IOWA HOSPITAL ASSOCIATION

Testimony Before
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The Iowa Hospital Association appreciates the opportunity to address the Subcommittee regarding the proposal you have been examining regarding access to health care for all Iowans.

I would like to address the bulk of my comments this morning on Division II of the proposal, specifically the need to fully fund Iowa's Medicaid program.

Despite the much-needed three percent Medicaid provider payment increase approved by the Iowa General Assembly in 2006, the ability of Iowa hospitals to provide high quality, comprehensive health care services is threatened by insufficient government health care program payments. In fact, even with two years of inflationary updates, Iowa hospitals still lose money when treating Medicaid patients.

Most Iowans are aware that Iowa receives one of the lowest Medicare payment rates in the nation. That is a well documented federal issue outside the control of the Iowa General Assembly. However, members of this subcommittee may not realize that Iowa's Medicaid program actually pays hospitals and physicians ***below*** Medicare rates. This negatively impacts the ability of Iowa hospitals to attract and retain quality health care professionals and creates financial pressures on private health insurance rates for large and small businesses that must make up for these inadequate payments.

Medicaid Provider Statistical and Reimbursement Report (PS&R) data reveals that Iowa hospitals lose approximately $118 million annually in providing services to Medicaid patients. When Iowa hospitals are paid below their costs to provide care to Medicaid patients, other parties who pay for health care services subsidize the program. Businesses and individuals who purchase insurance pay higher premiums or buy policies with higher deductibles or co-payments in an effort to deflect some of the increases due to cost-shifting of Medicaid payment shortfalls to other patients. This cost shift compounds the problem by increasing the number of people who can no longer afford health insurance or who cannot afford to pay the larger out-of-pocket costs when they need care.

Medicaid payments to Iowa hospitals are capped by the federal government, not to exceed what Medicare would pay for similar services. But because Iowa has one of the lowest Medicare payment systems in the nation, those Medicare caps are even more detrimental in our state. The State of Iowa should stand behind its own Medicaid

program and pay hospitals Medicare rates if we are to be credible in criticizing Medicare at the federal level. According to the Iowa Department of Human Services, it would take a state investment of about $20 million to bring hospital Medicaid payments to Medicare levels, funds which would then be matched with $34 million of additional federal revenue. And because of this nearly two-for-one federal match, from a purely economic development perspective there is no where else the state government can invest a dollar and receive a guaranteed return on investment of nearly 200 percent. Iowa should not leave these needed federal dollars on the table.

Additionally, it's important to understand that roughly half of a hospital's expenses are dedicated to salaries and benefits. While there is much attention now being paid to address getting teacher salaries to the national average, Iowa's health care system faces similar challenges regarding health care worker compensation. Bringing more than $50 million to Iowa hospitals is an important step in helping to attract and retain the quality caregivers Iowa will need as our elderly population continues to grow.

Unfortunately, the budget proposal released January 30 does little to assist Iowa's Medicaid program. Although the administration's budget does call for a $1 per pack increase in Iowa tobacco taxes, it ignores the need to support and sustain increased payments to Medicaid providers in the state. Not only does the current budget proposal fail to address the hospital advocacy message highlighting the need to bring Medicaid payments to Medicare levels, *it does not even include any inflationary updates for Iowa providers*. The assertion that the budget proposal "fully funds" Medicaid only relates that there is money in the budget to pay for expected utilization at current rates; this is not "full funding" by hospital or beneficiary definition. And although it is not reflected in the current budget, Governor Culver has expressed his full support for bringing hospital Medicaid payments to Medicare levels.

The Iowa General Assembly must recognize that provision of quality health care services is a cornerstone to the infrastructure of Iowa's communities and an essential force in the state's economic development. Preserving access to health care services for indigent and poor Iowans is a core function of state government, meaning the Iowa General Assembly should stand behind its own health insurance program. The proposal before you recognizes the need to move Medicaid payment rates toward Medicare levels and is enthusiastically supported by the Iowa Hospital Association.

There are several other topics addressed in this proposed legislation and/or which has been discussed in some manner in previous testimony. Although I won't go through them all today, the written testimony provided to the subcommittee addresses the Iowa Hospital Association in many of these areas.

Thank you. I would be happy to answer any questions at this time.

Other Issues:

Division V – Hospital Collection of Uninsured Patients. The Iowa Hospital Association appreciates the sentiment behind this provision and understands the interest in this data. Hospitals have been submitting this data as part of the UB-94 billing claim form for some time. However, the UB-94 claims form which is universally used to provide claims data will be replaced by a new UB-04 claims form in May, 2007. The use of this form by all hospitals in dictated by provisions in the Health Insurance Portability and Accountability Act (HIPAA). Unfortunately, the federal government has determined that the "employer" field on this claim form is no longer relevant, so it will not be possible to collect this data in FY 2008 without creating and implementing an entirely separate and new system, which undermines the administrative simplification provisions under HIPAA. Mandating this provision in Division V would impose yet another unfunded regulatory burden upon health care providers. IHA urges the subcommittee to reconsider this provision until an alternative data collection initiative can be determined, perhaps at the employer or insurer level.

