

COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE
HEARING

STATE CAPITOL
IRVIS OFFICE BUILDING
ROOM G-50
HARRISBURG, PENNSYLVANIA

WEDNESDAY, JUNE 10, 2015
9:05 A.M.

PRESENTATION ON
CERTIFICATE OF NEED

BEFORE:

HONORABLE MATTHEW E. BAKER, MAJORITY CHAIRMAN
HONORABLE FLORINDO J. FABRIZIO, MINORITY CHAIRMAN
HONORABLE BECKY CORBIN
HONORABLE MARCIA M. HAHN
HONORABLE AARON D. KAUFER
HONORABLE TIMOTHY KRIEGER
HONORABLE HARRY LEWIS, JR.
HONORABLE KRISTIN LEE PHILLIPS-HILL
HONORABLE PAUL SCHEMEL
HONORABLE JUDITH WARD
HONORABLE MARY JO DALEY
HONORABLE PAMELA A. DeLISSIO
HONORABLE GERALD J. MULLERY
HONORABLE MICHAEL H. O'BRIEN
HONORABLE MIKE H. SCHLOSSBERG

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ALSO IN ATTENDANCE:

WHITNEY KROSSE, REPUBLICAN EXECUTIVE DIRECTOR
NICOLE SIDLE, REPUBLICAN RESEARCH ANALYST
JUDITH SMITH, REPUBLICAN RESEARCH ANALYST
REBECCA SAMMON, DEMOCRATIC EXECUTIVE DIRECTOR
CAMILA POLASKI, DEMOCRATIC RESEARCH ANALYST

JEAN M. DAVIS, REPORTER
NOTARY PUBLIC

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1 P R O C E E D I N G S

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3 MAJORITY CHAIRMAN BAKER: The Health Committee
4 will come to order.5 We have a public hearing today on the issue of
6 certificate of need. This is an issue that we've had many
7 questions and concerns about over the years. We haven't
8 really visited this issue in a good many years -- excuse me
9 -- so we thought we'd proffer some testimony this morning.
10 Pardon me with my voice.11 If we could just go around and introduce
12 ourselves this morning, the House Members, while we await
13 some additional testimony, and then we'll get started.14 REPRESENTATIVE SCHEMEL: I'm Paul Schemel from
15 Franklin County.16 REPRESENTATIVE KRIEGER: I am Tim Krieger from
17 Westmoreland County.18 MS. KROSSE: Whitney Krosse, Executive Director
19 and General Counsel for the House Republican Caucus.

20 MAJORITY CHAIRMAN BAKER: Matt Baker, Chairman.

21 MINORITY CHAIRMAN FABRIZIO: Flo Fabrizio, Erie
22 County.23 MS. SAMMON: Becca Sammon, Executive Director,
24 Democratic Caucus.

25 REPRESENTATIVE DALEY: Mary Jo Daley, Montgomery

1 County.

2 REPRESENTATIVE KAUFER: Aaron Kaufer, 120th
3 District, Luzerne County.

4 REPRESENTATIVE WARD: Judy Ward, Blair County.

5 REPRESENTATIVE HILL: Kristin Hill, southern York
6 County.

7 REPRESENTATIVE LEWIS: Harry Lewis, Chester
8 County.

9 REPRESENTATIVE CORBIN: Becky Corbin, Chester
10 County.

11 REPRESENTATIVE MULLERY: Gerry Mullery, Luzerne
12 County.

13 REPRESENTATIVE O'BRIEN: Mike O'Brien,
14 Philadelphia.

15 REPRESENTATIVE SCHLOSSBERG: And Mike
16 Schlossberg, Lehigh.

17 MAJORITY CHAIRMAN BAKER: Thank you, Members.

18 And Gina, would you like to take the roll? Do
19 you want to do the roll? Okay.

20 (Roll was taken.)

21 MAJORITY CHAIRMAN BAKER: Thank you, Gina.

22 The first individual that we're delighted to have
23 join us this morning is Kenneth Artz, Managing Editor,
24 Health Care News, The Heartland Institute.

25 Welcome, sir.

1 MR. ARTZ: Hi. Thank you.

2 MAJORITY CHAIRMAN BAKER: And you may proceed
3 when you're ready.

4 MR. ARTZ: Okay.

5 Thank you for allowing me to speak today. My
6 name is Kenneth Artz. I'm the Managing Editor for Health
7 Care News and a research fellow at The Heartland Institute,
8 a 31-year-old national nonprofit research organization
9 dedicated to discovering, developing, and promoting
10 free-market solutions to social and economic problems.

11 States commonly use two mechanisms to limit
12 health-care competition: the approval process, known as
13 certificate of need, or CON, and state-imposed moratoria
14 banning the construction of new health-care facilities.

15 Pennsylvania is one of 14 states not requiring
16 hospitals to acquire certificate of need to introduce new
17 medical services or facilities. Pennsylvania's CON statute
18 expired in 1996 when legislators did not approve an
19 extension.

20 The primary goal of CON programs is to manage
21 health-care costs, yet research shows they've actually
22 increased costs for consumers by hindering competition and
23 disincentivizing providers from using newer facilities and
24 equipment. These are burdensome regulations that increase
25 the costs of and limit consumer access to needed

1 health-care services while benefiting those with political
2 connections.

3 Pennsylvania lawmakers should avoid returning to
4 a failed policy the state wisely abandoned decades ago.
5 Proponents of CON law say they help slow the growth of
6 health-care prices, promote consolidation of health-care
7 providers, and limit duplication of services. States with
8 such laws require CON commission approval for a wide range
9 of expenditures, including the construction of new
10 hospitals, purchase of major pieces of medical technology,
11 or offering of new medical procedures.

