AFT Connecticut
A Union of Professionals

Testimony of
Melodie Peters, President
AFT Connecticut

Public Health Committee Public Hearing
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SB 811 An act Concerning Parity in Hospital Sales Oversight

SB 916 An Act Concerning Hospital Conversions

HB 6938 An Act Concerning the Delivery of Quality Health Care and Modernization of Health Care Facilities

SB 954 An Act Concerning Transparency of Executive Pay in Certain Hospital Transactions

Good afternoon Senator Gerratana, Representative Ritter and members of the Public Health Committee. My name is Melodie Peters and I am the President of AFT Connecticut, a diverse union of 30,000 members. We are proud to represent approximately 7,000 healthcare workers in 10 acute care hospitals across the state. It is on their behalf that I am here to testify.

Our healthcare landscape is rapidly changing. The Affordable Care Act, increased reliance on expensive technology, economies of scale and profit-taking opportunities have spurred the growth of large multi-state for-profit healthcare corporations. These corporations have set their sights on Connecticut hospitals, while large in-state non-profit hospital systems also seek to expand.

How will these changes affect Connecticut's patients, communities and workers? Will the quality of healthcare be enhanced and will Connecticut's residents continue to receive high quality, affordable and secure care, or will profitability and the bottom line drive healthcare decisions?

Connecticut's statutes are largely vague and inadequate to protect citizens from the impacts hospital conversions can create. Despite a lack of clear standards, the Office of Health Care Access (OHCA) managed to develop a responsible path forward last year. Yet they were widely denounced as rogue regulators. Nothing could be further from the truth.

We applaud the diligent and thoughtful work the OHCA did when evaluating Tenet Healthcare Corporation's proposed purchase of Waterbury Hospital. Its interim decision was responsible and reflected OHCA's mission, to protect access to quality healthcare for all of Connecticut's citizens. We were disappointed when Tenet executives withdrew their application, rather than continue discussion on these significant issues. Their actions were unfortunate, but they should not cause us to abandon the principles that guide us or the needs of patients, communities and healthcare workers.

Further guidance in statute on all types of hospital conversions (profit or non-profit) would provide further direction to OHCA and would make the standards clear to any prospective acquiror upfront. There would be no surprises for contracting parties or for healthcare consumers.

SB 811 and SB 916

Taken together, SB 811 and SB 916 strike a balance between protecting the concerns of patients, communities and healthcare professionals while allowing hospitals to pursue conversion options. AFT Connecticut supports these bills.

SB 811 creates consistency in hospital conversion processes by requiring the same criteria to be applied to all types of hospital sales. We agree that all sales should be evaluated according to the same expressly defined standards and that the failure to execute a sale should also be an important consideration.

SB 916 strengthens the hospital conversion statute by expanding the role of the Attorney General, improving transparency and providing safeguards for the community. It provides the expressly defined standards needed to equally evaluate all hospital sales as required by SB 811.

SB 916 requires the transacting parties, whether for-profit and non-profit or all non-profit, to be fully transparent in all of their conversion dealings. It is a responsible approach that gives the Attorney General and the Department of Public Health the full complement of information needed for review and would allow them to best represent the interests of the state when making his determinations.

This enhanced process allows for reasonable timelines with extensions when warranted. It also establishes a much needed expedited review process for certain non-profit conversions, especially in cases where one transacting party is a distressed hospital facing significant financial hardship.

Also included in SB 916 is a key component of OHCA's interim decision on the Tenet-Waterbury conversion application – the requirement of an independent health care access monitor. This individual would serve the vital role of liaison between the new hospital, the Attorney General and the Department of Public Health during the five years following a conversion approval. The independent monitor would report on how faithfully the conversion is being implemented with particular attention paid to the levels of uncompensated care and community benefits delivered by the new hospital. It is a model that was included in the Sharon Hospital agreement and should be afforded to all communities whose hospitals are undergoing conversion.

With your indulgence, I have included proposed language to further strengthen some of the definitions in Section 1 of SB 916. They include an expansion of the term "community benefit" in order to fully protect access to patient care, an addition to the term "conversion" to include non-profit to non-profit conversions, a more comprehensive definition of "uncompensated care" and a definition of "bad debt."

> Sec. 1. Section 19a-486 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):
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> *(9) "**Community benefit**" means the provision of direct and preventive hospital services and protections for the community and hospital employees that meet the ongoing needs of the community for primary and emergency care in a manner that enables members of the community to maintain a relationship with a family member or other person who is hospitalized or receiving hospital services and shall include ~~s~~ from the time of any hospital ownership change or collaboration, but is not limited to, maintaining or increasing patient care, staffing ratios, charity care and uncompensated care, maintaining or increasing spending on public health and community outreach programs, a baseline community needs assessment by an independent evaluator and ongoing biennial reporting online, using data from the department of public health's health impact studies and other resources to identify appropriate care levels and needs, the progress of community benefit efforts, including those required by statute and local community benefit agreements.*

*(10) "**Conversion**" means any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, holds or owns, in the aggregate, ten percent or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital; or any change in ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which moves a service provided by or assets held by the hospital or healthcare facility to another entity, shadow entity, alter ego corporation or any other structure that has any impact on tax or employment issues.*

*(13) "**Uncompensated care**" ~~has the same meaning as in section 19a-659.~~ means the total amount of charity care, bad debt, and less than full Medicaid reimbursement amounts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which are on file at the office of healthcare access.*

(14) "Bad debt" is the cost of services provided by a hospital for which it bills but does not collect.

