Connecticut Health Policy Project

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TESTIMONY to the Insurance and Real Estate Committee
March 18, 2021

RE: Support for SB-1044, An Act Establishing a Task Force to Study Insurance and Health Care in this State, and for SB-1051, An Act Establishing a Task Force to Study Medical Practice Ownership Models.
Ellen Andrews, PhD, Executive Director

Thank you for the opportunity to share our support for these very important bills. These are important issues with profound implications for healthcare in Connecticut. They need deep, focused study to measure the impact of changing market forces and make recommendations to protect consumers. For twenty-one years, the CT Health Policy Project has worked to expand access to high quality, affordable healthcare for every state resident. We are a nonpartisan, nonprofit organization that advocates through detailed analysis of policy options to improve the health of our state.

One of the main drivers of rising healthcare costs is consolidation in the healthcare market. Consolidation is complex and it's getting worse. Connecticut's hospital markets are among the most consolidated in the US. A recent study found that all of Connecticut's hospital markets are consolidated. New Haven's hospital market ranked highly concentrated, 36th most concentrated among 112 local US areas. There is also growing concentration in Connecticut's physician market. Another recent study found that the percent of physicians affiliated with large health systems grew between 2016 and 2018 in every area of the state.

The trend toward consolidation is accelerating because of the pressures and economics caused by the pandemic. But the trend began years before COVID. Small practices and independent hospitals have difficulty affording the resources to comply with administrative burdens of payment and delivery reforms and are not large enough to take on the financial risks of new payment models.

There is considerable evidence that provider consolidation drives up prices for healthcare without improving quality. The costs are then passed onto consumers in higher premiums, lost wages, higher taxes, and more cost sharing.

While Connecticut has adopted some measures to promote competition in the marketplace, it isn't enough. In the last four years, of the 74 total Certificate of Need application decisions, the Office of Health Strategy (OHS) has approved all but three. Connecticut is not exempt from regulatory capture and revolving doors that undermine independent regulation. We also cannot rely on litigation to ensure competitive markets. Litigation requires that attorneys know about anti-competitive mergers, require strong evidence of harm, are expensive, take years, and only resolve the single case. Connecticut's healthcare market is already so consolidated that legislation and legislative oversight are needed to protect and encourage competition.

There are several legislative options to improve the competitiveness of Connecticut's healthcare market. Other states have adopted many of these options. It makes sense to convene a task force to consider them.

Anti-competitive provider-payer contract clauses

All-or-nothing clauses are used by health systems dominant in one market to leverage that clout to reduce competition across all their markets. With all-or-nothing clauses, the health system requires that if insurers want to include a "must have" provider from one market they must contract with all their affiliated providers in other markets, regardless of quality or cost. "Must have" providers may be critical to building a sufficient panel because they are the only one in the area, because of their reputation, or another reason. Network adequacy laws can contribute to this problem. All-or-nothing contracts often include nondisclosure provisions, so it is hard to connect them to market failures and higher prices. Massachusetts has prohibited all-or-nothing clauses for some plans and six other states are considering legislation.

Exclusive contracting requires insurers to only contract for certain services from one network of providers, excluding any of their competitors. This can make it impossible for other payers to assemble an adequate network of providers. Hospitals often do this with specialty groups, i.e., anesthesiologists, radiologists, pathologists, ER physicians – so those providers can only provide services at one hospital. Some states have addressed these contract provisions under general regulation of trade laws.

Anti-tiering or anti-steering clauses are used by dominant health systems requiring that they be placed in the least restrictive tier for consumers regardless of their quality or cost performance. Better provider tiers offer consumers lower cost sharing and are meant to reward provider groups who provide better quality or better prices. A recent study found members in plans with tiered networks had 5% lower costs than other plans. Connecticut's state employee plan is now implementing tiers. Gag clauses (below) prohibit consumers from finding out that they are being steered to lower quality and/or higher cost providers for financial reasons. Massachusetts restricts these contract provisions in law and a lawsuit is pending in South Carolina. Five other states are considering legislation

Gag clauses, also called price secrecy provisions, prohibit providers from disclosing price or other contract provisions to anyone, including consumers and other payers. It is important to note that prices are not trade secrets; there is no legal bar to sharing them. Gag clauses prevent the public and policymakers from getting all the information needed to make better purchasing decisions. They can serve to shield the impact of other anti-competitive contract clauses, making it more difficult to protect consumers and payers. Gag clauses also undermine patient trust in providers. Five states prohibit gag clauses in some circumstances, including Connecticut. A task force should determine if the legal protections are sufficient and if public disclosure of prices should be expanded.