12 In a study published by the Mercatus Center at
13 George Mason University, Thomas Stratmann and Jacob Russ
14 assembled a comprehensive database on CON regulations and
15 found those laws increased the cost and undermined the
16 quality of health care. Russ and Stratmann found CON laws
17 raised the prices of medical care by preventing new medical
18 providers from competing with existing hospitals.

19 CON law has also reduced the availability of
20 medical equipment and hospital beds, and states with CON
21 laws had 99 fewer hospital beds per 100,000 residents and
22 lower availability of MRI services, CT scanners, and
23 optical and virtual colonoscopies. The researchers
24 conclude more evidence of benefits of CON laws is needed
25 before the government is justified in restricting

1 competition among health-care providers.

2 Data from the Kaiser Family Foundation shows
3 health-care costs are 11-percent higher in CON states than
4 in non-CON states. Kaiser also found a positive
5 correlation between the number of CON law restrictions and
6 the cost of health care. States requiring certificates of
7 need on 10 or more services average per capita health-care
8 costs 8-percent higher than the \$6,837 average for states
9 requiring certificates of need for fewer than 10 services.

10 CON law has also given appropriate influence to
11 competitors during the vetting process. When a company
12 applies to enter a new market, competitors often use the
13 CON process to block potential competition. As a result,
14 CON laws raise the cost of medical care by preventing new
15 medical providers from competing with existing hospitals.

16 Patrick John McGinley explains in an article for
17 the Florida State Law Review, quote, "CON laws evolved from
18 the health care reforms of the 1940s and were heavily
19 promoted well into the 1970s by health care providers, who
20 found CON effective in sheltering their businesses from the
21 costly effects of a competitive marketplace. Congress
22 mandated CON in 1974, but quickly repealed the mandate when
23 CON failed to lower the nation's health care costs."

24 My testimony today will address two main points.
25 The first, a ban will shield current businesses from

1 competition, thereby driving up costs and driving down
2 quality for consumers; and the second, it is not the proper
3 role of government to impose an arbitrary ban on the
4 construction or entrance of health-care services, including
5 hospitals.

6 Point one. A ban will shield current businesses
7 from competition, thereby driving up costs and driving down
8 quality for consumers. According to data from the Kaiser
9 Family Foundation, health-care costs are 11-percent higher
10 in CON states than in non-CON states. States requiring
11 certificates of need on 10 or more services average per
12 capita health-care costs 8-percent higher than the \$6,837
13 average for states requiring certificates of need for fewer
14 than 10 services.

15 In a 2003 study, Christopher Conover and Frank
16 Sloan of Duke University examined Michigan's CON program
17 and found there is little evidence that CON results in a
18 reduction in costs and some evidence to suggest the
19 opposite.

20 Similarly, in a new study by the Mercatus Center
21 at George Mason University, Thomas Stratmann and Jacob Russ
22 found CON laws raised the price of medical care by
23 preventing new medical providers from competing with
24 existing hospitals. They also found states with CON laws
25 had 99 fewer hospital beds per 100,000 residents and lower

1 availability of MRI services, CT scanners, and optical and
2 virtual colonoscopies.

3 These are just a few of the citations from the
4 overwhelming academic and economic literature that shows
5 CON regulations drive up health-care costs and reduce the
6 quality of health-care services.

7 Point two. Is not the primary role of government
8 to impose an arbitrary ban on the construction or entrance
9 of health-care services, including hospitals? When
10 government considers imposing a heavy-handed protectionist
11 policy such as this, it is important to ask whether the
12 policy would solve a significant problem or whether there
13 are less intrusive and damaging solutions available.

14 For decades, the people of many states have
15 suffered the unintended consequences of these laws, and as
16 a result, numerous experts are calling for their repeal.
17 The Heartland Institute has called for the rollback in
18 repeal of these unnecessary regulations since at least 1991
19 when our recommendation appeared in its influential book
20 titled "Why We Spend Too Much on Health Care."

21 When government chooses to restrict competition
22 and impose needless barriers to entry for businesses,
23 consumers are harmed and so is the public health. States
24 should avoid implementing moratoria such as those discussed
25 here. Instead, lawmakers should allow more competition and

1 long-term care and other health-care markets. Supply and
2 demand will best determine whether there's a real demand
3 for new health-care facilities.

4 Thank you for the opportunity to testify today.
5 I've included a list of other documents that will provide
6 additional information about certificate of need laws.

7 MAJORITY CHAIRMAN BAKER: Thank you very much,
8 Mr. Artz.

9 Any questions, comments, from the Members? Staff?
10 Whitney?

11 Representative Mullery.

12 REPRESENTATIVE MULLERY: Thank you for your
13 testimony, Mr. Artz

14 Do you have any data regarding health-care costs
15 in the Commonwealth prior to 1996 and after to show us
16 whether or not any of the statements that you're making
17 here can be verified statistically?

18 MR. ARTZ: No, sir, I do not. I'm from Texas.
19 We don't have CON laws there. My organization, The
20 Heartland Institute, I'm sure has that information
21 available, and we can make it available to you.

22 (Inoperable mic.)

23 MAJORITY CHAIRMAN BAKER: Members, this is being
24 recorded and televised, so if you could use your mics. I'm
25 not sure---

1 REPRESENTATIVE MULLERY: It's off.

2 MAJORITY CHAIRMAN BAKER: Oh, it's off? Sorry
3 about that.

4 REPRESENTATIVE MULLERY: They saw me coming.

5 MAJORITY CHAIRMAN BAKER: Thank you,
6 Representative Mullery.

7 MS. KROSSE: Does The Heartland have any
8 suggestions on ways to drive down costs of health care?
9 Obviously this is something we're constantly looking at, so
10 if CON is not the way to do it, what are other ways that we
11 can look to drive down costs?

