HEALTH FINANCE COMMISSION

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MEETING MINUTES[1]

Meeting Date:	**July 23, 2003**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 431**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Connie Lawson; Sen. Marvin Riegsecker; Sen. Billie Breaux; Sen. Timothy Skinner; Rep. David Orentlicher; Rep. John Day; Rep.Carolene Mays; Rep. Scott Reske; Rep. Peggy Welch; Rep. Timothy Brown; Rep. Mary Kay Budak; Rep. David Frizzell.**

Members Absent: **Sen. Sue Landske; Sen. Beverly Gard; Sen. Gary Dillon; Sen. Vi Simpson; Sen. Connie Sipes; Sen. Greg Server; Rep.Charlie Brown, Vice-Chairperson; Rep. Craig Fry; Rep. Brian Hasler; Rep. Vaneta Becker; Rep. Robert Behning; Rep. Donald Lehe.**

Chairperson Senator Patricia Miller called the Health Finance Commission to order at 11:40 A.M. Senator Miller opened the meeting with introductions of Commission members present and remarks concerning the importance of the topic to be addressed.

Dan Evans, Jr., President and Chief Operating Officer, Methodist Hospital ,Clarion Health, Indianapolis

Mr. Evans gave an overview of Methodist Hospital's and Clarion Health's involvement in the provision of healthcare for the uninsured. He emphasized that Clarion provided $217 M in charity care and uncompensated care in FY 2002; this represented an increase of 12.3% over

[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.

FY 2001 (See also, Handout A). Mr. Evans presented a demographic portrait of the average uninsured Hoosier: a single person, under age 35, with income less than 185% of the federal poverty level, a member of a minority group, having no high school diploma, and living in Indianapolis or northwest Indiana. Of these individuals, 41% cite the cost of insurance as a major barrier to being insured.

Mr. Evans discussed Wishard Hospital's role in Marion County as the safety net hospital for uninsured individuals. Uninsured patients are a highly mobile population. When the Wishard Emergency Department is filled, patients are diverted to other centrally located hospitals in Marion County. Consequently, all area hospitals are affected by the growing number of uninsured patients that may be diverted from Wishard. Mr. Evans emphasized that the other area hospitals are committed to maintaining the services of Wishard Hospital. Mr. Evans stated that hospital emergency services are provided with no regard for the patient's ability to pay, and he suggested that access to hospital services is already universal. He further commented that the reimbursement system is not universal: political boundaries are irrelevant to the provision of healthcare. Mr. Evans stated that we need a reimbursement system that encompasses a larger risk pool than those currently recognized by politically defined funding boundaries. He further commented that part of the solution might be a tax.

Mr. Evans concluded by commenting that healthcare jobs will replace manufacturing jobs and that investment in safety net hospitals and providing services for the uninsured stimulates job growth in healthcare. He suggested the investment could be regarded as a tool for economic development.

Senator Miller asked the Commission members to hold their questions until after the three hospital presentations had been made.

Mr. Robert Brody, President and CEO, St. Francis Hospital and Health Center, Indianapolis

Mr. Brody prefaced his remarks with an overview of the Sisters of Saint Francis Health Services system in Indiana, stating that the system employs over 10,000 individuals, operating seven hospitals with ten healthcare campuses in the state. Last year, the system provided over $100 M in charity care and governmental subsidies (unpaid cost of services provided to Medicaid and Medicare patients). Mr. Brody gave examples of hospital costs that are not fully reimbursed by the federal Medicare program and then specified that Medicare pays 70% of the actual cost of services provided; Medicaid pays 53% of the actual cost of services. He reported that approximately 50% of the total discharges were for Medicaid or Medicare patients. The gap between the cost of care compared to the reimbursement received was historically cost shifted by hospitals to commercial insurers. Mr Brody stated that the ability to cost-shift has become increasingly difficult due to several factors: (1) insurers' demands for deep discounts, (2) an increasing number of uninsured or underinsured individuals; (3) hospitals' reliance on an increasingly scarce labor market; (4) increased pension costs due to the poorly performing investment market; (5) increasing health care costs for employees; and (6) physician competition for outpatient services.

Mr Brody stressed that community-based, not-for-profit hospitals are the backbone of the healthcare delivery system in the state. In many communities, as a major employer, they are the economic backbone as well. He further emphasized that Wishard Hospital is an irreplaceable resource and, as the safety net hospital, should receive continued support for its work.

Mr. Brody made three suggestions for consideration by the Commission: (1) study the revision of the Medicaid Disproportionate Share Hospital (DSH) program payment formula to include a

greater number of providers across the state; (2) study the impact of physician ownership of health care facilities; and (3) take a leadership role in advocating national reform for the financing and delivery of healthcare.

