

**MINUTES OF THE  
PRIVATELY OWNED HEALTH CARE ORGANIZATION TASK FORCE**  
Monday, December 12, 2005 – 1:30 p.m. – Room W135 House Building

**Members Present:**

Sen. Michael G. Waddoups, Senate Chair  
Rep. David Clark, House Chair  
Sen. Gene Davis  
Sen. John W. "Bill" Hickman  
Rep. Jackie Biskupski  
Rep. Stephen D. Clark  
Speaker Greg J. Curtis  
Rep. James A. Dunnigan  
Rep. Rebecca D. Lockhart

**Members Absent:**

Sen. Peter C. Knudson  
Sen. Mark B. Madsen  
Sen. Ed Mayne  
Rep. Brad L. Dee  
Rep. Patricia W. Jones  
Rep. Bradley G. Last

**Staff Present:**

Allison Morgan, Policy Analyst  
Catherine J. Dupont, Associate General Counsel  
Patricia Owen, Associate General Counsel  
Joy L. Miller, Legislative Secretary

**Note:** A list of others present, copy of related materials, and an audio recording of the meeting can be found at [www.le.utah.gov](http://www.le.utah.gov).

**1. Task Force Business**

Chair Waddoups called the meeting to order at 1:45 p.m. Sen. Mayne, Rep. Jones, and Rep. Last were excused from the meeting.

**MOTION:** Sen. Hickman moved to approve the minutes of the November 29, 2005 meeting. The motion passed unanimously. Rep. Biskupski and Speaker Curtis were absent for the vote.

**2. Hospital Financial Information**

Mr. Gordon Crabtree, Chief Financial Officer, University (University of Utah Hospital and Clinics), presented a brief history of his background and distributed a copy of his presentation. He said 6 percent of the University's patients are uninsured. Approximately 46 percent of its net patient revenue comes from government program patients, which tend to be the low payers in the marketplace, and the remaining 48 percent comes from commercial and employer sponsored plans. He distributed a copy of the University's "Financial Statements and Supplemental Schedules" for 2004 and 2005. He stated that the best financial review is at the corporate level where the data comes from publicly audited financial reports. He discussed the national rating agencies which measure the University's financial strengths and weaknesses in five areas: management, market position, financial performance, debt position, and legal structure. The University is currently rated A1 by Moody's Investor Service. Academic medical centers have a low margin nationally due mainly to the high percentage of government program and uninsured patients, charity care, bad debt, and their large responsibility related to the support of a SOM (School of Medicine).

Mr. Crabtree reviewed the payer mix in the Utah marketplace and the University. He reviewed the 2005 payer increases which were 0 percent for PCN (Primary Care Network) and uninsured, 1.5 percent for Medicaid, 3 percent for Medicare, and 5-7 percent for commercial plans. Labor costs increased 5 percent, drugs 8 percent, and supplies 7 percent. Major teaching hospitals are a safety net for Medicaid

beneficiaries. He discussed charity care and whether it should include bad debt and cited some examples of care that have been provided to uninsured patients at the University. He noted that the amount of total bad debt and charity care provided in 2004 by the University Health Care system was \$39 million. A total of \$23 million was provided for education support. The state currently provides \$4 million for education support. Mr. Crabtree suggested the Legislature implement the following recommendations: 1) restructure Medicaid to fund inflation, 2) equalize charity care, 3) share in the SOM education responsibility, and 4) continue its study of the Utah health care market.

Ms. Kim Wirthlin, Vice President, Government Relations, University of Utah, stated that teaching hospitals tend to have a higher level of tertiary, acute, or specialty care. In order to educate medical students and residents, they must be exposed to the entire spectrum of care. Surrounding states don't have the level of care that individuals can receive in Utah, which is a reason the University receives many transfer patients from other states.

### **3. PCN (Primary Care Network) Hospital Utilization**

Mr. David Gessel, Vice President, Utah Hospitals and Health Systems Association, gave a brief history of how the PCN was established. He distributed "PCN Inpatient Distribution" and "PCN Outpatient Uncompensated Charges FY 2005." Inpatient hospital charges for FY 2004-05 were approximately \$8.5 million. An additional \$5 million of outpatient care has been provided to PCN patients. Some hospitals have given more in charity care than was expected and some have given less than was expected. There is only a half-time person at the DOH (Department of Health) to do case management for the PCN population. He noted that the per member, per month cost has increased from what was originally projected. Almost half of the money for the program is going to pharmaceuticals.