12 MR. ARTZ: Well, of course the CON law is the
13 main one. Allowing more competition would reduce the cost
14 of health care in general, so that's kind of where we're at
15 on it.

16 MAJORITY CHAIRMAN BAKER: Mr. Artz, was one of
17 the reasons for CON, certificate of need, when it was
18 created to justify the costs so as not to have an
19 oversaturation of medical delivery services or equipment or
20 hospitals, was that -- I'm trying to get to why it was
21 created, and then obviously it was terminated by Congress
22 and the Commonwealth.

23 MR. ARTZ: Yes sir, Representative Baker. That
24 is one of the reasons why.

25 There was a secondary reason as well. They

1 thought that they could cross-subsidize health care by
2 creating a closed market for a few, you know, wealthy
3 hospital chains, for instance. This is what's going on in
4 North Carolina. They thought that they would be able to
5 use the higher prices that they charge to help subsidize
6 health care.

7 A lot of their earlier research on it, however,
8 showed that that didn't really happen, and that's why the
9 federal government decided to repeal it in a lot of cases.

10 MAJORITY CHAIRMAN BAKER: Okay. Thank you.

11 Let the record reflect that Representative
12 DeLissio is present and will be added to the roll.

13 Representative Daley.

14 REPRESENTATIVE DALEY: I'm sorry. Mr. Chairman,
15 I actually have to leave because I'm needed in my office.
16 So I'm really sorry.

17 MAJORITY CHAIRMAN BAKER: You may leave.

18 REPRESENTATIVE DALEY: I was going to ask some
19 questions, but I think I'll put that off.

20 MAJORITY CHAIRMAN BAKER: Okay.

21 REPRESENTATIVE DALEY: Okay. Thanks.

22 MAJORITY CHAIRMAN BAKER: Seeing no other
23 questions, thank you, Mr. Artz, for your testimony.

24 MR. ARTZ. Okay. Thank you. I appreciate it.

25 MAJORITY CHAIRMAN BAKER: Next, we have from the

1 University of Pittsburgh Medical Center, UPMC, Tom McGough,
2 who is the chief legal officer. Good to see you again.

3 MR. MCGOUGH: Mr. Chairman.

4 MAJORITY CHAIRMAN BAKER: And Scott Baker, Vice
5 President and Chief Government Relations Officer, and you
6 may proceed.

7 MR. MCGOUGH: Chairman Baker, Chairman Fabrizio,
8 and Members of the House Health Committee, I am Tom
9 McGough, Executive Vice President and Chief Legal Officer
10 of UPMC. I'm joined today by Scott Baker, who is Vice
11 President and Chief Government Relations Officer at UPMC,
12 and we appreciate the opportunity to discuss proposals to
13 reinstate certificate of need requirements in Pennsylvania
14 and to offer UPMC's perspective on this important topic.

15 As most of all of you may know, UPMC is an
16 integrated health system of more than 20 hospitals, 3600
17 physicians, a thriving international division, and the
18 state's second largest and fastest growing health insurance
19 company.

20 It's headquartered in Pittsburgh and provides
21 most of its services in western Pennsylvania, one of the
22 most interesting and dynamic health-care markets in the
23 country. You may have heard about some of the things that
24 are going on out there.

25 It wasn't always that way. Five years ago, the

1 region had one of the least competitive environments for
2 health care in the country, with one dominant insurer,
3 Highmark, and one increasingly dominant provider, UPMC.

4 Today, we have one of the most competitive
5 environments, with at least five major insurers, at least
6 two major health systems, and numerous community hospitals
7 all striving to distinguish themselves by delivering the
8 highest value health care to as many of the region's
9 residents as possible.

10 As a result of this transformation, the cost of
11 health care in western Pennsylvania now ranks among the
12 lowest in the country. I'm going to repeat that, because
13 that comes as a surprise to a lot of people: The cost of
14 health care in western Pennsylvania now ranks among the
15 lowest in the country.

16 A review in the last year of data compiled by the
17 Federal Agency for Healthcare Research and Quality showed
18 that among the 25 most populous metropolitan areas,
19 Pittsburgh now has the lowest commercial health insurance
20 costs.

21 In another indication of how far we've come,
22 Pittsburgh now has the fourth lowest priced Silver Plan in
23 the nation and the lowest east of the Rockies among more
24 than 36,000 health plans on the federal exchange at
25 *healthcare.gov*.

1 I would also note that this plan and several
2 others in the "lowest in the country" category are being
3 offered by the UPMC health plan. That transformation
4 simply would not have occurred had certificates of need
5 been required before competing health-care organizations
6 could introduce new services or expand existing services in
7 the region.

8 For example, when contract negotiations between
9 Highmark and UPMC stalled in early 2011, Highmark sought to
10 enhance provider-side competition by acquiring the then
11 failing West Penn Allegheny Health System, investing
12 significant capital -- indeed, it's now up to about
13 \$2 billion -- in improving that system and its services and
14 rebranding it as Allegheny Health System.

15 Had CON requirements been in place, that
16 transaction would have faced significant and perhaps
17 preclusive regulatory obstacles in light of the excess of
18 hospital beds in western Pennsylvania, and particularly in
19 the Pittsburgh area.

20 Similarly, Highmark's announced plan to open
21 medical malls to provide outpatient services in the region,
22 as well as its announced plans to add services to
23 underutilized facilities like West Penn Hospital in
24 Pittsburgh, would be difficult to maneuver past certificate
25 of need requirements.