Part of community responsibility is paying taxes. For-profit hospitals can and should pay property taxes, but they should do more than what Section 11 in SB 916 requires, which is for the for-profit hospital to reimburse the municipality for PILOT grants it would have received for real property owned by the former non-profit hospital during the transition year. We suggest that for-profit hospitals, should pay municipal property taxes on the fully assessed value of their real property and they should not be eligible for any tax credits or abatements in all future years and urge you to adopt the proposed language below:

Sec. 11. (NEW) (Effective October 1, 2015) When a for-profit corporation and a nonprofit hospital are transacting parties to a conversion that is approved by the Attorney General and the Commissioner of Public Health pursuant to sections 19a-486a to 19a-486h, inclusive, of the general statutes, as amended by this act, and the Attorney General and the commissioner approve the conversion during a municipality's assessment year, the purchaser that is a for-profit corporation shall reimburse the municipality in which the new hospital is located for grants in lieu of taxes, as provided in section 12-20a of the general statutes that the municipality would have received for real property formerly owned by the nonprofit hospital except for such conversion for the portion of the year that the hospital conversion has been completed. In future assessment years, municipalities shall not be eligible to receive grants in lieu of taxes as specified in section 12-20a with respect to real property owned wholly or in part by for-profit hospitals, clinics or outpatient facilities. For-profit hospitals and health systems shall pay property taxes on the fully assessed value of all real property to the municipalities in which those facilities are located and shall not be eligible for any tax subsidies, abatements or other reductions in any tax levied at the state or municipal level.

HB 6938

This bill attempts to address some of the underlying needs for struggling hospitals. Throughout the last 24 months we have heard these hospitals express their frustration at their inability to access much needed capital. I was the reason most cited for their desire to merge with out-of-state for-profit healthcare corporations. Rather than sending a distress call to another hospital or hospital system to

rescue them, HB 6938 may provide real solutions that financially unstable hospitals can utilize to improve their own circumstances. Requiring the Department of Economic and Community Development (DECD) and the Connecticut Health and Educational Facilities Authority (CHEFA) to consider financing options for hospitals to acquire equipment, update technology and renovate or build facilities is a smart, overdue move.

Studying the feasibility for hospitals to purchase prescription drugs with the leverage of the Comptroller's buying power and engage in other group purchasing contracts that are currently only available to state and municipal government is another worthy proposal. Such avenues may yield even greater savings than those currently achieved by the Value Care Alliance.

We support HB 6938.

SB 954

The Governor's SB 954 adds further transparency to the provisions outlined SB 811 and SB 916 and adds another lens through which to review in hospital conversions. By requiring applicants to disclose the positions and all types of compensation provided to officers, board members or managers who are a party to the transaction, it sheds an important light on motivations for conversion.

We suggest that this measure go further and require that compensation for all hospital CEOs and other top earners should be made clearly transparent. While hospitals urge the General Assembly to abolish the hospital tax and improve Medicaid reimbursement rates, they have cut frontline caregivers and ancillary staff. At the same time, CEO wages are astronomically high and appear to have no link whatsoever to patient or hospital outcomes. In addition, there appears to be no consolidated reporting that discloses how much some administrators earn as both CEO of a hospital and a health system.

Other states, facing similar budget constraints, have begun these discussions on excessive hospital executive compensation and the impact they have on healthcare delivery. We urge this committee to consider similarly creative efforts that would provide enhanced transparency and allow the state to allocate scarce dollars in a manner that benefits patients most.

- **OREGON**
  - SB 330 is currently being proposed and would require nonprofit hospitals to utilize a payment formula for executive compensation that is publically reported and has civil penalties if violated.

  - Initiative 39 was a proposed 2014 ballot measure that would have capped nonprofit hospital executives' annual compensation at fifteen times the wage of the lowest paid hospital employee. Contributions to executive pay would be limited if the hospital were part of a larger "parent corporation, health system, or combination of hospitals under shared services agreement.

- **MAINE**
  H.21 was proposed in 2011 and prevented the annual salary and compensation package of hospital administrators from exceeding the annual salary of the Governor. Hospitals applying for a license or license renewal would have had to certify that administrators' salaries complied with the above limitation.

- **MASSACHUSETTS**
  A proposed ballot initiative sought to limit hospital CEO compensation at 100 times the lowest paid employee and to limit excessive hospital operating margins to 8 percent. Civil penalties associated with any violations would have been imposed and would have gone into a Medicaid Reimbursement Enhancement Fund.

- **CALIFORNIA**
  A proposed 2013 initiative would have limited annual compensation at $450,000 for CEOs, executives, managers and administrators of nonprofit hospitals and affiliated entities. It gave the Attorney General power to investigate and impose civil penalties for violations of the statutes.

We would also like to bring to your attention a 2010 study that looked at the high rate of hospital CEO pay in Connecticut and its relationship to the CEO's performance at the hospital (Jeffrey Kramer, Rexford E Santerre, "Non-for-profit Hospital CEO performance and Pay: Some Evidence from Connecticut," Inquiry August 1, 2010). The authors found that higher CEO pay was associated with the admission of higher paying, privately insured patients, sometimes at the expense of charity care. The study suggests that disclosing or capping CEO compensation could be a useful way to encourage CEOs to refocus on their nonprofit missions.

Thank you for the opportunity to testify before you today. By supporting SB 811, SB 916, HB 6938 and SB 954, we are not just speaking out for ourselves as healthcare professionals, but for our patients, their families and our communities. We want our hospitals to be financially strong, but also responsible. Taken as a package, these four bills will significantly move us in that direction. Thank you.