The State Senate

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FINAL REPORT

OF THE

SENATE STUDY COMMITTEE ON

ACCESS TO HEALTHCARE

COMMITTEE MEMBERS:

Thomas E. Price of the 56th, Chairman

Don Balfour of the 9th, Susan W. Cable of the 27th,

Jack Hill of the 4th, Michael S. Meyer von Bremen of the 12th,

Connie Stokes of the 43rd and Nadine Thomas of the 10th

2001

Prepared by the
Office of Senate Research

Creation and Duties

Lieutenant Governor Mark Taylor created the Senate Study Committee on Access to Healthcare. The committee was charged with reviewing and evaluating exclusive provider contracts between hospitals and insurers in addition to various aspects regarding the ability of consumers to gain access to healthcare.

The Lieutenant Governor appointed Senator Don Balfour, Senator Michael Meyer von Bremen, Senator Susan Cable, Senator Jack Hill, Senator Connie Stokes, Senator Nadine Thomas, and Senator Tom Price as committee members, with Senator Price serving as Committee Chair. The legislative staff members assigned to the committee included: Betty Conner, Legislative Assistant to Senator Price; Dodie Lawton, Office of Senate Research; and Sandy Laszlo, Office of Legislative Counsel.

Scope of the Committee

The committee held public meetings in Atlanta on June 5, 2001 and July 10, 2001.

The focus of the committee was on three different areas: Certificate of Need (CON), the Uninsured/Undersinured, and Exclusive Contracts/Access to Healthcare. The purpose of focusing the committee in these specific areas was to provide a foundation of knowledge in order to identify possible specific legislative proposals that may improve Georgians' access to healthcare of the highest quality with the most efficient delivery.

During the two public meetings the committee heard from various people with expertise in the areas of concern. During the first meeting the committee heard from: Russ Toal, former commissioner of the Department of Community Health; William Custer, Ph.D., Georgia State University, Center for Risk Management and Insurance Research; Per Normark, Attorney General's Office; John Oxendine, Insurance Commissioner; and Kelly McCutchin, Georgia Public Policy Foundation. During the second committee meeting, the committee heard from: Mike Boggs, Coliseum Health System; Don Faulk, President and CEO of Medical Center of Central Georgia; Dan Callahan, Pulmonary Specialist; Ann Harvey, Northpoint Pulmonary; Sam Evans, President of Roswell/Alpharetta AARP; John McHenry, Ayres McHenry & Associates, Inc.– pollster/research; Jack Murphy, Small Business Owner; Rich Chaffin, Assistant Administrator for City of Roswell; Dr. John Harvey, North Atlanta Physician; Dr. Mike Bailey, Atlanta Physician; John Holland, CEO of North Fulton Hospital; Dr. Russell Dryer, Emergency Physician; Bob Quattrocchi, Executive Vice President of Northside Hospital; John Werrnick, CEO of Pheobe Putney Hospital; and, Andy Morley, Chief Medical Officer of Georgia First Network,Macon

Summary of Findings

1. Senate Bill 148

Senate Bill 148 was introduced by Senator Price and others during the 2001 General Assembly Regular Session. This legislation would prohibit the renewal, amending or execution of any healthcare services contract between an insurer and any hospital providing obstetric services located in a county where more than five acute hospitals are located, when the distance between the contracting hospital and any other hospital in the county is more than ten miles and thirty minutes driving time, and when that contract has the effect of interfering with a patient's ability to receive or obtain healthcare services from another hospital located within that county that will accept the patient under the same terms as the contracting hospital.

There had been increasing concerns voiced to various members of the committee and Legislature about difficulty people were having in receiving their healthcare at facilities of their choice. Most citizens receive their health insurance policy through a third-party, usually their employer. While this has allowed more individuals to be covered by health insurance, it has had the byproduct of removing the individual patient from most decisions at the time of purchase of the health plan – including any restrictions that might exist. Senate Bill 148 was an attempt to address a very narrow aspect of a larger problem and currently rests with the Senate Insurance and Labor Committee.

2. Certificate of Need (CON)

Georgia's CON law was established in 1979 under Governor Carter in an effort to help contain rising healthcare costs as mandated by the federal government. The State attempts to control costs through CON rules that restrict construction of new healthcare facilities or expansion of existing facilities. State approval must also be obtained to provide certain medical services, including obstetrics.

The objective during the initial implementation of CON was how to contain costs without reducing access to care.[1] There are some studies that demonstrate that CON may have had little effect on reducing healthcare costs. In fact, by restraining competition in healthcare markets, CON regulation may have increased costs and lowered the quality of health.[2] However, others point to evidence of some benefit from the existence of CON laws. Russ Toal, then Commissioner of the Department of Community Health (DCH), testified that CON remains essential to the care of Georgia's uninsured until the state's safety-net hospitals have sufficient funds to cover their uninsured expenses.

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[1] Testimony presented by William Custer, Ph.D., Georgia State University, June 5, 2001.
[2] William Custer, Ph.D., Certificate of Need Regulation and the Health Care Delivery System, (Atlanta: Center for Risk Management and Insurance Research, Georgia State University), iv.