1 At bottom, certificate of need requirements are
2 designed to reduce costs by discouraging supposedly
3 wasteful competition among providers and by preventing
4 duplication of medical services. As my colleague, Scott
5 Baker, will point out, differentiating between duplication
6 of services and improving services is a highly subjective
7 process, loaded with political implications and bias. Nor
8 is there any proof that CON requirements actually help
9 contain costs. Now, that point was well made, I think by
10 Mr. Artz, who preceded me in testimony.

11 Health care is currently in a state of rapid
12 change, not just in western Pennsylvania but across the
13 country. The emergence of integrated delivery and finance
14 systems like UPMC and Highmark/AHN, the transition from
15 cost-based reimbursement to value-based incentives, the
16 creation and growth of insurance exchanges and narrow
17 networks, and the growth of so-called consumer-directed
18 health care, including higher copays, deductibles, and
19 coinsurance, are combining with other accelerants too
20 numerous to mention to transform the way we deliver and
21 choose our care.

22 UPMC suggests that this is not the time to
23 reimpose outdated inertial regulations like certificate of
24 need onto Pennsylvania's health care system, and I'll add a
25 footnote here. There's a little bit of irony in UPMC,

1 Mr. Baker, and myself testifying against certificate of
2 need regulation, because UPMC would likely be the biggest
3 beneficiary on the provider side of certificate of need.

4 As Mr. Baker will explain and as I've implied,
5 certificate of need regulations entrench the incumbent. If
6 you're there and you're providing the services, you have a
7 huge competitive advantage over anyone who wants to come in
8 and displace you.

9 UPMC now provides up to 60 percent of the health
10 care in western Pennsylvania. Certificate of need would
11 entrench us in that position. Nevertheless, we don't think
12 certificate of need is an appropriate regulation for the
13 Commonwealth of Pennsylvania.

14 Thank you.

15 MR. BAKER: Chairman Baker, Chairman Fabrizio,
16 and Members of the Health Committee, my name is Scott Baker
17 and I'm Vice President and Chief Government Relations
18 Officer at UPMC.

19 I'm prepared to discuss my experience as
20 Secretary of Legislative Affairs back in the mid-nineties
21 when this decision was made. I guess the committee wanted
22 to hear how it came to its sunset when so many programs do
23 not ever reach that point.

24 While many organizations supported the
25 certificate of need program back in 1995, it was under

1 attack as having evolved into a program that benefited
2 large health-care institutions and those incumbent
3 organizations with CON approvals in place.

4 In particular, many legislators from suburban
5 districts complained to me directly that their community
6 hospitals were being blocked from expanding services that
7 would benefit patients from their area. Their CON
8 submissions were being opposed by larger urban hospitals
9 who, from their view, wanted just to restrict competition.
10 These larger urban hospitals had lawyers and lobbyists
11 familiar with Department of Health rules and
12 decisionmakers, and many legislators felt their constituent
13 hospitals were outmaneuvered.

14 As a member of the Governor's senior staff, I
15 recall calling the Department of Health at the request of
16 legislators to ask about the status of a couple of CON
17 pending approvals, but found that a discussion was off
18 limits to the Governor's Office to prevent any interference
19 with the CON merit-based process.

20 This is frequently the case with agency
21 regulatory decisions, so it's not surprising or unusual
22 that that would not be discussed. What was surprising to
23 me was to walk the halls of this Capitol and find out that
24 lobbyists could tell me exactly what was going on with the
25 CON that I could not find out about. So the process was

1 not as straightforward as it appeared.

2 To me, this revelation raised the question of
3 whether CON decisionmaking was impervious to outside
4 influence or just off limits in terms of the influence of
5 elected officials such as legislators and the Governor.
6 The fact that some lobbyists for CON clients who were the
7 strongest advocates for the extension of the CON program
8 only undergirded my concern.

9 As the sunset deadline approached, it became
10 apparent that the Senate Republican majority was not going
11 to extend the CON authorization, as they saw the program as
12 unresponsive to the wishes of their individual hospitals
13 and possibly because they saw it as a protector of the
14 interests of larger institutions.

15 The House leadership, also Republican at the
16 time, did not seem interested in compelling any action in
17 the program authorization reached at sunset. Following the
18 sunset, I'm unaware of no significant or promising efforts
19 to resurrect CON during the Ridge administration term.

20 While the issue of outside influence in a CON
21 program could be addressed in any new program, I'm not
22 convinced the issue of a CON program favoring incumbent
23 institutions already approved for a specific service can be
24 mitigated.

25 Also, as you've heard from Tom, changes in

1 reimbursement of health care have rendered the
2 reinstatement of a CON program superfluous. Today,
3 Medicaid is under managed care. Over half of Medi --
4 Medicaid is under managed care. Over half of Medicare
5 subscribers are managed, and most commercial insurers
6 quickly challenge payment for unnecessary services.

7 Also, the health-care marketplace is rapidly
8 moving to bundle payments, payments for outcomes, and not
9 by procedure by procedure. These improvements, combined
10 with higher deductible plans, copays, and transparency, is
11 empowering and incentivizing the consumer and employers to
12 make wise choices.

13 A provider, be it a hospital or a physician
14 practice, would add duplicative and unnecessary equipment
15 and services in this environment at their own risk. So in
16 my view, the marketplace is quickly and efficiently moving
17 beyond the need for government control.

18 Thank you for the opportunity to appear.

19 MAJORITY CHAIRMAN BAKER: Thank you very much for
20 your testimony.

21 So if what I'm hearing, and correct me if I'm
22 wrong, is that you view CON as anticompetitive, anti-free
23 market, and is really the antithesis of having the freedom
24 to manage your health-care systems in the way you would
25 like to see done. Is that correct?

