Legislative Services Agency

MINUTES

Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

November 14, 2007

MEMBERS PRESENT:

Senator Jack Hatch, Co-chairperson
Senator David Hartsuch, alternate for Senator Jerry Behn
Senator Joe Bolkcom
Senator Amanda Ragan
John Aschenbrenner
David Carlyle
Larry Carl, alternate for Steven Fuller
Amy DeBruin
Barb Kniff
Timothy Kresowik
Julie Kuhle
Jan Laue
Jay Christensen
Russ Sporer
Sarah Swisher
Representative Ro Foege, Co-chairperson
Representative Elesha Gayman, alternate for Representative David Jacoby
Representative Clarence Hoffman
Representative Mark Smith
Representative Linda Upmeyer
Joe Teeling
Sharon Treinen

Ex Officio members:
Kevin Concannon, Director, Department of Human Services
John McCalley, Director, Department of Elder Affairs
Tom Newton, Director of Public Health
Susan Voss, Commissioner of Insurance

MEETING IN BRIEF

Organizational staffing provided by: Ann Ver Heul, Legal Counsel, (515) 281-3837

Minutes prepared by: Patty Funaro, Senior Legal Counsel, (515) 281-3040

I. Procedural Business

Call to Order and Adjournment. Co-Chairperson Foege called the seventh meeting of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families to order at 9:07 a.m. on November 14, 2007, at Northeast Iowa Community College, Town Clock Center, Dubuque, Iowa. The meeting was adjourned at 3:53 p.m.

II. Approval of Minutes, Commission Disbursements, Review of Agenda

The minutes of the October 10, 2007, and October 17, 2007, meetings were approved as distributed. A report of the disbursements from the Commission's appropriation, to date, was distributed. Co-chairperson Hatch noted that the agenda included presentations regarding charity care, hospital finance, health care quality, and wellness, and that the remainder of the day would be used for workgroups to meet and work through details of their recommendations. Co-chairperson Hatch noted that the December meeting would be used to finalize recommendations, and that an additional meeting in January would be utilized to review and approve the final report and recommendations, which might include continuation of the Commission.

III. Motions

Co-chairperson Foege reviewed three motions before the Commission.

- That the Commission requests that the Legislative Council authorize the Legislative Services Agency to send up to three people to the Medical Home National Conference in Washington, D.C., on December 6, 2007.
- That the Commission requests the Legislative Council to authorize the Commission to hold an additional meeting on January 8, 2008.
- That the Commission requests the Legislative Council to authorize the Legislative Services Agency to enter a sole source contract with an entity for the purpose of modeling the Commission's proposals for health care coverage reform in Iowa to determine feasibility and cost.

Dr. Carlyle provided additional information regarding the Medical Home National Conference, noting that he and Director Newton would be attending. Representative Smith moved that the motion be approved, Representative Hoffman seconded the motion, and it was approved unanimously on a voice vote. Co-chairperson Hatch moved that the request for an additional meeting on January 8, 2008; it was seconded by Representative Hoffman, and approved unanimously on a voice vote. Senator Hartsuch noted that he would prefer a request for proposals process rather than a sole source contract for modeling. Senator Bolkcom moved approval of the sole source contract for modeling, Ms. Laue seconded the motion and the motion was approved on a voice vote, with Senator Hartsuch being recorded as a "no" vote.

IV. Charity Care in Iowa

Research Methodology. Dr. Gary Rosenthal, University of Iowa, College of Medicine, presented a report on charity care in Iowa. Determining the amount of care being provided to patients without insurance is important in assessing the economic impact of broadening health care coverage for Iowans. Much of this care is written off as charity care, and the care is delivered through a wide spectrum of clinicians and delivery settings. The research conducted for this report focused on the cost of charity care provided by hospitals to patients without health insurance in the following locations: acute care inpatient settings, hospital-based ambulatory surgery settings, and emergency room (ER) visits. This focus was selected because of the large proportion of charity care provided in these settings, the availability of public data provided by the hospitals, and the lack of readily available data for care in other settings. "Cost" was determined based on total charges in the Iowa Hospital Association databases and on cost/charge ratios submitted by hospitals to the Centers for Medicare and Medicaid Services (CMS). The equation used is: costs=(charges)x(hospital cost-to-charge ratio).