Mr. Nathan Checketts, Director, PCN, DOH, commented that there have been issues over the years regarding distribution of inpatient donations the hospitals have been making, including the equity of distribution of costs. The majority of those costs come from PCN clients going directly to the emergency room for care. As a result, the case manager is not able to direct them to individual hospitals that may have a lower utilization at that time. The overall donation rate of hospitals is about \$10 million. The DOH has formed a work group to consider different aspects of the program to help it go forward. He briefly reviewed the Covered at Work issue. He said they have recently sent notices to parents of CHIP and Medicaid recipients advising them about the program and explaining how they can enroll.

Mr. Crabtree pointed out that the PCN is an important component in delivering care to those without insurance. The DOH is trying to develop a mechanism that allows for an equitable distribution for the cost of PCN.

### **4. IHC (Intermountain Health Care) Capital and Reserves**

Mr. Greg Poulsen, Senior Vice President, IHC (Intermountain Health Care, Inc.), indicated that IHC's financial philosophy is to generate an adequate operating margin to meet community needs. All of the financial margin generated by IHC is returned for community purposes. The goal is not to maximize earnings, but to generate the minimum funding needed to meet future needs. IHC annually projects

building and equipment needs over a 30-year time frame. It has estimated that an operating margin of 3 percent per year is needed. He reviewed rating agency reports of IHC from Standard and Poor's and Moody's Investor Service. Mr. Poulsen pointed out that IHC has over \$1 billion in debt and has an annual payroll of \$1.2 billion.

## **5. Uncompensated Care and Community Benefit**

Mr. Poulsen stated that IHC is mission driven to provide the highest quality health care at the lowest possible cost; outreach services to the medically indigent; and teaching, research, and other community services. He said IHC has always been very careful in accounting for charity care and bad debt separately and distinctly. In 1990 the State Tax Commission set a standard for measuring the value of indigent care to reflect the discounts hospitals would otherwise take. IHC reduced its 2004 charity care total of \$95.2 million by nearly 30 percent to arrive at the value adjusted figure of \$67.3 million. The \$67.3 million figure is what is reported to the communities and included in IHC's annual report. It is estimated that for 2005 IHC will have provided approximately \$80 million of net charity care on a gross level of \$113 million. In 2004 IHC enhanced its charity care policy to better serve the needs of uninsured patients and others that are unable to pay for medical services. In 2005 additional enhancements were incorporated, including applying the same process used for the uninsured to the underinsured. Mr. Poulsen discussed IHC-operated low-income clinics and other supported clinics. IHC also provides medical research, professional education, and other community services. IHC provided \$44.1 million in 2004 for these community benefits in addition to the direct charity care provided in the hospitals.

Mr. Spencer Stokes, MountainStar Healthcare, said they have a three-pronged program when dealing with charity care. Individuals are provided with financial counseling to determine if Medicaid or other government programs would be involved. Charity care is received at 200 percent of the federal poverty level. An uninsured discount plan is provided if the individual does not qualify for charity care. MountainStar Healthcare spent \$8.3 million in charity care and had \$29 million in bad debt in 2004. He pointed out that in 2003 HCA (Hospital Corporation of America), MountainStar's parent company, provided \$3 billion in bad debt and charity care. In response to questions from the Task Force he indicated he did not know how HCA hospitals in Utah compare with HCA hospitals in other states regarding charity care and bad debt but stated he would obtain that information and provide it to the Task Force.

Mr. Ben Cluff, Utah Market Chief Financial Officer, IASIS, explained their charity policy is similar to others regarding the 200 percent of poverty guideline. At that point the individual is entitled to a 100 percent write-off. IASIS does not have a tremendous distinction between charity care and bad debt. All uncompensated care is immediately reviewed and applications screened for government benefits. If the individual does not meet the criteria for those benefits, charity care is provided to them.

## **6. Other Items / Adjourn**

**MOTION:** Sen. Davis moved to adjourn. The motion passed unanimously.

Chair Waddoups adjourned the meeting at 3:55 p.m.