1 MR. McGOUGH: I think that is correct. And I'd
2 also add, Ms. Krosse asked earlier, how do we keep down the
3 cost of health care? I think if you look at western
4 Pennsylvania as a laboratory, in a sense, we are proving
5 how you keep down the cost of health care.

6 You have robust competition in both the insurance
7 market and in the provider market and the cost of health
8 care comes down, and that's the object lesson to be learned
9 there. Certificate of need restricts competition on the
10 provider side of that equation.

11 MAJORITY CHAIRMAN BAKER: Okay. Thank you.

12 Representative DeLissio.

13 REPRESENTATIVE DeLISSIO: Thank you, Mr.
14 Chairman.

15 We talk about the marketplace and certificate
16 of need. This is really interesting, because my first
17 post-degree internship out of college in 1978 was to work
18 with the Regional Health Systems agency, and it was to map
19 all the services in the five-county southeastern PA area,
20 all around this concept of certificate of need. So here I
21 am, 37 years later, having a similar conversation, at the
22 same time of year, actually.

23 So I am fascinated by this concept of marketplace
24 when it comes to the delivery of health care for the sole
25 reason that in the marketplace, you know, I have come out

1 of the Philadelphia area. Within two miles of my house, I
2 probably have five different grocery stores I can go to.
3 That's the marketplace. Those markets, those groceries,
4 can do whatever they want to attract me as a customer.

5 In health care, it's not truly an open
6 marketplace, because the customer is absolutely restricted.
7 There are restrictions on the customer through any number
8 of parameters, you know, the insurance their employer is
9 providing, whether they've made -- if they've even had the
10 opportunity to choose their insurance. So it's very
11 restricted.

12 So my concern, and I understood what you both
13 said about competition and incumbency and entrenchment and
14 all of that, but how do we really then control costs if
15 you're, you know, going to get the next whiz-bang type of
16 piece of equipment. It doesn't function like the true
17 marketplace does is my premise, at all.

18 So when I hear sort of that marketplace approach
19 offered, it's just not -- that's not how health care
20 operates, because then I would have the freedom to go to
21 what other health-care provider I choose to go to for
22 whatever my issue or concern is, and I don't have that
23 freedom. It's dictated by the insurance.

24 Well, I do have that freedom, but it's the
25 difference between out of network and in network. It's the

1 difference between my ability to pay out of pocket and not
2 out of pocket.

3 So I think the premise of certificate of need was
4 to try to control those costs in an industry and in a
5 sector where there isn't -- it doesn't function as the
6 marketplace. So I'm very interested in this discussion and
7 to hear the testimony today of the folks to do that. Do
8 you have any comment to that statement?

9 MR. MCGOUGH: Sure. Sure.

10 REPRESENTATIVE DeLISSIO: It's not a question per
11 se, and a little bit of rambling there, but this is my
12 fourth thing this morning.

13 MR. MCGOUGH: Many of your points, many of your
14 points are well taken. The health-care system is in the
15 process right now of moving from a highly controlled system
16 with very little in the way of consumer choice and consumer
17 direction to one that is very much driven by consumer
18 choice and consumer direction. It has been a journey and a
19 process.

20 The types of choices that you are describing,
21 where your employer picked your health plan and you were
22 restricted to that type of health plan, and that health
23 plan determined who was in network and out of network, is
24 becoming -- and then you had, you could go anywhere but you
25 would have no ability to choose on the basis of price to

1 you, in part because you weren't, you had low copays and
2 they were uniform across the system or because you just
3 didn't know how much things cost. All that is very rapidly
4 evolving -- is very rapidly sunseting, if you will.

5 We now have---

6 REPRESENTATIVE DeLISSIO: As a result, you're
7 saying, of the Affordable Care Act or for whatever---

8 MR. McGOUGH: Well, the Affordable Care Act is
9 one piece. The Affordable Care Act and the creation of the
10 health-care exchanges are one piece of that.

11 Right now on the health-care exchanges, which
12 really is a marketplace for health insurance, insurance
13 competition is a huge part of this. You've got to have
14 insurance competition.

15 Seventy percent of the health plans on the
16 health-care exchange are what are known as narrow network
17 plans. If you choose this plan, you are choosing the
18 provider system or network that you will access. So by
19 choosing Plan A -- you would be able to take it to
20 Pittsburgh. By choosing Plan A, you would access, if you
21 chose a UPMC health plan, you would access UPMC and some of
22 the community hospitals for your health care. If you
23 choose a Highmark health plan on the exchange, you would
24 access Allegheny Health Network and some of the community
25 hospitals.

1 And so the choice has been handed to the consumer
2 to choose the network where they want their care, and the
3 tradeoff for that is a lower price, lower premiums, more
4 control by the insurer over the network and the costs that
5 can be charged.

6 So what you're seeing happen in Pittsburgh is
7 people are being offered -- and this isn't just on the
8 exchange. These are employers who say, we'll offer a --
9 their employees the choice between a UnitedHealthcare plan
10 and a Highmark plan, or an Aetna plan and a UPMC plan, and
11 say, look, here are the price points; here is how much your
12 monthly contribution is; here are the networks you will
13 access, and those consumers are then choosing the networks
14 they will access at the time they choose their insurance.

15 And then within those networks you have what I
16 referred to as "consumer-directed health care." These are,
17 and this is probably an even bigger driver than the
18 Affordable Care Act, and that is more patient and consumer
19 responsibility for the cost in terms of copays,
20 deductibles, and coinsurance. What this does is it asks
21 the consumer to be a shopper and to compare prices.

