procedures to a business in which the physician has a financial interest or ownership. He stated that 31 other states already limit this practice.

Tim Kennedy, Indiana Hospital and Health Association

Mr. Kennedy defined a niche provider as a provider of selected services, or services for a specific group of patients or medical conditions. Examples would be heart hospitals or free-standing clinics. Most niche providers select high cost or high volume product lines that have high reimbursements in order to yield better profits. Most of the niche providers have a physician ownership component. Mr. Kennedy commented that advances in technology enabling the purchase of equipment and payer pressures for outpatient provision of services to

avoid the cost of inpatient care allow the expansion of specialty providers.

Mr. Kennedy reported that the Hospital and Health Association has no uniform position on the issue of niche providers. The Association members are concerned about the cannibalization of services from community hospitals. He added that the physicians who take profitable business lines from the hospital still maintain privileges at the hospital. When a patient cannot pay for services or needs more complex care unavailable at the specialty facility, that patient is referred to the community hospital. Mr. Kennedy commented that specialty hospitals may offer some quality advantages, but these providers leave the safety net hospitals at risk of financial failure. (See Attachments C and D.)

There was additional discussion regarding the impact governmental cost shifting has on the market behavior of health care providers and the role that Certificate of Need might have in a legislative response.

Ed Roberts, Indiana Manufacturer's Association

Mr. Roberts discussed changes in the benefit and medical cost components of the worker's compensation rates. He stated that in 1960, 1/3 of the cost was medical expense and 2/3 was attributable to the benefit. That relationship is now reversed; 2/3 of the cost is now medical expense while 1/3 is the benefit. Mr. Roberts stated that this illustration of increasing medical costs has a serious impact on economic development in Indiana.

Mr. Roberts reported on the preliminary results of a survey of the Manufacturer's Association membership. The members that have responded, have indicated that the issue of controlling health care cost is ranked above tax and regulatory burden issues. Members are concerned about the rising cost of health care in general and pharmaceuticals in particular. The increasing costs impede the ability of the employers to provide health insurance.

There were questions from the Commission regarding what specific items unique to Hoosiers drive the increased cost in this state and regarding the Manufacturer's Association position on Certificate of Need.

Galinton Brian, Indiana Federation of Ambulatory Surgery Centers

Mr. Brian reviewed the purpose of the Federation of Ambulatory Surgery Centers and reported that of 119 licensed outpatient surgery centers in the state, 97 are members of the Federation. Mr. Brian stated that outpatient surgery centers are generally not regarded as problematic niche providers. The centers have been developed in response to scheduling and crowding in inpatient surgical facilities and may provide only same-day surgical procedures. The number of procedures that are performed on an outpatient basis is expanding due to technological advances such as micro-surgery procedures. Mr. Brian elaborated that surgery centers must be Medicare- and Medicaid-approved as required by insurers and that the centers save funds within the total health care system. Mr. Brian stressed that outpatient surgery centers are providers as well as employers that offer health insurance benefits. The Federation would be interested in exploring the concept of linking quality standards to reimbursement.

David Hale, United Auto Workers (UAW)

Mr. Hale reported that health care costs are an issue of interest to the 55,000 UAW members and the 40,000 retirees who have benefits. Mr. Hale commented that availability of data regarding quality of care might be part of the solution to controlling increasing costs. He added that the Union supports the concept of Certificate of Need to eliminate excess capacity and redundancy in the system. Mr. Hale thought that CON did not necessarily need to be labor

intensive to limit capital expansion that does not meet demonstrated community need. He added that while CON might not cure the problem of overexpansion, without it, duplication and overbuilding will continue. (See attachment E.)

Russ Towner, DaimlerChrysler and Alliance of Automobile Manufacturers

Mr. Towner reported that health care is the single largest component and the fastest increasing cost component of DaimlerChrysler's products. Health care cost affects the competitiveness of products, and the cost cannot be covered by increasing the cost of the product. Mr. Towner reviewed the company's position statements on Certificate of Need issues that are included in Attachment F. Mr. Towner reported that DaimlerChrysler supports the reinstatement of CON in Indiana.

There was some discussion of UAW benefits being used to support niche providers and the existence of "any willing provider" contract provisions.

Jim Zieba, Indiana State Medical Association (ISMA)

Mr. Zieba commented that ISMA supports the patient's right to receive care at the facility of their choice with the least restriction of access. He added that specialty hospitals offer advantages of quality and efficiency while allowing the staff more control over administrative issues. He commented that community hospitals have become more business-like, and individual clinical decisions are influenced by business decisions on issues such as centralized purchasing. Mr. Zieba reported that physician ownership is not necessarily a bad situation; physicians have, for years, had ownership interests in specialty hospitals such as the Mayo Clinic that have contributed to better quality of care everywhere.

Mr. Zieba discussed the various definitions of "cost" that have been mentioned to the Commission; insurance premium increases may not necessarily relate to health care cost when Anthem Insurance Co. reported a 67% profit for the 2nd quarter of 2003. He stated that medical cost means different things to different people depending on their view of the issue. Mr. Zieba commented that the cost of insurance represents a complex issue that cannot be addressed with a quick-fix response, especially in light of the fact that the issues are not unique to Indiana.

Kim Williams, Indiana Academy of Ophthalmology

Ms. Williams commented on the advantages of outpatient surgery centers for ophthalmology procedures. She questioned how overutilization could occur, when procedures are subject to prior authorization by insurers.

Provider Agreements and Health Care Contracts

David Wilson, MD, Physician's Associate Group

Dr. Wilson introduced himself as a pulmonology specialist from Columbus. He described a problem with provider health care contract clauses referred to as "most-favored-nation clauses". Dr. Wilson explained that these clauses require that the provider accept reimbursement from the insurer at a price that cannot be more than any other price the provider might negotiate with another group. These clauses limit the ability of new insurers to enter the market. Most commercial health insurance is dominated by a few very large companies that maintain market dominance and limit competition. Dr. Wilson related the circumstance of a local employer trying to self-insure basic care for a small group of employees, being unable to negotiate a lower price due to the most-favored-nation clauses of large insurance companies. Dr. Wilson suggested

that Indiana consider banning these contract clauses.

Elizabeth Merchiers, Indiana State Medical Association

Ms. Merchiers stated that ISMA supports the concept of doing away with the limiting provider agreements in health care contracts.

Other Business

Marjorie Maginn, Anthem Insurance

Ms. Maginn reviewed information in Attachment G regarding health insurance profits in response to questions about excessive profits raised at the September 24, 2003, meeting of the Commission. She emphasized that the company's net revenue was a very small percentage of overall premium prices. Ms. Maginn commented on the proliferation of specialty hospitals and stated that convenience and luxury services such as valet parking and manicures were being used as marketing tools for new facilities, not the quality of the services. She stated that Anthem supports exploring the concept of CON or some type of moratorium mechanism. (See Attachment H also.)

In response to questions regarding the "most-favored-nation clauses" in provider contracts, she confirmed that Anthem does include these clauses in their contracts. There was more discussion regarding "any willing provider" contract clauses and reimbursement based on quality data.

Next meeting date: 10:00 A.M., October 30, 2003.

The meeting was adjourned at 1:25 P.M.