John Pakutka
Testimony to the Health Care Cabinet of the State of Connecticut
11/15/16

Thank you for the opportunity to provide testimony in response to the "Connecticut Healthcare Cabinet Recommendations Preliminarily Approved on November 1, 2016."

My name is John Pakutka. I am the Director of The Crescent Group, a network-model advisory firm specializing in health policy and management. Firm clients have included Fortune 500 companies, Global 100 law firms, the United States Department of Justice and a range of non-profit health systems. I am the co-author of *Social Insurance: America's Neglected Heritage and Contested Future.* My CV is attached. I have lived on the Connecticut shoreline for the last twenty-seven years.

I offer my unqualified support for (1) the recommendations you have approved and (2) the recommendation not yet voted upon entitled "Directly Reduce Cost Growth" and described the following way: *"The Legislature should A) adopt a state-wide health care cost growth target and B) set targets for value-based payment for all payers in the state."*

Among states, Connecticut has the third highest per capita healthcare costs.[1] (Of course, America has the highest per capita healthcare costs in the world.) Only two insurers participate in our state's health insurance exchange. Large delivery systems have extraordinary leverage over the participating insurers.

On January 1st, 2017, my family plan premium for a $6,000 deductible health plan will increase from $1,115 per month to $1,618 per month. (Shopping on the exchange and through a broker has produced only comparable options.) This is no time for tentative steps. Who among us can shoulder easily a high double digit increase in a major family expense?

I supported with great skepticism and many reservations the unproven Affordable Care Act approach of health plan competition and Medicaid expansion. In the interest of building bipartisan support—which, of course never materialized--we ignored the successful experience of every other developed nation on Earth in controlling healthcare costs and covering all citizens. America spends 30-50% more per capita than every other nation to buy healthcare that provides similar, often substandard, health outcomes.

One of the lessons of the international experience is that markets do not work in healthcare the way they do elsewhere. Markets work well when well-informed consumers shop for high value products, that is, ones with a high ratio of quality to price. Suppliers respond by trying to improve product quality and drive down costs. Over time, only high value products in great demand tend to survive. In most product markets, we see value rising over time. Think about how computers have become smaller, cheaper and more powerful. There are countless examples of this sort.

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[1] See http://kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Health%20Spending%20per%20Capita%22,%22sort%22:%22desc%22%7D

Such competitive markets possess characteristics such as well-informed, rational consumers and responsive, profit-seeking suppliers. But, do these same market dynamics apply to healthcare goods and services? We know from decades of observation and recent academic research that they do not.[2] And, we know from neoclassical microeconomic theory that there are many reasons to doubt markets work well in healthcare. Most prices for most healthcare goods and services haven risen continuously over the last four decades, often well in excess of general inflation. Provider incomes rise almost continuously. Many healthcare innovations cost small fortunes and improve outcomes slightly, if at all. In healthcare, we see an ever-increasing level and mix of effective and ineffective care that is misused, overused and underused.[3]

Healthcare is different from computers for a number of reasons. First, consider the demand side of healthcare. Patients, renamed "consumers" for purposes of market analysis, do not tend to shop for care. They may be ill or injured, incapable of shopping. Prices for healthcare are not often available in advance of or at the time of care.[4] Even if a consumer can shop, how do they know what they want or need? They ask their health care provider—the seller of health care goods and services—what they should do. The theoretical assumption of well-informed consumers does not apply to the purchase of most healthcare.

Further, even for those consumers who try to be well-informed, there are other stumbling blocks to fully informed choices. No consumer can know as much or more than an educated provider. At best, a consumer can only speculate as to whether the recommended care and the facility in which the provider practices is optimal. Thus, what economists call information asymmetry typically exists between consumer-patients and supplier-physicians. This is not a condition that leads to optimal outcomes of low prices and high quality. Patients are dependent upon the advice and care location choices of their providers; they are seldom cognizant of price or value levels. This is not the restaurant business, where unhappy customers casually switch dining establishments when food quality or taste wanes or menu prices rise.

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[2] See for instance the recent work of Yale's Zack Cooper, who gained access to and analyzed an enormous database of Aetna, United and Humana healthcare claims: http://insights.som.yale.edu/insights/why-healthcare-so-expensive. "Why are some hospitals able to charge 17 times more than other hospitals? Why can one provider charge 9 times what another does within a city for the exact same thing? Because the markets are not functioning effectively. When hospitals merge, they have the opportunity to charge incredibly high prices. Monopoly hospitals can extract higher prices when it comes to negotiations with private insurers. If you are the only provider in the area, you have the chance to get much, much higher prices than if you were facing meaningful competition. The advantage is still there in duopoly or triopoly markets."