Noncompete clauses for provider contracts with health systems, also called restrictive covenants, are allowed under Connecticut law for "legitimate business purposes". These provisions tie providers to a health system, reducing competition in the marketplace. As they usually include higher compensation or other benefits extending into the future, they raise healthcare prices. The American College of Physicians and the American Medical Association recommend "that physicians should not sign contracts with restrictive covenants that "(a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician."

Regulatory options to promote competition

There are many options to improve regulatory review and approval of healthcare mergers and acquisitions. The state should require OHS notification and approval for all proposed mergers and acquisitions regardless of size including economic and financial information on the transaction. Multi-agency approval should be required for significant transactions to include DPH, AG, CID, and OHS. The review should include the impact on prices, volume of care, impact on market competitiveness, self-dealing and conflicts of interest, access to care, quality implications, referral patterns, consumer choice, community benefits, impact on underserved communities, health disparities, and the impact on the state and local budgets and local economies. Reviews should include sufficient time for public notice and comment, solicit comment from affected communities, and other providers in the market. Any presumption for approval should be removed from the law.

Too often mergers are approved with promises of better outcomes, but there is no follow up to ensure things improve or to monitor for unintended consequences. Even if harm is identified, it is too late to do anything about it. Merger approvals should include enforceable conditions on the mergers, as necessary, to address potential harms identified in the review. The conditions should be developed with extensive public input and feedback on consequences. Written responses should be provided to all commenters and available to the public, as in the federal rule making process. Conditions on merger approvals must come with automatic consequences if they are not met, potentially to include dissolution of the merger. It should require legislative action to modify or remove the consequences.

Significant mergers should require post-merger evaluations of impact on prices, volume of care, market competitiveness, self-dealing and conflicted interests, access, quality, referral pattern changes, consumer choice, community benefits, impact on underserved communities, health disparities and the impact on the state and local budgets and local economies. Evaluations should be conducted by an independent monitor, chosen by the state, not by the health system. There must be full public disclosure of the evaluation process and it should be subject to Freedom of Information laws as happens in other states, to include compliance reports, health system responses, and improvement plans.

Other policy options to preserve competition

As mentioned earlier, new payment reforms carry incentives for provider consolidation. In fact, the Accountable Care Organization model (ACO) promoted by Medicare and others, relies on consolidating providers into large health systems to save money. Despite years and significant investments promoting the model, there is little evidence that ACOs either save money or improve the quality of care. Despite this failure, payers continue to promote the model.

The state can mitigate at least one anti-competitive consequence of payment model consolidation. *In-network referral requirements* in provider/health system contracts are designed for "leakage control". The intention is to keep patients from getting care outside the network, retain revenue, regardless of the quality of care or patients' needs. The American College of Physicians opposes these contract provisions because "employment contracts should not restrict physicians' actions to promote patients' best interests."

Private equity ownership of provider groups and hospitals is growing, often with unfortunate consequences. According to the American College of Physicians, "Typically, private equity firms purchase a large stake in a physician practice, invest resources to expand market share, increase revenue (for example, by adding services), decrease costs, and then sell the practice within a few years to generate returns for the firm's investors. The practice may be sold to another private equity firm, a large health care conglomerate, the public via an initial public offering, or an insurance company. This desire to sell the practice soon after acquisition can create the incentive to sell off parts of the practice or undertake drastic short-term cost-cutting measures, including staff layoffs, to make a potential sale more attractive. Insurance companies may further narrow their networks or restrict patient access to only their employed physicians." These practices clearly weaken existing healthcare institutions, reducing competition and driving up prices at remaining health systems. The state must monitor these transactions for harmful, anti-competitive business practices and taking action to preserve the market.

Price transparency can promote competitive markets. When employers and payers can compare prices across health care systems and providers, combined with quality information, they can make better decisions about value. Transparency gives employers and payers the ability to use price information to design high-value networks and to negotiate with providers on behalf of consumers. In addition, disclosure of high prices that are not linked to quality can raise public pressure to drive down rates and promote a competitive market. This has happened in Massachusetts and New Hampshire.

In sum, Connecticut's healthcare markets are increasingly consolidated and less competitive driving up prices and premiums. Both the causes and policy remedies are complex and risk unintended consequences. The problem needs thoughtful public study and discussion in a task force of independent minds with diverse perspectives to find the best policy options to make healthcare more affordable. I urge you to support these two bills.