22 And then you need the third piece, which is price
23 transparency. The consumer needs to know, if I go, if I
24 have my MRI done here, my out-of-pocket payment will be
25 \$100, but if I go there, it will be \$200, and that sort of

1 transparency is now being pulled into the system because
2 consumers are demanding it. So those are the changes in
3 the market that all of us as providers and insurers and as
4 patients are experiencing.

5 REPRESENTATIVE DeLISSIO: Well, and I appreciate
6 those comments, and I'm trying to sort of tie this
7 together, because the other one factor and driver that
8 always kind of concerns me is that often a health-care
9 provider, you go for treatment, a physician assistant, a
10 nurse practitioner, you know, MD, DO, very often the
11 treatment is dictated by what insurance is covered. What
12 treatment does your insurance cover as opposed to what
13 treatment is best for you in that situation.

14 So for me, I'm trying to figure out how the
15 certificate-of-need discussion fits into that bigger
16 discussion, because for me, you know, if I'm going to a
17 health-care provider -- I'm not going to my insurer for
18 health care. You're the mechanism by which that's paid.
19 You're not the -- my health-care provider is the one who
20 should tell me what treatment is appropriate for me for my
21 situation.

22 And very often -- and in fact I had this just
23 about two and a half weeks ago. I needed to consult a
24 health-care provider, and he's like, what insurance are you
25 covered by, because this is what I would recommend if your

1 insurance covers it; if not, we'll have to take a different
2 path. I'm not sure that that approaches the best -- oh, I
3 know it's not the best approach for the citizens of the
4 Commonwealth.

5 So just as a heads-up, I'm going to try to be
6 sorting out how the certificate-of-need discussion fits
7 into that larger discussion of, who's the real driver here
8 in the health-care marketplace?

9 MR. MCGOUGH: Yeah.

10 REPRESENTATIVE DeLISSIO: Thank you, Mr.
11 Chairman.

12 MAJORITY CHAIRMAN BAKER: Representative Krieger.

13 REPRESENTATIVE KRIEGER: Thank you, Mr. Chairman.
14 Thank you, gentlemen, for being here.

15 I have a two-part question. The first, you
16 gentlemen know I represent Greensburg, and we have an
17 independent community hospital, Excelsa Health. So talking
18 with them, I think we're all acutely aware of the
19 competitive environment, particularly in western
20 Pennsylvania.

21 A two-part question. The first part, and Tom, I
22 was very interested in hearing you talk about costs,
23 because the common individual out there doesn't -- that's
24 not the perception. In one of them you say costs, and in
25 the context you use it, are you saying that absolutely and

1 objectively costs to fall nor the rate of increase has been
2 less than other areas of the country?

3 MR. McGOUGH: I don't know that -- there are some
4 areas, some situations I am aware of, particularly in the
5 employer-based market, where premium costs and costs to the
6 employer have actually come down. That is, both Highmark
7 and UPMC and Aetna and United and Cigna are bidding for
8 employer contracts at reductions year over year, year to
9 year.

10 When you look out at the individual market, the
11 exchange, I believe that there has been a gradual drift
12 upward across the whole exchange, but there has been an
13 either stabilization or reduction in western Pennsylvania,
14 at least for the prices quoted for 2015.

15 REPRESENTATIVE KRIEGER: All right. The second
16 part---

17 MR. McGOUGH: But it's a little bit of both.

18 REPRESENTATIVE KRIEGER: Okay. And then the
19 second part of that, and we've had discussions, and we've
20 had discussions with Highmark with regard to this, the
21 competitive environment. And we have an aging population
22 in western Pennsylvania, discussion about hospital beds, do
23 we have too many, and I guess that's a preface to ask the
24 second part of this question. That is, are the benefits
25 you're describing sustainable? That is to say, again,

1 20 years from now our population will look very different
2 in western Pennsylvania. That may impact the finances of
3 either you or Highmark or the community hospitals. Are
4 those benefits sustainable?

5 MR. MCGOUGH: I think they're sustainable as long
6 as Highmark and UPMC -- that is the dominant insurer and
7 the dominant provider -- are competing against each other.
8 We're both large organizations. We both know how to price
9 our services. We both also have significant ability to
10 adjust our operations in ways that will continue to allow
11 us to keep the cost, the premiums that we charge our
12 subscribers and the cost of the health care we provide,
13 lower.

14 So yeah, I think it is sustainable, as long as
15 the major players are competing with each other.

16 REPRESENTATIVE KRIEGER: Thank you, and thank
17 you, Mr. Chairman.

18 MAJORITY CHAIRMAN BAKER: Thank you,
19 Representative Krieger.

20 Representative O'Brien.

21 REPRESENTATIVE O'BRIEN: Thank you, Mr. Chairman.

22 In your testimony you had said that West Penn
23 Allegheny Health System was a failing system.

24 MR. MCGOUGH: Yes, sir.

25 REPRESENTATIVE O'BRIEN: And that you guys came

1 in; you acquired it.

2 MR. McGOUGH: No, we didn't. Highmark did.

3 REPRESENTATIVE O'BRIEN: Highmark did. Put a
4 billion dollars into it, you said.

5 MR. McGOUGH: I think it's closer to 2 now.

6 REPRESENTATIVE O'BRIEN: Closer to \$2 billion.

7 Would you by any chance -- well, first of all, is it a
8 general hospital or is it specialized?

9 MR. McGOUGH: It's five hospitals ranging from
10 small community hospitals like Allegheny Valley to large
11 urban hospitals, a large urban hospital, Allegheny General,
12 a trauma 1 center.

13 REPRESENTATIVE O'BRIEN: Okay. So they're all
14 general hospitals?

15 MR. McGOUGH: Offering -- some offer some
16 services, some offer the others, but they are secondary or
17 tertiary hospitals.

