Oregon State Council
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Service Employees International Union – Oregon State Council
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Testimony to the House Committee on Health Care in Support of HB 2362

Chair Prusak and Members of the Committee,

My name is Katie Shriver and I am here representing the Service Employees International Union (SEIU). SEIU is an organization of 85,000 working Oregonians who are members of our Union. Our mission is to achieve a higher standard of living for our members, their families, and dependents by elevating their social conditions and by striving to create a more just society.

SEIU approaches healthcare policy from the perspectives of our members. This includes members who work in hospitals delivering critical care, members who collectively are significant purchasers privately and through PEBB, and of course SEIU members and their families who use the system as patients. In each instance – as health system employees dealing with short staffing and cost constraints, as major purchasers, and as patients – our members have been struggling for too long with rising healthcare prices.

On behalf of them and all Oregonians who struggle to access affordable care, I am here today to testify in support of HB 2362. This bill will provide a comprehensive review process for proposed healthcare mergers, acquisitions, and affiliations throughout our healthcare market to ensure all transactions enhance access to low-cost, high-quality services.

While the state is currently pursuing important efforts to control costs, one significant cost driver that has yet to be tackled looms large on the horizon: healthcare consolidation. Proponents of consolidation often argue it will lead to increased efficiency and better care. Instead, research has shown that consolidation leads to higher prices, does not necessarily improve quality, and can lead to reductions in services in underserved areas and even the denial of care for marginalized groups. Below, we outline concerning trends in healthcare consolidation that demonstrate the urgent need to take action in our state.

Healthcare Consolidation Has Increased Dramatically in Recent Years

In 2018, 51 percent of all physicians and 91 percent of hospital beds in the U.S. were affiliated with a health system.[i] And this trend is accelerating — in just two years (2016-2018), the share of physicians affiliated with health systems grew by more than 27%.[ii] Health systems themselves are merging too — there were 50 mergers or acquisitions of systems by other systems from just 2016 to 2018. Most of the systems that were acquired were relatively small (with median numbers of 2 hospitals and 148 physicians), whereas the acquirers were larger, offered more services, and were more likely to operate

in multiple states.[iii] In addition, providers have begun developing their own insurance offerings, and so called "payvider" deals (in which insurers buy or partner with medical groups and other providers) have exploded in 2020, a trend that is predicted to continue.

Oregon's Healthcare Industry Has Become More Concentrated

Here in Oregon, we have experienced similar trends. The number of independent hospitals has declined from 28 to 16 since the year 2000 – or 43 percent. At the same time, hospitals and health systems have expanded their outpatient offerings in Oregon at a rapid clip, through acquiring existing practices and opening new clinics. In the Portland metro area, for example, the share of physicians affiliated with health systems grew from 39% in 2016 to 71% in 2018 – an 82% increase.[iv] Providence employs the largest share of physicians in Portland (28.7%) and nearly tripled its market share over the same two-year period. In Albany and Corvallis, nearly 60% of doctors are affiliated with a health system, and Samaritan Health Services employs virtually all of them.[v]

Oregon's Department of Consumer and Business Services considers a market "highly concentrated" if the four largest insurers hold 75 percent or more of the market. Under this definition, individual and small-group ACA-compliant and commercial lines of business are all highly concentrated. Oregon's largest insurers, Providence and Kaiser, are also among the largest providers in the state; together they control nearly half the insurance market. Other providers have also gotten into the insurance business: Legacy bought half of PacificSource in 2017 for nearly $100 million; and Samaritan Health Services offers its own insurance offerings.

Consolidation Leads to Higher Prices, and Oregon's Prices are Already Too High

Unfortunately, the effects of price increases extend further into our economy. A recent RAND study found that the price increases that result from consolidation are ultimately passed on to workers in the form of lower wages and less generous benefits. The researchers found that wages for workers who receive employer-sponsored insurance declined by an average of $638 per year after a hospital merger took place in their region. [vi] In other words, as healthcare prices increase due to consolidation, employers compensate by lowering wages.

Given that research has shown that income is perhaps the most important social determinant of health, these lowered wages ultimately drive down the health potential of many. Worse still, workers of color are more likely to be paid poverty-level wages than white workers. However, most employers set their benefits equally across employees, regardless of salary. Therefore, rising healthcare costs have a disproportionate impact on workers at the lower end of the wage scale and can contribute to increased inequality.