Hospital Data. The data demonstrates that the percentage of hospital admissions of uninsured patients has remained fairly steady from 2001 to 2006 at somewhere between a low of 3.4 percent and a high of 4.1 percent, with the percentage for 2006 being 3.9 percent. Based on a comparison by state, Iowa ranks fairly low on these types of admissions, with the lowest being Maine at 2.1 percent and the highest being New Jersey at 9.8 percent in 2003. Characteristics of the individuals admitted to the hospital without insurance include that the mean age is 33 years of age, which is substantially lower than the mean age for the insured (for insured it is 55 years of age), 50 percent are male and 50 percent are female (for insured the split is 60 percent female and 40 percent male), 73 percent are white, 2 percent black, and 25 percent other or unknown (for insured the breakdown is 66 percent white, 5 percent black, and 29 percent other or unknown), and the source of admission is 42 percent ER and 45 percent MD referral (for the insured it is 33 percent ER and 54 percent MD referral).

The more urban counties have the higher number of uninsured hospital admissions, but the more rural and smaller counties have the higher percentage of such patients. The most common diagnostic categories of uninsured admissions from greatest to least by diagnosis are newborn, circulatory, pregnancy, digestive system, respiratory, musculoskeletal, and nervous system. The total cost of hospital admissions for the uninsured was $294 million for the six-year period from 2001 to 2006. The ER visits by uninsured patients for 2005 and 2006 have remained stable at about 13 percent as have ambulatory surgery visits at about 2 percent. For 2005, the total cost of admissions of uninsured patients was $51.1 million, for ER visits was $47 million, and for ambulatory surgery was $13.1 million. For 2006, the total costs remained similar with the cost for admissions at $60.7 million, ER visits at $53 million, and ambulatory surgery at $11.4 million.

Caveats. Caveats for the study include that the designation of "uninsured" was based on those who are described as "self-pay." The self-pay variable does include a small number of wealthy patients who elect to pay for health care out-of-pocket. Among the uninsured poor, hospitals likely receive partial payment for some patients, and, therefore, it is unknown how much of the care provided to those without insurance is actually written off as charity care. Determining costs using

Medicare hospital cost reports is only an approximation of costs because actual cost data is typically regarded as proprietary.

Discussion. The aggregate costs incurred by Iowa hospitals in treating uninsured patients in 2005 was $111 million and in 2006 was $125 million.

In response to inquiries, Dr. Rosenthal noted that the uninsured category does not include IowaCare patients, and that his final report will include a breakdown of ER costs by diagnosis. Due to confidentiality protections, the data does not allow for a determination of repeat admissions or uses of the three settings studied. Information regarding charity care outside of the hospital setting is not available. It is difficult to determine the cost savings to the system through elimination of charity care and bad debt if all Iowans were to have health care coverage. The cost-to-charge ratio is roughly 50 percent.

V. Hospital Finance

Overview. Mr. Greg Boattenhamer, Senior Vice President of Government Relations, Iowa Hospital Association (IHA), presented information regarding hospital finance.

Even though law requires hospitals to charge everyone the same rate, no two payers pay the same rate, no payer pays all providers the same, government pays below costs (neither Medicare nor Medicaid pays at cost, so these costs are shifted to other payers), commercial payers negotiate rates, and charity care and underpayment impact overall costs for everyone else.

