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Testimony of Laurie Kennington, Bob Proto and Sue Silvestro regarding Proposed Senate Bills 813, "An Act Concerning Health Care Price, Cost and Quality Transparency," SB 809, "An Act Concerning Facility Fees," SB 810, "An Act Concerning Provider Price Variation and Reform," and SB 815, "An Act Concerning Health Care Policy and Cost Containment. Before the Connecticut General Assembly Committee on Public Health, March 10, 2015

Good Morning Senator Gerratana, Representative Ritter and members of the Committee

We are Presidents of UNITE HERE Locals 34, 35 and 217, here on behalf of the 7,000 members of UNITE HERE in Connecticut and their families, including 900 health care workers at the Yale University School of Medicine's clinical practices. Thank you for your attention to this vital issue.

We offer this testimony because of our deep concern that hospital monopolies will raise health care costs and make quality improvement more difficult. This is particularly urgent for Local urge the General Assembly to take vigorous action to confront the single most powerful threat to the success of health care reform: the growth of provider monopolies.

Federal law encourages price competition between health insurance plans as a systemic cost control measure. Yet at the same time, federal policy is pushing providers to combine into Accountable Care Organizations, and Medicare regulations make it far more profitable for physicians to be employees of hospitals than run independent practices. This has stimulated rapid consolidation in the health care industry, and undermines the possibility of insurance competition creating real systemic cost control.

Monopolies in health care, as in virtually every other industry, invariably lead to market distorting prices. When hospitals in close proximity in already concentrated markets merge, prices go up by more than 20%. Courts and policymakers have begun at last to confront the breathtaking pace of health care monopoly formation:

- In Massachusetts, a Superior Court Judge recently rejected a proposed consent agreement with Partners HealthCare over its proposed purchase of South Shore Hospital. The proposed agreement included 7 years of hard price caps, but the new state Attorney General believes that Partners' existing market power has created monopoly prices and cannot be allowed to grow.
- The Federal 9th Circuit Court of Appeals recently upheld a District Court judge's ruling blocking the acquisition of Idaho's largest group medical practice by the state's largest hospital.

The Committee must understand that market circumstances in Connecticut demand immediate urgent action. Possible health care monopoly does not pose a theoretical future threat to health care cost and access. In southern Connecticut, health care monopoly is already here. Right now. In 2012 when Yale-New Haven Hospital was taking over the Hospital of St. Raphael, our union obtained general acute inpatient care discharge data for all Connecticut hospitals from the Office of Health Care Access, showing how many residents from each town in the state had received care at each hospital. The results were sobering to those who negotiate health care prices for our members in Connecticut:

- For New Haven and 10 surrounding towns – an area with a population of more than 400,000 people – 94% of all discharges were from what was about to become the newly merged Yale-New Haven Health Services Corporation.
- At a 25 minute driving radius from Yale-New Haven and St. Raphael's, we found market concentrations higher than those that had caused the federal government to intervene to stop a merger in Ohio on anti-trust grounds.

And that's just for inpatient care. The events since the Yale-New Haven takeover are well known. In the past three years, Connecticut hospitals have gobbled up physician practices in large numbers, with Yale-New Haven showing a special urgency. In its 2011 annual report, Yale-New Haven Health Services Corporation reported that Northeast Medical Group, Yale-New Haven's medical foundation had:

“completed its first year of operation, and expanded its membership to more than 350 physicians, representing 40 practices”

In Yale-New Haven's filing of its Group Practice data for 2014, newly required under Public Law 14-168, NEMG had 555 physicians. Two months later, its website boasts of “Strength in Numbers” through “100+ Physician practices,” with “600+ Medical Experts.”

Of course, Yale-New Haven is not alone – Hartford Hospital has also gained market power in the northern half of the state, and hospitals of all sizes are seeking to control doctors' practices.

Without systemic oversight by the State of Connecticut, the consequences are inevitable. We will hear a great deal about how hard hospital/physician conglomerates are working to “control cost.” What that really means is that their high prices will force patients to do without care, especially as employers try to control premiums by heap ever-increasing cost-sharing onto patients

We strongly support the vision embodied in SB 815 – the establishment of a permanent health care policy and cost containment agency similar to the Massachusetts Health Policy Commission or the Maryland . The Commission would collect and disseminate quality and cost data, set statewide cost growth benchmarks, and provide crucial policy guidance. The HPC's analysis of the proposed Partners/South Shore merger lent enormous credibility to the opposition.

Obviously, there is work to do to flesh out the vision. Such an agency should have the resources and authority to set statewide cost benchmarks, monitor compliance and issue escalating sanctions when organizations fail to hit those benchmarks. Those sanctions should include the power to set and regulate rates when market forces fail.

Regardless what else happens on health care policy this session, the General Assembly must require hospitals and other providers to make their outcomes data and prices fully transparent to the public. Imagine walking into a drug store and because of who you are, you pay 65 cents for a candy bar, while your neighbor pays 45 cents for the same candy bar at the same store, a friend from across town has to pay a dollar and a quarter and your boss gets to pay a dime. Same candy bar. Same store. And none of you know what the other is paying!

That, with no exaggeration, is how health care pricing works. Hospitals and payers negotiate their pricing structures by contract, in secret, and consumers simply pay their portion. Now, imagine that the drug store in question is the only place within 30 miles where you can buy your favorite candy bar, and it's virtually impossible to build another drug store. There are no meaningful market forces in play. All the power rests with the seller.

Our union has worked hard to empower our members to control their own health and costs through intensive wellness programs and education about the difference in costs between the Emergency Room and other sites of service. But in the end the ability of individual consumers to affect the market through individual choice is very limited. By the time a patient seeks health care, the prices are set and her out of pocket costs are already negotiated between her employer and insurer. And in Southern Connecticut, for many services, there is only one provider realistically available.

For price transparency to have real value, institutional purchasers like public and private employers, health plans and policymakers must also have the data they need to negotiate tough price bargains with hospitals. That starts with full transparency. We urge the committee to clarify Section 38a-1091 and SB 813 to ensure that prices will be published not by payer category, but by individual payer, so everyone knows what everyone else is paying.

Moreover, the data must be presented in a form that allows the people who make institutional health care purchasing decisions to view the market as a whole. Massachusetts has begun publishing prices by service by payer, but at the moment they can only be accessed at the level of an individual encounter. That's not good enough.

It's long past time to bring health care prices all the way into the sunshine.

Finally, the most egregious example of monopolistic price gouging is the imposition of so-called "facility fees" when hospitals buy up physician practices. A loophole in Medicare regulations allows hospitals to charge far more for the same care delivered by the same professionals at the same office once they change the sign on the door. Sooner or later the federal government is going to close what its own advisory panel acknowledges is a costly loophole. Connecticut shouldn't wait, we should pass SB 809 to begin the process of equalizing payments in what are essentially the same settings.