F I S C A L I M P A C T R E P O R T

SPONSOR Payne **DATE TYPED** 3-2-05 **HB** HM 43

SHORT TITLE Public Notification of Hospital Changes **SB**

ANALYST Collard

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY05	FY06	FY05	FY06		
			NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to HB 762

SOURCES OF INFORMATION
LFC Files
Adverse Health Events in Minnesota Hospitals (www.health.state.mn.us)
Centers for Medicare and Medicaid Services
Kaiser Family Foundation (www.statehealthfacts.kff.org)
America's Health Insurance Plan

Responses Received From
Department of Health (DOH)
Health Policy Commission (HPC)

SUMMARY

Synopsis of Bill

House Memorial 43 requests hospitals and health system associations in New Mexico work with appropriate state agencies to develop a process by which hospital changes, relative hospital quality and annual increases in charges of hospitals may be made easily available to consumers.

Significant Issues

DOH indicates the memorial seeks to develop a process to make hospital information regarding charges and aspects of quality readily available to healthcare consumers to enable informed healthcare choices and to clarify confusing cost charge issues. Making this information readily available could not only serve to better inform the consumer, but enhance hospitals' accountability for charges and aspects of quality.

Since different state agencies have authority over different aspects of healthcare regulation, it is appropriate that they work together with hospitals and the New Mexico Hospitals and Health Systems Association to develop the process for making this information available to healthcare consumers.

FISCAL IMPLICATIONS

DOH notes there are no fiscal implications associated with this memorial and HPC notes the resources involved in planning are within the current staffing levels of the HPC.

ADMINISTRATIVE IMPLICATIONS

DOH notes staff time will be needed to participate in the process development and indicates this could be done within existing resources.

HPC notes the resources required would be meeting time, research and legal review, especially with respect to the confidentiality requirements behind some of the quality information. However, other states, such as Minnesota, do have public reporting of quality information of hospitals which could be used as a template for New Mexico on quality reporting. HPC indicates this could be done within existing resources.

RELATIONSHIP

House Memorial 43 relates to House Bill 762, which covers hospital quality information disclosure requirements.

TECHNICAL ISSUES

HPC suggests deleting the word "annual" when used in reference to charge increases since increases do not have to be made and are not always made on an annual basis.

HPC also notes the memorial does not ask for a report or any indication of progress towards completion of its goals and suggests a report to the legislative Health and Human Services Committee at its October meeting.

OTHER SUBSTANTIVE ISSUES

DOH notes it is difficult and confusing for healthcare consumers and their families to obtain and understand complex issues of hospital charges, especially when faced with emergency situations. Also, there is no central location for information regarding the quality of hospitals to assist healthcare consumers in making informed medical decisions. Therefore, it is important that this information is easily accessible and understandable through a variety of resource locations such as local hospitals, appropriate state agencies.

HPC indicates without a legal change, the current Hospital Inpatient Discharge Data information collected by HPC could not be used as comparative data as is desired in this memorial. Also, the data collected by HPC is inpatient data only and is not charge element specific. Consequently, the memorial asks that a new process be developed by which charges are made easily available to the public as well as increases in charges.

HPC research shows hospital charges are a significant amount of the total health spending in New

Mexico and, consequently, a significant amount of the health insurance premium dollars. The latest data that compares New Mexico with other states is dated 1998, but it shows New Mexico's total hospital spending per capita as $1,389. This is higher that that of surrounding states. Utah's spending per capita is $1,016, Arizona's is $1,085, Colorado's is $1,147, and Texas' is $1,274.

The inpatient use rate for hospitals (discharges per 1,000 population) would be another variable increasing total hospital spending, but the data shows New Mexico's rate at 90 per 1,000 population, Utah at 89, Arizona at 106, Colorado at 93, and Texas at 115. Assuming length of stay and resource intensity per case as constant, it would appear that a variable driving higher hospital spending in New Mexico is rates, not inpatient utilization.

It is possible that part of the higher number in total spending in New Mexico is a higher use of outpatient hospital services and outpatient hospital rates compared to other states. 1999 data for Medicare outpatients only showed Medicare hospital outpatient services per 1,000 Medicare beneficiaries at 738 in Utah, 559 in Arizona, 723 in Colorado, 632 in Texas and 678 in New Mexico. The data is incomplete on the components of hospitals spending as to whether it is rates, intensity of service, or utilization of services driving total spending for hospital care.

Also, the percent of the total health care spending on hospital care in New Mexico was 43.3 percent, compared to Utah's 37.2 percent, Arizona's 35 percent, Colorado's 34.4 percent, and Texas' 37.5 percent. The national percent was 37.4 percent. Total health care spending would include home care, nursing home, physician, drug as well as hospital spending.