18 REPRESENTATIVE O'BRIEN: Do you by any chance
19 know what their daily census is?

20 MR. McGOUGH: I know that systemwide---

21 REPRESENTATIVE O'BRIEN: Percentagewise.

22 MR. McGOUGH: Systemwide, the latest numbers I
23 saw, which were year end -- and this is for the
24 Highmark/AHN system. The latest numbers I saw for
25 Highmark/AHN were systemwide. I think their utilization

1 rate or their in-bed rate was about 60 percent.

2 REPRESENTATIVE O'BRIEN: About 60 percent.

3 I don't know; I just sort of have to wonder if
4 it's worth \$2 billion, you know, to rescue a failing system
5 or if the money is better served with existing facilities.

6 Just amusing. Thank you, gentlemen.

7 Thank you, Mr. Chairman.

8 MAJORITY CHAIRMAN BAKER: You're welcome,
9 Representative O'Brien.

10 Just a couple of comments, if I may.

11 Very impressed with your testimony, particularly
12 as it records that you now rank among the lowest in the
13 country in health-care costs. I'm curious, do you know how
14 the rest of the state and regions fare in terms of, for
15 instance, the southeast, Representative O'Brien's area.

16 MR. McGOUGH: I haven't looked at the southeast.
17 I do know -- first of all, one thing about *healthcare.gov*,
18 that information is easily ascertainable on an apples-to-
19 apples comparison.

20 You can look at, for example, a Silver Plan for a
21 27-year-old with certain deductibles and copays, and you
22 can price that out right on your computer in Allegheny
23 County and you can price it out in Philadelphia, and it
24 would be an apples-to-apples comparison.

25 I do know that for the same Silver Plan for a

1 27-year-old, if you go from Allegheny County and you cross
2 into Ohio, if you cross into West Virginia, if you cross
3 into Maryland, or if you cross into central Pennsylvania,
4 the average monthly premium will go up by about \$20 a
5 month.

6 MAJORITY CHAIRMAN BAKER: Okay.

7 And with respect to health-care costs, that is
8 one great statistic. Is there a correlation between
9 health-care costs and the quality of care, and what metrics
10 are used for that?

11 MR. McGOUGH: Well, there's a huge debate about
12 how you get metrics onto quality of care. I will say that
13 UPMC is ranked in the top honor roll by U.S. News & World
14 Report as one of the best health-care systems in the
15 country.

16 And as I mentioned, the fourth lowest Silver Plan
17 on *healthcare.gov* is a UPMC health plan product that offers
18 you access that has as its core the UPMC Health System.

19 So you are not getting or you are not sacrificing
20 quality in exchange for that price break.

21 MAJORITY CHAIRMAN BAKER: And my last question,
22 which I cannot resist, is the impact of all of this on
23 rural Pennsylvania. Could you add some comment with
24 respect to the CON on rural areas?

25 MR. BAKER: I was going to say, Mr. Chairman, one

1 of the things that Tom and I talked about before here is
2 that with consolidations and all of that, you know, the
3 committee may be more concerned with unmet need in some of
4 these areas, because you're going to have consolidation and
5 you're going to have areas that feel like they don't have
6 the specialists they need and all of that, and we see that
7 as maybe a more challenging issue than the duplication.

8 MAJORITY CHAIRMAN BAKER: So would it be
9 accurate to say that CON would be even more perplexing and
10 anticompetitive and perhaps damaging to rural health-care
11 delivery systems that are looking to integrate,
12 collaborate, reach agreements, for instance, with tertiary-
13 care specialists from out of the area?

14 MR. McGOUGH: Yes, I think that's absolutely
15 right. I think it is a barrier to entry, and in
16 particularly rural areas, you don't want to erect any more
17 barriers to the entry of needed services.

18 MAJORITY CHAIRMAN BAKER: Thank you very much.

19 Any other questions, comments, from the
20 Members?

21 Seeing none, thank you very much for your
22 testimony.

23 And we have with us, as our last presenter,
24 Scott Bishop, representing the Hospital & Healthsystem
25 Association of Pennsylvania, HAP. He is the Senior Vice

1 President for Legislative Advocacy.

2 Welcome, Scott.

3 MR. BISHOP: Thank you, Chairman Baker, Chairman
4 Fabrizio.

5 Members of the committee, good morning.

6 You have our written statement, so I'm not going
7 to read that, but there are just -- and you've heard a lot
8 of good points previously, so I'm just going to share a
9 couple of thoughts that we have, and I can tell you just a
10 couple of notes.

11 The last time HAP presented on this issue, we
12 represented 250 general acute-care and specialty hospitals,
13 and I come before you today now representing 240. In that
14 same general time period, we've seen a decrease, and we
15 shared some of those numbers. The number of general
16 acute-care hospitals has gone down. The number of
17 hospitals with emergency departments has gone down. The
18 number of hospitals with OB units has gone down into the
19 tens of hospitals.

20 So in a time -- and certificate of need expiring
21 happened about in the middle of that transition.

22 And even with all those changes, it's still
23 important to note that, you know, the hospital community,
24 the hospital industry, is still responsible for about
25 111 billion dollars' worth of positive economic impact and

1 nearly 600,000 jobs across the Commonwealth. So I think in
2 the context of what certificate of need has done or hasn't
3 done, I think the industry, the community, has moved
4 forward very well.

5 We're well aware, it doesn't matter if you're a
6 health-care leader, if you're a consumer, if you're a
7 policymaker, if you're an employer, the costs of health
8 care are front and center in all of our minds collectively.
9 And I think all of you know, being a part of this
10 committee, all the different factors that go into the cost
11 and quality of care. It's a wide range.