[3] See https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/07-17-healthcare_testimony.pdf. See also the Dartmouth Atlas of Healthcare at http://www.dartmouthatlas.org/.

[4] See http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/april-may/in-focus. "It's no secret that the U.S. health care market is unlike any other market: patients rarely know what they'll pay for services until they've received them; health care providers bill different payers different prices for the same services; and privately insured patients pay more to subsidize the shortfalls left by uninsured patients. What's more, prices for health services vary significantly among providers, even for common procedures such as laboratory tests or mammograms, although there's no consistent evidence showing that higher prices are linked to higher quality." See also http://www.rwjf.org/en/library/research/2012/08/what-s-the-price-of-health-care-.html. "Current limitations and cultural resistance conspire against the publication of true health care prices in a meaningful way that consumers can understand."

Rational actors, who can afford to, buy health insurance to protect against financial ruin. When fully insured, they arguably are free from financial concerns about the cost of care because they have prepaid for care. The partly-insured, while also face high cost-sharing (as is the American trend), may forego necessary care entirely because they cannot afford it or want to save their share of the costs. This is particularly true of lower income patients. Decades of study show patient cost sharing reduces their utilization of all medical care, not just unnecessary care.[5] Costs go down, as does health status. Thus, patient cost consciousness often leads to worse outcomes, and a less efficient health care market.

On the supply side, providers have financial and professional incentives to provide care that is high in cost and modest in benefit. Why not do anything and everything to help a patient, regardless of its cost? If there is marginally valuable information that a test can offer, why not order it? The more a physician does, the more a physician earns in income. And, who needs a lawsuit for failing to diagnose accurately? This is not to claim that physicians or other medical professionals are motivated solely by economic incentives. They have been trained to help sick people and often are prepared to try anything and everything that might make a positive difference.

There are yet more differences in how we should think about healthcare economics. We do not fret much if consumers in many other markets cannot afford the products they desire. Wanting a high-powered computer or a new car does not justify its social provision. But, what if a tuberculosis victim is unable afford the hospital? We all risk infection and that provides one basis for social provision. From a more altruistic perspective, what if the premature baby's parents can't afford a month at the neonatal intensive care unit that charges $3,000 per day? No one wants to let that baby die. There is in healthcare economics a community interest. Both enlightened self-interest and moral obligation lead most of us to want outcomes that normal market forces alone cannot reliably produce.

In healthcare, the "invisible hand" fails to drive down costs, improve quality, or ensure sound distributional outcomes. We can tinker with the rules, regulations and payment schemes that govern medical care. But, the forces that increase the demands for, prices and supply of care are relentless. This is far from a perfectly competitive market.

So, what shall we do? Continue to try and make the markets for health insurance and healthcare work better seems to be the will of the Cabinet.

But we need a backstop if these efforts continue to fall short. I urge you to set in motion the proven strategies that give the state power to limit cost-growth and address our high and dramatically rising prices. It will take years to implement such strategies. How many more years of double digit premium increases (driven by large healthcare cost increases) can our state's economy and its residents manage? We must begin the work now.

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[5] RAND Health, "The Health Insurance Experiment, A Classic RAND Study Speaks to the Current Health Care Reform Debate," 2006 available at http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf.

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EDUCATION

Wesleyan University, Completed 1st year toward Master of Arts in Liberal Studies between 1996-2005.
Yale University, Master of Public & Private Management, 1992.
Cornell University, Bachelor of Science, Electrical Engineering, 1986 (Phi Kappa Psi, Sphinx Head).

TEACHING

Yale Law School, co-led *Innovations in Health and Healthcare* student reading group, Fall, 2014.

Yale University School of Management, visiting lecturer in *Product Planning* class (2007-14), visiting lecturer in *Health Policy & Management* at Executive Management Program (2004-5), teaching assistant for *Political Analysis for Management* (1992).

PUBLISHING

"Addressing State Health Care Challenges through Regulation: Use of a Public Utility Model," with Megan Cole, PhD '16, Brown Univ., https://reformtotransform.wordpress.com/papers/, October, 2015.

Social Insurance: America's Neglected Heritage and Contested Future, with Theodore Marmor (Yale School of Management) and Jerry Mashaw (Yale Law School), Congressional Quarterly Press, 2013.

"Learning from International Health Policy Experience," with Theodore Marmor, Journal of Academic Health Centers, January, 1999.

