May 27, 2020

The Honorable Ned Lamont
State Capitol
Hartford, CT

Re: Need to Delay Health Care Cost Growth Benchmark Initiative

Dear Governor Lamont:

We are a broad group of advocates and providers writing to urge you to delay the initiative created under Executive Order #5, issued on Janury 22nd, to implement health care cost containment benchmarks, in light of the COVID-19 pandemic which is challenging our health system. Advocates have many concerns about this concept and proposal that we will share over time, but we wanted to share our proximate concerns about timing and committee process now. If this controversial proposalis rushed ahead it could risk the health of our fellow Connecticut residents with the highest care needs. **Critical** to the success of this process is the revamping of the committee input structure to engage diverse groups of stakeholders with broad representation, encourage multiple viewpoints, avoid conflicts of interest, build trust, and engage all stakeholders in solutions that can suceed when the process begins post-pandemic.

As the Commissioner of Social Services has noted, cost control in Connecticut Medicaid, run not through capitated insurers but directly by DSS on an efficient fee for service basis, has been very successful. The average per member per month annual rate of inflation in Connecticut Medicaid for the last four years is a phenomenal 1.35%. See https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20200214/HUSKY%20Financial%20Trends%20February%202020.pdf. However, outside of Medicaid, health care inflation continues to outpace general inflation rates. Many of us have ideas for how to reduce costs which can help to control inflation in these non-Medicaid programs without harm and, in many cases, improve health outcomes.

Nevertheless, the drive to meet arbitrary cost growth benchmarks could have serious unintended consequences, including for individuals at the highest risk: older residents, people with disabilities and individuals with chronic health conditions, the same groups put at greatest risk by COVID-19 . But this list of kinds of people put at risk by this proposal is non-exhaustive. Individuals of all ages and with a broad range of health care conditions and needs could be negatively impacted.

As insurers and large health systems are put under increasing pressure to stay under the cost growth benchmarks, high cost patients will be targeted for reductions in services. This could negatively impact people of color who already suffer significant health disparities. While higher primary care spending often correlates with some improved health outcomes, we are also concerned that increasing primary care spending to an arbitrary physician-centered standard, especially while also constraining total healthcare costs, could have even worse consequences for high-need people and could fail to support improved primary care practice or improved access. It also misses the need for social service support in communities, especially during a recession, to improve health and lower healthcare costs. Accordingly, we should look with great caution at any proposal which could have these harmful, though unintended, consequences.

In any event, this is not the time to enter into an experiment with cost control which has the potential for significantly restricting access to needed treatments. The COVID-19 crisis has dramatically altered the provision of health care, precipitated an economic crisis, sharply increased unemployment, likely increased both uninsurance and Medicaid enrollment, while threatening state budget revenue .

As a result, overall health costs have shifted dramatically in just the last two months. Expenditures on elective surgeries and other procedures have dropped over the last two month, creating pent-up demand post-pandemic. At the same time, some people who would have otherwise not needed treatment are experiencing extended stays in hospitals, including ICUs, for COVID-19, at very high cost. New coronavirus treatments and vaccines, and their prices, the possibility of a second wave, and countless other uncertainties make it impossble to predict when Connecticut will return to predictable health costs. Assumptions about baseline years for benchmarking no longer apply. Indeed, it is widely acknowledged by health policy experts and state officials that health care expenditures in 2020 are highly unusual and that both 2020 **and** 2021 will have abnormal costs due to the pandemic.

We have already seen the deeply disparate impact that the COVID-19 epidemic has directly had on persons of color and people with disabilities/chronic health conditions in our state. Poorly designed or timed cuts resulting from an imposed cost growth benchmarks could exacerbate these already very problematic consequences. Put simply, an unpredictable pandemic is the worst possible time to impose cost controls with uncertain impacts.

Finally, as result of much higher infection control costs to treat COVID-19 patients and the loss of income from elective surgeries and procedures, most hospitals in Connecticut are facing significant financial constraints. Two recent articles in national newspapers explain this phenomenon, threatening the independence if not the very existence of independent, non-profit hospitals, one of which focuses specifically on a small community hospital in Connecticut: https://www.nytimes.com/2020/05/15/us/hospitals-revenue-coronavirus.html ; https://www.washingtonpost.com/health/2020/05/13/coronavirus-damaged-hospital-financial/ Expecting these hospitals to "tighten their belts" next year to meet arbitrary cost benchmarks is the wrong approach, and could be counterproductive.

For all of these reasons, while this controversial initiative would at any time require extensive input and consideration because of the threat to already at-risk individuals throughout the state, it is unwise to proceed with developing these benchmarks now. In addition, delaying this initiative will allow you to correct some of the deficiencies in the structure for input developed by the Office of Healthcare Strategy. Trust in state health care policy-making is extremely important but does not currently exist in Connecticut. The best way to correct this is to provide for a robust system of input from all stakeholders, especially consumers and advocates whose sole job is to represent them.

The system of input established by OHS left it entirely to that one agency to define the membership of both the Technical Team and the Stakeholder Advisory Board. The committees between them have only a very small number of independent consumer advocates, who represent the individuals most likely to pay the price of the proposal's unintended consequences. In addition, the structure skipped over Connecticut's time-tested method of choosing members of advisory committee members by public official bipartisan appointments, nominations from both stakeholder groups and the public, and the use of objective qualifications. This has worked very well for such entities as the Medical Assistance Program Oversight Council, the Behavioral Health Oversight Council, and the Health Care Cabinet. Following that successful process will help to restore trust and increase the chances of success.

In sum, we have serious concerns with this initiative and its likely consequences for Connecticut residents. At a minimum, we urge that all efforts to develop benchmarks for cost containment be tabled until the pandemic has passed. We also urge you to restructure the input process so that, when the time is right, you will have broad input in a time-tested process which has long served Connecticut state policy makers and the residents of the state, bringing back a level of trust that is needed for this initiative to be fairly assessed. Given the threatened harm from the proposal, such broad input is essential.

Thank you for your attention to this request.

Respectfully yours,

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