Indiana Rep. Tim Brown

Physician ran for legislature 20 years ago with goal of shaping health policy, and has since emerged as key leader on tax policy

by Kate Tormey (ktormey@csg.org)

Dr. Tim Brown had long considered running for public office.

But in the beginning, he didn't imagine it would be at the state level — in part because of his passion for health policy.

"I would have said you were crazy if you thought I would run for state representative," he says. "I thought, 'It doesn't pay very well, it takes up a lot of your time, and all of the action is at the federal level. Why not just run for Congress?' "

But things began to change in the late 1980s, he recalls, and so did his thinking about the impact he could have in the Indiana legislature.

More and more decisions were being left up to the states, which, in turn, were becoming laboratories of policy reform.

Brown, a doctor in central Indiana, began testifying at the Indiana Statehouse as part of a nationwide conversation about health care reform. And he soon saw a way to contribute to his state.

"No one [in the legislature] had a clue about what it was like to be on the front lines of delivering care and how it affects people on a day-to-day basis," Brown says. So he decided to bring that perspective to the legislature, successfully running as the Republican candidate for an open House seat in 1994.

He lives in Crawfordsville, about an hour west of Indianapolis. Raised in rural Illinois, Brown eventually settled in Indiana to practice after medical school. He is board certified in family medicine and currently works in the emergency department of a small critical-access hospital.

"One of the things that physicians are taught early on is listening and trying to empathize through reflective questioning," he says. "That is part of the skill set I also use as a legislator: putting myself in other people's shoes."

In addition to his longtime work on health care policy, Brown serves as chair of the House Ways and Means Committee. Since taking that leadership post, Brown has had two goals: balance the budget and adjourn on time. (Both were accomplished in 2013.) This year, during an off-budget year in Indiana's biennial cycle, the committee focused on resolving concerns about a property tax on business equipment.

CSG Midwest spoke with Brown about the recent legislative session and his 20-year tenure in the House. Here are some excerpts from the interview.

Q: Can you talk about the legislation that was passed this year regarding equipment taxes for businesses?

A: In Indiana, we tax businesses' "personal property" and have a very convoluted schedule about how we depreciate it, and whether local governments can abate it. If you look at some of the studies, we were falling behind the rest of the country in competitiveness on this tax. ...

In Indiana, it affects different counties at varying levels. Revenue [from the tax] is used for local expenditures at the city and county level. We have some counties where 1 or 1 ½ percent of their budget is from it, and for others, it is 30 percent.

So we started looking at an example in Vermont, which in 1992 started a local option. We made it such in Indiana: It would be up to the local governments to decide [whether to] eliminate this tax for new investment in business property. It won't change for existing businesses, and some said that was part of the downside — if you have a business that's been here for 80 years, you are penalizing them. But if they bring in new equipment, they will have the same advantage as a new business coming in.

Bio-sketch: Dr. Brown

- ✓ first elected to Indiana House in 1994; now serving his 10th term
- ✓ current chair of the Ways and Means Committee
- ✓ represents west central Indiana
- ✓ is a physician who practices emergency medicine at a critical-access hospital in Crawfordsville
- ✓ has four daughters with his wife, Jane

Q: What is your take on the federal Affordable Care Act as a way to solve the nation's health care challenges?

A: I think it is going to be very difficult for a centralized, top-down solution to work, because health care is so individual and unique to every situation.

Medicaid, by definition, is very dysfunctional; providers don't like it, patients don't like it, and it's a bureaucratic nightmare and headache. … My opinion is that we are taking a very dysfunctional system and making it bigger and more dysfunctional. That is, in essence, what we have done during my time in the legislature; we have tweaked the rules of Medicaid. Fundamentally, I think there needs to be reform to Medicaid.

Q: You were instrumental in helping create the Healthy Indiana Plan, which is a public-health program operated under a federal Medicaid waiver. What is the goal of the program?

A: There are three basic tenets [in the plan] that speak to the idea of individual ownership. There are some premium copayments — even as little as $10 a month. We have statistics showing that in Indiana, if you even had a $10-a-month premium payment, that your utilization of the emergency room went down by at least 16 percent versus those who had no copayment.

It also offers a POWER account, which is what you pay into with the $10 a month, similar to a health savings account. … It rolls over from year to year, so if you are sick one year, it is there for your use — but if you are healthy and do the right things, it rolls over for you and helps pay for your expenses next year.

And the preventive services that are covered [under the Healthy Indiana Plan] are not charged to your POWER account [which encourages beneficiaries to get checkups and screenings]. …

The Healthy Indiana Plan was created with a Medicaid waiver, so in a way it's making Medicaid "bigger and more dysfunctional" — but at least we are putting some consumer [responsibility] into it.

Q: You consider legislation regarding long-term-care insurance one of your most important accomplishments. Can you explain your bill?

A: I worked on long-term-care insurance reform in a couple of bills, which I hope is a first step to getting people interested in long-term health care insurance. We started out in Indiana where you could have what's called "dollar-for-dollar asset protection" if you had long-term-care insurance. For example, you could have a $100,000 policy, and so you could have $100,000 protected and go to your heirs. In other words, if your policy was used up, you would then go onto Medicaid for long-term care, but because you had that policy, some of your assets would be protected.

We passed legislation saying that if you had four years of long-term-care coverage, you could have 100 percent of your assets protected and go to your heirs, and you could go on Medicaid. On average, the length of stay in a long-term-care facility is less than three years, so only about one-third of the population would ever qualify for that provision, which is how it would be to the state's benefit actuarially.

Q: What would be your top reform on the path to reducing health care costs?

A: In health care, a small percentage of the patients account for a lion's share of the costs. … At our children's hospital in Indianapolis, 5 percent of the cases account for 85 percent of the costs. We had a mental health center in Bloomington cite the same statistics. So if we could manage and control that 5 to 10 percent of cases — [which lead to] 85 to 90 percent of the costs — in a highly integrated management system that is a public-private partnership, we could leave the other 90 percent of the people alone and start to bend this cost curve.

Last year, I introduced a bill to look at a case-management system for this high-cost population. The Insurance Committee evaluated it and it's going to be studied this summer. I think there is an opportunity here for states to be the laboratories of innovation and change; let us look at high-utilizing, very sick people. If we could get them to the right person to get the right treatment when they need it, I think we could give better, more cost-efficient care. Meanwhile, we are creating all kinds of rules and regulations for the other 90 percent [of patients], when we could [instead] be focusing on this 10 percent and do a much better job.