3. Uninsured/Underinsured

The committee heard testimony from the Department of Community Health (DCH) addressing the uninsured in Georgia. The commissioner spoke about the "Business Plan for Health" initiative for the uninsured proposed by DCH. The plan features tax credits for small businesses to insure employees, multiple expansions of current Medicaid and PeachCare programs, and wider coverage for the disabled. The plan is designed to create options to deal with the states estimated 1.3 to 1.5 million uninsured. Almost a fifth of the state's under 65 population has no health insurance, and two thirds of the uninsured are in families headed by full time workers. The percentage of Georgia's uninsured, 19 percent, is about two percent higher than the national average of 17 percent.

There is another group of people also at risk in the healthcare arena – the underinsured. These are people having insurance policies with poor benefits and/or prohibitive out of pocket responsibilities. Testimony was heard highlighting the problem of the state increasing the number of mandates on insurance companies. This has the unintended consequence of decreasing the number of insured due to higher insurance costs. The mandates may increase benefits, but in turn they lower the number of people covered by insurance as either the individual or employer determines they are no longer able to afford to purchase health insurance.

4. Exclusive Contracts/Access

The majority of hospitals and physicians in Georgia participate in managed care networks, contracting with multiple different plans. One of the primary objectives of managed care organizations (MCO) has been to increase the efficiency of healthcare delivery. Both hospitals and physicians have participated in exclusive contracts with one or more MCO's in an effort to ensure a predictable revenue stream. The existence of these types of contracts is usually without the knowledge of the insured (the patient).

It was brought to the committee's attention that some Georgia hospitals participate in exclusive contracts with insurers to exclude other neighboring hospitals from managed care networks in exchange for lower prices. Opponents of exclusive contracts argue that these strategies obstruct patient choice and force many patients into long commute times and dangerously long waits for surgical procedures because closer hospitals were excluded from their managed care networks. In addition, the committee heard testimony from numerous consumers about excessive waiting periods for treatment, overcrowded emergency rooms, and bed shortages at hospitals that participated in exclusive contracts.

The quality of information patients receive about their healthcare plan allows them to make informed choices about their healthcare options.

The committee believes that more information should be given to insured about their healthcare policies. This may result in positive changes being made in policies from input by individuals.

The committee's work on this area was somewhat truncated by the decision of a major metro area Atlanta hospital to end any exclusionary contracts with insurers. Insurers will be asked to amend their existing contracts and the hospital will re-examine insurers' patient volume commitments and other issues. If new contracts between hospitals and insurers eliminate discounts offered in exchange for patient volume, there could be an impact on healthcare premiums paid by businesses and consumers.

Committee Recommendations and Findings

1. In light of the committee's findings and recent developments, it is the recommendation of the committee that legislation be introduced into the General Assembly regarding information disclosure to enrollees and prospective enrollees of health insurance plans.

The proposed legislation would add a stipulation to current disclosure requirements that any licensed managed care plan in Georgia must obtain a signed Affirmative Consent form from each enrollee at the time of enrollment and at least annually thereafter acknowledging that the enrollee has been informed of and accepts the following:

a. The number, mix, and distribution of participating providers available to the enrollee. An enrollee or a prospective enrollee will be entitled to a list of individual participating providers, and the list of individual participating providers must also be updated at least every 30 days and may be published on the Internet service site made available by the managed care entity at no cost to the enrollee;

b. The existence of limitations and disclosure of such limitations on choices of healthcare provider; and,

c. A summary of any agreements or contracts between the managed care plan and any healthcare provider or hospital as they pertain to O.C.G.A. §33-20A-6 and 33-20A-7. Such summary will not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any healthcare provider or hospital; however, it may include a disclosure of the category or type of compensation (capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise) paid by the managed care plan to each class of healthcare provider or hospital under contract with the managed care plan.

This language is identical to that already in existing law regarding information that an individual may request from the managed care plan. The difference with these changes would be that the insurer would be required to inform the enrollee or prospective enrollee of the above information. The committee feels that this may begin the process of increasing awareness on the part of the public and allow for greater feedback to the insurers from the insured regarding their concerns.

2. The committee further believes that there are some issues relating to CON that should be addressed in the near future. These include some of the restrictions on improvement to facilities that would not directly affect the provision of healthcare, however may prevent providers from instituting essential improvements. For example, parking facilities around medical buildings are currently included in CON financial determinations and have no direct bearing on healthcare, only ease of access or efficiency. Any such legislation would be difficult in the current environment as there is a reluctance to open up 'Pandora's Box'.

3. The committee wishes to commend the Department of Community Health for it's work in the area of the uninsured and underinsured. Many of their proposals in the 'Business Plan for Health' have merit and will be addressed by the General Assembly this next session.

Respectfully Submitted,

Senator Thomas E. Price - Chairman
District 56

Senator Don Balfour
District 9

Senator Susan Cable
District 7

Senator Jack Hill
District 4

Senator Michael S. Meyer von Bremen
District 12

Senator Connie Stokes
District 43

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District 10