Mr. Joseph Loftus, representing the Health and Hospital Corporation of Marion County.

Mr. Loftus reported that Matt Guttwein, the CEO of Wishard Hospital, had been requested to attend a meeting regarding federal funding for large safety net hospitals in Washington, D.C., and was unable to attend the Commission meeting. Mr. Loftus then referred to the Indianapolis Star articles that reported a $35 M budget deficit for Wishard Hospital and commented that the story was largely accurate. The deficit constitutes about 10% of the operating budget. He reported that the shortfall in budgeted funds would be covered with surpluses available from prior years' recoupment of federal reimbursements. These funds were originally planned to be used for capital expenditures, not to subsidize operating deficits.

Mr Loftus reviewed Wishard's role as the safety net hospital for Marion County, providing two-thirds of all indigent care in the county (See Handout B). The high level of indigents, as well as Medicaid and Medicare patients, means that Wishard has limited opportunity to shift costs to private payers. The county property tax levy for the Health and Hospital Corporation is at the maximum. The strategy being pursued currently is to maximize federal funding available through the Medicaid Disproportionate Share Hospital program, upper payment limits, and intergovernmental transfers. The budget for next year has been cut from $360 M to $312 M. Mr. Loftus reported that additional federal funds are being sought.

Mr. Loftus stated that locally, management is looking to prioritize services and only if necessary determine where cuts might be made. He emphasized that no cuts in service have been proposed and no decisions have been made at this time, although everything is on the table for consideration.

Senator Miller thanked the three speakers and asked them to remain for questions from the Commission. Discussion followed regarding redesign of the healthcare payment system, restructuring of the risk pools that provide funding, and the taxing system that provides public financial support.

Mr. Tim Kennedy representing the Indiana Hospital and Health Association.

Mr. Kennedy reviewed the legislative background for providing care for the uninsured. Mr. Kennedy stressed that the DSH reforms in HEA 1813-2003 were enacted to help ensure that Wishard is able to continue in its role as the safety net hospital in Central Indiana. He stated that the federal Medicaid program is shrinking the allotment for the DSH program at a time when the demand for services for the uninsured is increasing. The state formula for DSH qualified 10 hospitals for DSH money in 2001; another 10 or 12 hospitals may qualify for DSH funding in 2002. This means that the pool of available funds will be spread to more hospitals. DSH federal funds require a state match; about $10 M comes from the state General Fund and the remaining $70 M comes from the hospitals. The bulk of the funding from hospitals comes from Wishard and Clarion. Mr. Kennedy suggested that one way to ensure the healthy operating status of community hospitals is for the state Medicaid program to fully fund hospital services provided to Medicaid recipients and to work with federal officials on the same problem in relation to Medicare. Mr. Kennedy also commented that the practice of spinning off profitable business lines from the community hospital base is another problem.

Senator Miller asked staff to find out what fully funding Medicaid hospital services would cost the state. Representative Welch asked that physician funding be included in this inquiry. There was additional discussion regarding DSH funding and current allocations.

Mr. Douglas Stratton, Executive Director, Indiana Comprehensive Health Insurance Association (ICHIA).

Mr. Stratton reported that ICHIA lost $66 M last year. However, since January 2003 the program has negotiated new contracts and expects $10 M in potential savings as a result. These anticipated savings are in addition to the ICHIA revisions enacted by the General Assembly in SEA 462-2003. Mr. Stratton reported that the bad news was that while the legislative revisions should result in additional savings, more people will come into the ICHIA program.

Mr. Stratton commented that anything that happens within the healthcare financing arena impacts almost everyone, and harsh reality indicates that we cannot afford to do all we have done, or can do. Healthcare financing will continue to consume larger amounts of resources forcing hard decisions.

In response to Representative Welch's request for him to comment on earlier discussions regarding risk pools for health insurance, Mr. Stratton emphasized that in order to stop the spiraling cost of insurance and the resulting increase in the uninsured, all people in the state must be included in a risk pool. There should be no ability to opt out. He further commented that there is room to have a private system and a public system but that initial policy must define the role of each sector. Mr. Stratton referred to the Harvard Policy Forum regarding dual health insurance programs that would be regulated and interdependent, in response to Representative Frizzell's request to comment on a single-payer system. A dual system could take advantage of strengths in both programs: commercial interests drive advances and improvements, and the bureaucratic process protects the interests of those not able to access the free enterprise system. Such a system requires that funds from the commercial sector be used to provide funds for the public sector.

Senator Miller asked commission members to identify other issues they wished to address and asked that participants interested in the discussion on the uninsured to contact staff.

The next two meeting dates were selected as August 20th and September 24th.

There being no further business to conduct, the meeting was adjourned at 1:00 P.M.