Losses Incurred. Costs or losses incurred by Iowa hospitals include $102 million annually in Medicare, $118 million annually in Medicaid (which pays below Medicare rates), $119 million annually in charity care (people who qualify for the hospital's charity care program), $120 million in other uncollected patient expenses (bad debt that is identified after the care is provided and is written off), and $39 million in community health improvement services (such as free clinics, immunizations, and other community activities). Even though 82 of Iowa's 117 hospitals are critical access hospitals, and therefore receive cost-based reimbursement under Medicare, this only applies to about 10 percent of hospitals' overall business in Iowa. The impacts of the losses to hospitals include the ability of hospitals to attract physicians, the ability to retain nurses and clinical staff, health care costs to private businesses, the ability to provide charity care and to support the IowaCare program, the ability to meet technology and infrastructure needs, and to provide wellness and prevention programs. Mr. Boattenhamer noted that the saying with regard to hospital finance is "no margin, no mission."

Payment Information. Both Medicare and Medicaid payments from 2001 to 2007 have been substantially less than the hospital salary increases provided. Payments for hospital services are approximately 44 percent by Medicare, 19.2 percent by Wellmark, 15 percent by other commercial, 10 percent by Medicaid, 6 percent by self-pay, and 8 percent by other. Iowa ranks 44th in the nation in the average expense per inpatient admission and ranks 50th in the amount of the charge per outpatient visit.

The Uninsured. Approximately 7 to 9 percent of Iowans, or approximately 250,000 to 270,000 are uninsured. Approximately 97 percent of children are covered. Of the uninsured, roughly one-third

are self-insured, one-third have access to insurance, and one-third truly are without access to coverage. The uninsured do not include those who are self-pay. Self-pay persons pay their bills, and in Iowa the self-pay are not charged more for their care, because all Iowa hospitals share the Iowa Hospital Association principles that prohibit care being denied based on resources, have written financial aid policies that allow for discounting for those with incomes of up to 1000 percent of the poverty level, and refrain from aggressive collection practices such as the sale of a home, body liens, and forcing bankruptcies to collect the full charge amount.

Medicaid. Hospitals require an operating margin and reserves to cover employee costs (50 percent), capital and technology expenses, bond and debt financing, uncertainty regarding government programs, emergency services and the fluctuating health care economy. Statewide in 2006, patient revenue was -3.2 percent, operating revenue was 2.4 percent, and total revenue was 5.9 percent. In 2006, of 117 hospitals, 78 lost money in patient revenue, 45 in operating revenue, and 13 in total revenue. Hospitals support investing in Medicaid because states cannot control Medicare losses, but can impact the Medicaid program. Medicaid is important to both beneficiaries and providers with a guaranteed federal match of almost 2 to 1. Investing in Medicaid is the single most effective action Iowa can take to impact insurance costs for families and small businesses. Methods for investing in Medicaid includes insuring the approximately 30,000 parents of Medicaid children to 100 percent of the federal poverty level ($49 million), moving hospital payments to Medicare levels or the upper payment limit ($27 million), and moving physician payments to Medicare levels as was mandated by state law in 2000 ($5 million).

Pricing. With regard to hospital price transparency, beginning in January 2007, Iowa hospitals will publicize hospital charges via the IHA web site. Mr. Boattenhamer noted that the majority of patients, even given cost information, go to the hospital used by their own physician. There is a link to Iowa hospital data on quality and patient safety via the Iowa Healthcare Collaborative (IHC). There is also a role for other health care providers and the vendor community with regard to transparency.

Mr. Boattenhamer stated that hospital financing is very convoluted and complicated. There is really no relationship between the cost of care and the charges. The charges are inflated because they are used to negotiate and determine patient reimbursement. However, generally, the cost-to-charge ratio is roughly 50 percent. In response to a question regarding how charges are set if there is no relationship between charges and costs, Mr. Boattenhamer responded that each hospital uses a "chargemaster." Mr. Christensen added that the relationship between charges and costs is limited because pricing is competitive and determination of pricing is based partly on what payors will pay and on the competition.