HPC also notes one of the main strategies to slow cost growth may be to give consumers financial incentives to use less health care and to be sensitive to prices for services. One of the more significant changes for the health care system this past year has involved changes in the benefit structure—primarily increased patient/employee cost sharing—for the health maintenance organization (HMO) and preferred provider organization (PPO) products that privately insured people utilize. Consumer driven health plans (CDHP) and health savings account (HSA) plans, which push this approach further, will become more available this coming year as HSA products are developed in New Mexico as a result of passage in 2003 of the federal Medicare Modernization Act.

HSAs build in a deductible incentive for the employee to shop around for the least expensive and highest quality care, but the information for that decision is not easy to obtain or understand. HSAs shift more first-dollar costs to employees, lower an employer's policy cost and reduce the amount of premium paid by the employer.

Preliminary results show that Health Savings Accounts products are helping with the uninsured problem. Preliminary results showed that 20 percent of individual HSA sales are for previously uninsured.

Much of the New Mexico hospital market is one that could be characterized as monopoly or oligopoly with considerable distances to the next hospital for many New Mexicans. Only Albuquerque and Las Cruces currently have more than one acute care or specialty hospital. Monopoly markets are usually defined as ones in which sellers have the ability to profitably maintain prices above (or below) competitive levels for a lengthy period of time. In addition, barriers to entry are significant because of the large capital required to build and operate a hospital.

Possible characteristics of hospital pricing in New Mexico which might be changed under the memorial are as follows:

- There is limited price competition (except possibly to large third party payers) and limited consumer choice for many services. Much of the hospital competition is service and quality competition to doctors and patients. The insertion of information into the market may result in well-informed consumers asking questions and obtaining better value for their hospital dollar. Information may also lead to the discouragement of pricing that has adverse consequences on New Mexico payers and consumers. The dynamics of the market could change with information made available to consumers.
- There is also limited public knowledge or information about pricing or quality. "Purchasers" in many cases are not true payers. Patients and physicians are largely insulated from costs paid by other third parties ($10 co-pays). There are also price distortions in the market with reimbursement to providers almost always not what the list price is.
- There is an inelastic, yet growing demand. However, price increases or decreases do not change demand much, if any, as is the case with other industries and other services.
- Pricing discounts without need for the service means nothing (e.g. there no discounted sales on appendectomies and you do not procure one unless it is required to do so).
- "Economic principles assume very different personalities in an industry where the product is as personal as one own health or the health of a loved one." (quoted from a NM Healthcare System CEO). Few consumers would say "that cancer treatment does not fit into my budget so I'll skip it" in the same way you shop for other products.

The memorial may help diminish the dearth of information noted above. However, there can also be negative effects associated with public reporting.

HPC notes a monopoly market may be good for quality outcomes through higher volume hospitals obtaining better mortality/morbidity results. This conflicts with competition theory about quality. However, there are numerous studies correlating positive patient outcomes with more volume.

- Price reporting may increase rates in lower priced hospitals closer to higher priced ones. This artificial inflation would be a negative consequence.
- Consumer behavior through better knowledge may lead to higher, not lower utilization.
- Increased patient awareness of hospital price differences might help slow rising costs, but disclosure of prices negotiated between health plans and hospitals would backfire by increasing hospitals' bargaining clout with health plans which would then result in higher health insurance premiums. This would be a negative consequence. Gross charges would need to be the focus of any reporting.
- Information on hospital care cost may be available only in forms that are so complex that even the most sophisticated consumers can be baffled (e.g. ask for the list charge of a serum amylase or a CT scan).
- Hospitals charge on a fee-for-service basis that is highly detailed—down to charges for each pill or service.
- Patients all have different needs, so developing an estimate of what the charge would be for any single patient is something that not all hospitals have been willing to do. It may be only a gross estimate.
- Gross charges may be limited in value to many but the uninsured.
- Gross charges may not matter with health plans or consumers that have limited choice of hospitals or live in one-hospital towns.

There would be some quality reporting information which may fit under the Review Organizational Immunity Act (41-9-1) for peer review purposes that could not be disclosed. This issue would need

to be researched. However, under the current statute, public hospitals in New Mexico are already under some degree of access for quality reporting if requested. See (14-6-1c) –"Statistical studies and research reports based upon confidential information may be published or furnished to the public, but these studies and reports shall not in any way identify individual patients directly or indirectly nor in any way violate the privileged or confidential nature of the relationship and communications between practitioner and patient."

KBC/lg