Consolidation Could Exacerbate Health Disparities in Oregon

A commentary published by the *New England Journal of Medicine* recently argued that when hospitals raise prices in the private insurance market (as is often the case after consolidation), resources are redirected back into facilities that serve the disproportionately white and wealthy populations that can afford private coverage. Meanwhile, Medicaid patients (who are disproportionately Black and Latinx) are steered to facilities that rely on fixed federal reimbursement rates and do not benefit from inflated payments from private insurers to pay for

state-of-the-art facility upgrades and additional staff. These patients are then served by hospitals with fewer resources and inferior clinical quality – deepening existing racial and ethnic health disparities.[vii]

This preference for privately insured patients can be observed locally. In 2013, when Legacy Health opened its first clinics in the Portland Metro area's west side, the local medical society's newsletter commented on the likely patient population the clinics would attract: "The locations for the new clinics are in high-income areas, so they will attract many insured patients who have the choice of where they go to be treated and can benefit from some of the deluxe services Legacy Medical Group Cornell offers that seem tailor-made for large county employers such as Nike Inc. and Intel Corp. These include what Legacy calls 'performance evaluations,' such as bicycle fittings and running and golf-swing analyses."[viii] Meanwhile, other patient populations continue to be underserved and overburdened by the high cost of care.

Consolidation Could Lead to Reduced Access to Services in Our State

RAND researchers recently found that, following affiliations, rural hospitals were more likely to lose onsite imaging, outpatient nonemergency care, and obstetric and primary care services. At the same time, the hospitals in the study saw a significant increase in operating margins (by 1.6–3.6 percentage points within two to five years, compared with -1.6 percent before the affiliation).[ix] The study's authors ultimately conclude that, "Given the potentially negative consequences of affiliation, policy makers should support mechanisms that help rural hospitals remain financially viable without it."[x]

In addition, reproductive, gender-affirming, and compassionate end-of-life care are at risk when partnerships are formed with religiously affiliated healthcare entities governed by ethical religious directives. In Oregon, 30 percent of acute care beds are controlled by systems that restrict access to these services.[xi]

Economic Impact of COVID-19 Adds New Urgency for Action

Independent practices, small clinics, and community-based hospitals have been stretched thin by the pandemic and are increasingly vulnerable to larger health systems looking to capitalize on the profit-potential. A national survey of more than 100 health system executives conducted in mid-June found that approximately three-quarters expect that physician practices and hospitals will turn to mergers and acquisitions over the next year as a result COVID-19.[xii]

Hospitals and health systems that were succeeding before the pandemic have amassed billions in reserves that better enable them to weather financial uncertainty. On top of this, they received a disproportionate share of federal pandemic relief funds. Kaiser Family Foundation found that hospitals with the highest share of private insurance revenue received an average of $44,321 in CARES relief funds per hospital bed, compared to just $20,710 for hospitals with the lowest share.[xiii] Here in Oregon, some of the largest and wealthiest systems have received significant cash infusions through federal COVID relief. For example, Providence St. Joseph Health was awarded $1 billion in CARES Act funding, yet recorded $682 million as revenue.[xiv]

Oregon's Healthcare Markets Are Already Concentrated; Need to Act is Now

Oregon's most competitive healthcare market is not only highly concentrated, but also one of the priciest in the nation. In 2017, Portland had the 14th highest healthcare prices out of 124 large metros.[xv] However, the Portland metro is also arguably the most competitive market in the state. Outside of Portland, not a single community is served by more than two competing health systems. Therefore, even despite its high prices, the Portland area often has some of the lowest cost healthcare in the state, with Southern and Eastern Oregon being far more expensive.

In addition, private equity investors have also been increasingly entering this space. A study published earlier this year in the Journal of the American Medical Association found that while the share of physician practices currently owned by private equity investors is relatively small, acquisitions have increased across specialties in recent years "with unknown implications for care delivery and patient outcomes." Because private equity firms typically expect greater than 20% annual returns, the authors further cautioned that "these financial incentives may conflict with the need for longer-term investments in practice stability, physician recruitment, quality, and safety."[xvi] We need to protect Oregonians from those who would prioritize profits over patients.