The Uninsured. Iowa's community hospitals are committed to providing high quality health care services to everyone, regardless of ability to pay. While it is certainly not the most appropriate entry point into the health care system, ultimately all Iowans—insured or uninsured—have access to care via the hospital emergency room, meaning hospitals are the ultimate safety net for the uninsured. In addition, every Iowa hospital has endorsed principles regarding medical debt developed by the Iowa hospital association, which include written and generous financial assistance policies for patients. Despite this, the rate of uncompensated care continues to skyrocket for community hospitals, topping more than $334 million in actual costs in 2005. This level of uncompensated care adds additional pressure on the ability to provide quality services to all Iowans and is another example of a hidden cost that must ultimately be born by those with traditional health insurance.

Tobacco Tax Increase. The Iowa Hospital Association joins the host of others who have testified before this subcommittee regarding the need to increase Iowa's tobacco tax by $1.00 per pack of cigarettes. Tobacco use in Iowa is taking its toll on citizens and the economy. The 2004 National Youth Tobacco Survey showed that 22 percent (38,000) of Iowa's youth are smoking, higher than the national average of 20 percent. The survey indicated that nearly 6,000 children will begin smoking and will contribute to the nearly 7.7 million packs of cigarettes which will be purchased in Iowa. And, according to the U.S. Surgeon General, their smoking will not only contribute to their own tobacco-related illnesses but also affect everyone they come in contact with while smoking. The effects of smoking on smokers themselves have become increasingly self-evident in recent years, but this year, the U.S. Surgeon General released a long-anticipated report which concluded that smoking is the single greatest avoidable cause of disease and death for both smokers *and* non-smokers. In the report titled, *The Health Consequences of Involuntary Exposure to Tobacco Smoke,* second-hand smoke was found to be even more harmful than previously thought. The report concluded that not only are smokers

harming themselves, but they're harming everyone they come in contact with while smoking. This is especially true with children whose parents smoke. According to the Campaign for Tobacco-Free Kids, in 2007, 231,000 Iowa children will be affected by the second-hand smoke from their parents. Recognizing the public health risks of smoking and second-hand smoke, the IHA Board has endorsed a policy calling for all Iowa hospitals to adopt smoke-free campuses (which includes *all* hospital property). Seventy-five of Iowa's 118 hospitals have committed to enact smoke-free hospital campus policies by the end of 2007, and many others are considering evaluating this issue. IHA supports all initiatives designed to reduce smoking and other tobacco use, including a $1.00 increase in Iowa's tobacco tax as a means of improving the health of Iowans.

Quality Health Care. Despite Iowa's low government reimbursement rates, the Center for Medicare and Medicaid Services (CMS) rates the quality of the health care provided in Iowa as the sixth-best in the nation. But Iowa's provider community is not satisfied with even that level of excellence. In 2004, the Iowa Hospital Association and the Iowa Medical Society formed the Iowa Healthcare Collaborative (IHC), a unique undertaking whereby health care providers voluntarily collect and publicly release quality information. IHC has now evolved into a separate 50(c)3 organization and is not only publicly reporting hospital-specific quality information on national evidence-based practice parameters, but is working to share best practices among Iowa's health care community to lead to actual process improvement and enhanced quality. All Iowa legislators received a copy of the IHC Annual Report prior to the 2007 legislative session. The IHC work plan for 2007 remains aggressive, with new measures to include additional work in ambulatory care reporting, infection rates, chronic diseases management, and greater engagement at the physician-specific level. This unique partnership is making Iowa a national model regarding how to improve health care quality in a meaningful, voluntary partnership for the good of all citizens.

Price Transparency. In an era of increasing health care costs and consumer-driven financing alternatives, the need for pricing transparency in health care services has taken on increasing importance for Iowa's citizens. Iowa hospitals are committed to sharing information in ways that will help people make informed decisions about their health care services. The goal of pricing transparency is to provide consumers with useful information about hospital and other health care prices on a comparative basis across the various services provided. Hospitals are committed to public information and accountability. On January 10, 2007, Iowa hospitals began to *voluntarily* publicize hospital charge information via the Iowa Hospital Association Web site, www.ihaonline.org. This public portal allows consumers to conduct either basic or more advanced searches of charges associated with all hospital inpatient and outpatient services, as well as provide the opportunity to compare hospitals to one another. While this is a significant *first step* in the arena of health care pricing transparency, other entities in the health care community must make similar commitments. This includes the need for more transparency on the part of insurance companies, pharmaceutical companies, medical equipment vendors, and physicians on how their products are priced for consumers.

As demonstrated time and time again, Iowa hospitals are committed to providing consumers with meaningful information about the performance regarding the state's hospitals. Whether this is evidenced in the availability of hospital-specific quality information, financial information, or economic impact data, Iowa hospitals have been at the front lines of voluntarily reporting relevant consumer information. This newest commitment to releasing comparative hospital price information and providing a consistent definitional framework for providers and consumers alike is another step in this evolution toward enhanced public accountability and transparency by Iowa hospitals.