WORK EXPERIENCE

THE CRESCENT GROUP, LLC, New Haven, CT **1999-2016**
Founder and Managing Director

- Lead health services advisory firm providing expert witness, management and policy consulting.
- Partial list of client-team accomplishments:
  - $1B turn-around of national Catholic healthcare system (1999-2002).
  - Defense verdict in $5B inter-company mass toxic tort case (2002-05).
  - Defense verdict in $1B healthcare financial dispute (2002-10).
  - Recovery of $421M for United States Department of Justice and states in cases of alleged pharmaceutical pricing fraud (2006-2015).
  - Growth of health system market share from 25 to 40% at expense of HCA (2001-2015).
  - Defense verdict in $320M medical screening case (2016).
- Assist health systems with various product/business development and innovation initiatives, in areas including oncology, primary care/behavioral health integration, patient centered medical home, ACO development and population health improvement.
- Advisor to Health Employer Exchange initiative comprised of Cleveland Clinic, Baylor, UCLA, Yale New Haven, and UVA Health Systems, as well as private sector partners.

APM/CSC HEALTHCARE, New York, NY **1996-98**
Associate and Senior Associate Consultant

- Managed reengineering projects at Midwestern academic medical center and Northeastern community health system. Scope included patient care delivery redesign, clinical effectiveness program development, performance management system design, and technology transfer program.
- Redesigned departments at various community health systems by leading hospital staff teams through reengineering process. Assessed core process flows, demand and staffing patterns, management structure, and automation opportunities.

YALE UNIVERSITY, School of Management, New Haven, CT **1992-96**
Health Policy Research Associate, Alumni Affairs Director

- Researched history of American welfare and health care policy and politics; assisted in the preparation of courses, articles, op-eds, and Congressional testimony for Yale Professors.
- Developed and implemented framework to help states (Kentucky and Delaware) and health providers understand economic, social, and political effects of various health system reform plans.
- Performed cost, break-even, and sensitivity analysis for not-for-profit health service provider concerned about effects of the move to managed care in the Medicaid program.
- Managed all aspects of alumni affairs including fundraising; doubled alumni donations.

EXXON/RELIANCE ELECTRIC, Cleveland, OH, Boston, MA, Albany, NY **1986-90**
Sales Engineer

- Marketed industrial control systems to distributors and end users in paper and steel industries.
- Ranked in top 10% of sales force in 1988-9.

PRE-COLLEGE GRADUATION WORK, Vestal and Ithaca, NY **1981-86**
Dishwasher, Waiter, Chemical Worker, Parks Counselor, Navy ROTC, Rush Chair

PUBLIC SERVICE & ADVOCACY

Knights of Columbus, Council 3928, 1st Degree (2016-present).
Catchment Area Council #8, South Central CT Regional Mental Health Board, Advisor (2016-present).
Commonwealth of Virginia, Excellence in Mental Health Act Steering Committee (2015-present).
Guilford Little League, Summer Ball Commissioner and various coaching roles (2012-present).
A.W. Cox Elementary School, Parent Teacher Organization Advisory Board (2012-14).
Foote School, Parent Teacher Council, Volunteer (2014-present).
Connecticut Speaker of the House's Task Force on Small Business Healthcare Costs (2011-12).
Connecticut Association for Human Services, Director (2006-10).
Fellow, Healthcare Financial Management Association (2006-09).
Connecticut Citizenship Fund, Office of the Secretary of State, Director (2002-11).
Town of Guilford, Parks and Recreation Commissioner (2003-07).
Fellow, American College of Healthcare Executives (2001-present).
City of New Haven, Board of Aldermen, 9th Ward Alderman (Elected three times - 1993-96).
Political Campaign Work: (Field Organizer, Congresswoman DeLauro Reelection '92, Third Congressional District Field Director, Curry for Governor '94, Strategist, Nappier for Treasurer '98.)
United States General Accounting Office, Policy Evaluator (Summer Internship, 1991).
Big Brothers of South Central Connecticut, Director (1990-91), Volunteer (1989-Present).
Urban League of New Haven, Director (1990-93).

PERSONAL

Married to Christine Merritt Pakutka; Children: Noah, 11, Elaina, 7, and Isabella, 4.
Member, Fleur de lis Society of Bon Secours and Sorin Society, University of Notre Dame.
Member, St. George Church, Guilford, CT.
Funder of *Below the Beltway* and *Newlyweeds,* an official selection of 2013 Sundance Film Festival.
New Haven Labor Day 20K, 11-time finisher, 1998-2016.
Interests: Notre Dame Football, MLB & Fantasy Baseball, Bruce Springsteen and the E-Street Band, country music, tennis, family travel.