Oregon Should Follow the Lead of Other States Addressing Consolidation

Recognizing the limitations of federal oversight and intervention, states have begun to take action to address the negative impacts of consolidation on their own. For example, as part of a 2012 landmark law designed to reduce healthcare spending, Massachusetts charged its newly created Health Policy Commission with reviewing merger proposals, conducting cost and market impact reviews, and referring its findings to the state's attorney general for enforcement. California has aggressively pursued legal action against systems for anticompetitive practices and extensively reviewed proposed mergers – denying some and applying conditions on others that were allowed to proceed.

Washington passed legislation in 2019 to ensure the state's attorney general is aware of a broad array of transactions that federal antitrust agencies may not be notified about or identify as anticompetitive. Healthcare entities must now notify the attorney general at least 60 days before a "material change" transaction is to take place – with no minimum dollar threshold. Washington is also currently considering new legislation that would establish greater pre-transaction review and post-transaction monitoring.

HB 2362: Placing Patients at the Center of Healthcare Deals

In Oregon, three different state agencies review disparate parts of healthcare transactions, each with its own set of procedures and standards. However, these processes apply only to a small portion of transactions and remain limited in scope. More importantly, they utilize an antiquated rubric based primarily on whether the entities will have enough financial resources to continue operating post-transaction, without evaluating whether the health of Oregonians will be better served. While

HB 2362 would create a robust oversight process for proposed healthcare mergers that builds on OHA's existing authority to review transactions involving Coordinated Care Organizations (CCOs) and extends this review to the full healthcare market — from service providers to insurance carriers. HB 2362 would:

- Require healthcare entities to notify OHA before transactions take place, including changes in revenue of $1 million or more or reductions in services (including access to the full range of reproductive and end-of-lifecare options).

- Engage impacted communities through an open public process during the review period.
- Require entities to demonstrate the transaction will benefit Oregonians by either: 1) reducing patient costs, 2) increasing access to services in medically underserved areas, or 3) addressing historical and contemporary factors contributing to the lack of health equity in our state.
- Maintain a holistic picture of the impact of consolidation in the state by reviewing changes in access, cost and health equity on a four-year cycle.
- Be budget neutral and fee-funded.

We urge you to address this important issue by passing HB 2362. Oregonians deserve a process that ensures healthcare deals taking place in our state truly benefit all residents -- by promoting health, access and equity rather than runaway price increases. Thank you for the opportunity to comment on behalf of our members.

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[i] Furukawa, et al. "Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18." *Health Affairs*, Aug 2020.

[ii] Ibid.

[iii] Ibid.

[iv] Kimmy, Laura, et al. "Geographic Variation in The Consolidation of Physicians Into Health Systems, 2016–18." *Health Affairs*, Jan 2021.

[v] Kimmy, Laura, et al. "Geographic Variation in The Consolidation of Physicians Into Health Systems, 2016–18." Health Affairs, Jan 2021.

[vi] Arnold, Daniel and Christopher Whaley. "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages." RAND Corporation, July 2020.

[vii] Kaplan, Alan and Daniel O'Neill. "Hospital Price Discrimination Is Deepening Racial Health Inequity." *NEJM Catalyst*, Dec 2020.

[viii] *Portland Physician Scribe*, June 2013.

[ix] O'Hanlon, Claire, et al. "Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation." *Health Affairs*, Dec 2019.

[x] O'Hanlon, Claire, et al. "Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation." Health Affairs, Dec 2019.

[xi] Solomon, Tess, Lois Uttley, Patty HasBrouck, and Yoolim Jung. "Bigger and Bigger: The Growth of Catholic Health Systems." Community Catalyst, Oct 2020.

[xii] "Industry Professionals Weigh In: Future of Healthcare Survey." Advis, June 2020.

[xiii] Schwartz, Karyn and Damico, Anthony. "Distribution of CARES Act Funding Among Hospitals." Kaiser Family Foundation, May 2020.

[xiv] Providence St. Joseph Health, 2020 Q3 Continuing Disclosure Quarterly Report.

[xv] Health Care Cost Institute, Healthy Marketplace Index. Data from 2017, Retrieved Dec 2020.

[xvi] Zhu, Jane, Lynn Hua and Daniel Polsky. "Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016." *JAMA,* Feb 2018.