12 And so when we talk about certificate of need and
13 particularly the reasons why we don't support, the hospital
14 community doesn't support the notion of reinstating
15 certificate of need, is that going in that one direction in
16 and of itself can't have the impact that all of us want to
17 have, which is always the greatest amount of access, the
18 lowest cost, and the highest quality that we can do, and
19 focusing on certificate of need is just not that way to
20 go.

21 And again, I don't want to repeat the previous
22 comments made by the first presenter and by the folks at
23 UPMC, but again, it's clear to us from the hospital
24 community that the data is just not there to prove
25 conclusively that certificate of need reduces cost.

1 And I think the second more important point I
2 think was raised very well is the notion of government
3 making decisions about what services, what facilities, what
4 access is important to a community. It's highly
5 subjective, and we're not sure, there could be a set of
6 standards by which a government entity could, successfully,
7 consistently go through that process, and I think that's
8 one of the reasons why it was important when the
9 certificate of need program expired that it stay expired.

10 So again, it's not fair to articulate that there
11 are a lot of different reasons or a lot of different things
12 that impact the cost of health care, the quality of health
13 care, and then not, you know, talk about where the hospital
14 community would be with regard to talking about how we
15 would get at some of those things.

16 So I think in our testimony we listed some of the
17 kinds of ideas that we think continue to be important,
18 talking about accountability, and that's accountability
19 across the continuum. Whether or not you're a hospital, a
20 physician, an insurer, part of that, I think, is the place
21 to go.

22 I think there's been a good discussion about the
23 balance between market forces and regulation. The hospital
24 community has always understood and supported and
25 understands that the Commonwealth has, you know, a focus on

1 public safety, and there's a need for regulatory guidance
2 to hospitals and other facilities, and I think balancing
3 that with what the market truly demands, and Representative
4 DeLissio is not still here, but I think the notion is, as
5 Tom mentioned, the changing marketplace, the changing
6 nature of competition, is a driving factor in quality.

7 Public reporting. As you all know on this
8 committee, HAP and the hospital community continue to
9 support PHC4. We continue to support the notion of
10 increased points of data to help folks make decisions about
11 cost and quality, and we will continue that.

12 And lastly, again, we could spend hours and hours
13 and days talking about reimbursement and the financial side
14 of health care, but clearly that's a place where we
15 continue to work with the legislature and work with the
16 administration on making sure that specifically hospitals
17 are funded at the level to allow us to do all the kinds of
18 things that our patients, our communities, expect us to do,
19 and I think that it's important to recognize that that's a
20 major issue for us.

21 So I think it bears repeating, just one last
22 point, and again, I come to you on behalf of the hospital
23 community. And to be clear, there have been moments in
24 time where individual hospitals, due to specific
25 circumstances, have seen merit in CON. But largely, when

1 we think about the ways in which making sure the hospital,
2 the right hospitals are in the right communities providing
3 the right care at the right time at the right cost, it has
4 always been about quality. And last week you gave us the
5 opportunity to talk a little bit about our 2015 quality
6 report, and I think that's important just to bear, to
7 repeat a couple of points in that.

8 And you've heard a little bit about the
9 competitive environment, and it is, it's highly
10 competitive. But in that competitive environment,
11 hospitals are working together, working collaboratively, to
12 reduce all those kinds of things that happen sometimes in
13 the hospital setting that cause re-admission or cause an
14 outcome that a patient certainly wasn't expecting when he
15 or she first went in.

16 And all of that work, we're seeing, you know,
17 tens of thousands of reductions in these kinds of incidents
18 of harm, but just this part of our quality work alone has
19 resulted in almost 700 million dollars' worth of savings to
20 the system. That's where accountability should be. That's
21 where the benefit of competition, that's where we'd like to
22 see the focus be as opposed to, you know, an arbitrary
23 process to determine whether or not this hospital should be
24 here or this service should be provided there.

25 So with that I'll stop and see if there are any

1 questions. Again, thank you for the opportunity to be
2 here.

3 MAJORITY CHAIRMAN BAKER: Thank you, Mr. Bishop.

4 And so to just sum up HAP's position, it's in the
5 conclusion at the bottom of the second page that
6 Pennsylvania hospitals and health systems do not support
7 reinstatement of CON; correct?

8 MR. BISHOP: Correct.

9 MAJORITY CHAIRMAN BAKER: And perhaps I should
10 ask this of Mr. Artz or others, but is there a trend
11 nationally for CON states to terminate this policy, or are
12 there still quite a few states, to your knowledge, that
13 still have CON, even though Congress terminated the
14 program?

15 MR. BISHOP: I think there are a few that still
16 have it.

17 I mean, we do go back and forth with our
18 colleagues in other state associations. I can tell you
19 that there's not a clear trend one way or the other; in
20 other words, some momentum growing where, you know, they're
21 going to fall or the opposite, where states are
22 considering, you know, reinstating or things like that.

23 I think it's state specific, at least from what
24 our colleagues are telling us, because they'll share with
25 us, hey, we've got CON again, and what's going on in your

1 state? So that's our perspective anyway.

2 MAJORITY CHAIRMAN BAKER: Okay. Thank you.

3 Any questions of Mr. Bishop? That's easy.

4 Thank you very much for your testimony, and we
5 thank all the presenters this morning for their testimony.

6 This concludes the Health Committee hearing.

7 Thank you very much.

8 (Whereupon, at 9:55 a.m., the hearing concluded.)

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1 I hereby certify that the proceedings and
2 evidence are contained fully and accurately in the notes
3 taken by me on the within proceedings and that this is a
4 correct transcript of the same.

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8 Jean M. Davis

9 Notary Public
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