Mr. Boattenhamer noted that if Medicare and Medicaid rates are not made more competitive, this will drive providers out of state. Members provided scenarios of self-funded plans and their successful attempts to renegotiate charges for employees. Hospitals will negotiate with private, independent payors, but many times, small employers do not have the time to do this. A member stated that not only is there no relationship between charges and actual costs, but the cost then has nothing to do with quality of care and the current system is counterproductive to providing quality health care in the state. A question was raised about strategic planning for hospitals since there is so much concern about reimbursement and the ability of hospitals to stay afloat, and

whether it is necessary for every hospital to provide every service. Mr. Boattenhamer stated that hospitals do strategic planning and are finding creative ways to provide access. Others will be forced to close. Some members noted that it is hard to reconcile the building of new hospitals when others are financially challenged.

VI. Commission on Wellness and Healthy Living

Overview. Lieutenant Governor Patty Judge began by thanking the members of the Commission for their critical work. Everyone is talking about health care and the high costs associated with the present system. She noted that a lot can be done to prevent the higher costs that come with delaying health care, by focusing on prevention. Six months ago, the conversation was changed from a system that addresses illness to one that focuses on wellness, when Lt. Governor Judge convened the Commission on Wellness and Healthy Living in the summer of 2007. The commission held 10 town hall meetings across the state, and based on the recommendations presented at the town hall meetings, the commission developed five steps to make Iowa a healthier state. The five steps are: remove unhealthy food from schools; improve the health of Iowa's children; encourage more Iowans to quit smoking; encourage physical activity for seniors; and promote wellness efforts among Iowans.

Remove Unhealthy Food in Schools. Childhood obesity is at epidemic levels. The current generation is the first to have a lower life expectancy than the generation before it. Change can start in the schools. Two options are the healthVen program, a revolving school loan program that will allow schools to purchase vending machines that carry only healthy foods, and improving school lunches to provide more fruits, vegetables, and lean meats. Some will say that the schools need the vending machines as a revenue stream. But the Lt. Governor said that this is just wrong and that there are a number of vending companies that can provide healthy food options.

Improve the Health of Iowa's Children. Action steps include setting physical activity guidelines for Iowa's schools and encouraging wellness among students, including well-child screenings. The health of Iowa's children depends on them being involved in physical activity. The activity guidelines would not be mandated, but would be developed as guidelines. Currently, physical education classes do not always include actual physical activity.

Encourage More Iowans to Quit Smoking. Communities should be provided the authority to pass local smoke-free ordinances and smoking cessation programs should be expanded. Lt. Governor Judge stated that she is a former smoker and learned to smoke during nurses' training in the 1960s. She quit 30 years ago, after several attempts, determining that she wanted to live long enough to be a burden to her children. When she was trying to quit, she was told that only a handful — 3 or 4 — in the class would actually quit. There are many options for quitting and support is needed.

Encourage Physical Activity for Seniors. The Department of Elder Affairs and the Department of Public Health should work together to expand physical activity programs for Iowa's seniors.

Promote Wellness Efforts Among Iowans. Encourage Iowans to get regular health screenings, including mental, dental, cancer and other preventive steps, and work with the Department of Public Health to connect them to those services. Additionally, create a wellness Internet site for

individuals to learn about successful wellness efforts, best practices, and what communities are doing in the state, and to assist individuals in creating their own personal wellness plans, including information on healthy eating, physical activity, and health screenings.

Other Issues. Issues that also need to be addressed include: mental health care, which is a serious problem with provider access being at a crisis point; dental coverage for kids; and disease prevention. Not everything is included, but the Commission determined that the five steps are a strong starting point and it will be an ongoing effort.

Discussion. In response to an inquiry about using "sin" taxes to change behavior, Lt. Governor Judge agreed that this could be added to the mix of options to assist people in making better choices, but that ultimately the person has to make the decision. Senator Bolkcom noted that his subgroup on cost containment had adopted all of the Lt. Governor's steps as a recommendation. Additionally, he asked about ways to increase the investment by the Department of Public Health and communities in prevention efforts. Lt. Governor Judge suggested that there are existing programs such as Lighten Up Iowa that are great motivators. She stated that she hopes to involve state employees on a greater scale this year by starting in the Governor's Office and challenging all of the departmental directors and other elected officials to form teams.

In response to a question regarding how to make it easier for people to get regular screenings, Lt. Governor Judge responded that the Wellness Commission can dovetail its work with the work of this Commission and also make the screenings available through insurance products. Local health departments offer screenings but these services are underutilized, and also need adequate funding. Mr. Carl suggested that dental care should be comprehensive and that the ISmile program should reflect this. Ms. Trienen voiced her support for nutrition education in schools including replacing pop with milk. Lt. Governor Judge said that one thing that can be accomplished at the minimum is providing healthy snacks in schools.

VII. Health Care Quality in Iowa

Overview. Dr. Tom Evans, Iowa Healthcare Collaborative (IHC), presented information relating to the quality of health care in Iowa. The IHC is a statewide, provider-led foundation formed to improve the quality, safety, and value of health care. The cornerstones of the collaborative are to align and equip health care providers on quality and value, responsible public reporting, engaging the community for clinical improvement, and raising the standard of care in Iowa.

Professionalism is being redefined and there is a new era of transparency and accountability based on a value-driven health care system. Leadership for a high-quality system requires innovation, a sense of ownership, nimbleness, and a commitment to collaboration.

Work Plan. The IHC 2007 work plan includes responsible public reporting. Data sources include both clinical and administrative data and publicly available and voluntarily reported information sources. Data that is suitable for comparative purpose includes the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services hospital compare and the Agency for Healthcare Research and Quality of the United States Department of Health and Human Services administrative data set. Data that is not yet suitable for comparative purposes includes the National Quality Forum 30 safe practices information and health care-

associated infection measures. Dr. Evans described the various quality indicator tools. Iowa has excellent quality that generally meets or exceeds national measurements, but still has work to do.

IHC Recommendations. Dr. Evans presented a number of recommendations to improve health care performance. With regard to quality, he suggested that variability must be reduced. Improved patient safety requires creation of a new culture. With regard to value, efficiency must be improved by reducing duplication, waste, and administrative burdens and promoting value improvement techniques. The IHC has worked to get all providers going in the same direction, and providers are engaged through such efforts as the 5 Million Lives Campaign to reduce medical harm in hospitals, voluntary reporting initiatives, the infection control practitioner community, the lean learning collaborative, and the ambulatory learning community. In Iowa, hospitals and providers are collaborating, and this is unique nationally. Other recommendations include seriously addressing wellness and prevention. Trust must be built between all stakeholders including payors, purchasers, providers, and patients. Public reporting mandates might stifle innovation and provider engagement, and is not necessary to provide transparency. Consumers need to be actively involved in their own treatment, but the data given to them must be good and not have unintended consequences. Even if consumers have good information, they will generally continue to go to the same physician. Dr. Evans concluded by asking that the Commission and state continue to support the work of IHC.

VIII. Small Group Work

Following the presentations, the members of the Commission broke into small groups for discussion. The Commission then reconvened and each group presented its report to the full Commission. The reports, with the exception of the Workforce Shortages Report which is not available, are attached and by this reference made a part of these minutes.

1. Workforce Shortages.
2. Electronic Health Records.
3. Medical Home.
4. Health Care Coverage.
5. Purchasing Consortium.
6. Funding — Cost Containment — Patient Rights.

IX. Materials Filed With the Legislative Services Agency

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the <Additional Information> link on the Committee's Internet page: http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=208.

1. Medical Home Workgroup Documents — Draft Report.
2. Health Care Coverage Workgroup Documents — Draft Report
3. Purchasing Pools - Pharmacy Workgroup — Draft Report.
4. Cost Containment/Funding Workgroup Documents — Draft Report.
5. "Health Care Quality" — Dr. Tom Evans, Iowa Healthcare Collaborative and Dr. Marcia Ward, University of Iowa College of Public Health.
6. Charity Care by Dr. Gary Rosenthal.
7. Health Care Commission Disbursements through 10-31-07.
8. Improving Iowa's Health Care System Flow Chart.
9. Iowa Hospital Association Presentation by Greg Boattenhamer.

3656IC