October 7, 2020

To: Laurence Grotheer, Office of Health Strategy,
laurence.grotheer@ct.gov
From: Gaye Hyre, patient advocate
Re: Public comment on "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team"

For public comment, I am submitting copies of two letters to the Governor signed by dozens of stakeholders voicing concerns about plans to control healthcare costs. The concerns voiced in the letters have not been addressed in the final report. We've received no response to our letters.

As stated in the letters, advocates have worked with the state to lower the burden of healthcare costs on our state and we remain committed to working with the state to control healthcare costs without harming patients, the healthcare system, or communities.

Thank you for your attention to this.

Sincerely,

Gaye Hyre

September 22, 2020

The Honorable Ned Lamont Governor, State of Connecticut Executive Chambers, The Capitol Hartford, Connecticut 06106-1591

Dear Governor Lamont:

We are a broad group of advocates writing to follow up with new concerns on the letter of May 27, 2020 (attached) about the Office of Health Strategy's (OHS) project to control healthcare costs under Executive Order #5. In that letter we offered constructive recommendations to ensure the success of the project. Recognizing the profound impact of the COVID pandemic on both patients and the healthcare system, we urged a delay in the process until all the stakeholders who will be necessary to achieve responsible, sustainable cost control are able to fully participate. We also asked that the process be opened up to engage all stakeholders before any substantive decisions were made to avoid serious unforeseen consequences. Unfortunately, we received no response to our letter, neither concern was addressed, and further concerns have arisen.

No one is more affected by rising healthcare costs than consumers. Consumers pay those bills either directly, as out-of-pocket costs and premium contributions, or indirectly, as taxes and lost wages. Healthcare cost increases have moderated in Connecticut, as they have across the US, led by Connecticut Medicaid's extraordinary success in both cost control with improvements in quality and access to care. However rising costs in other parts of the health system continue to burden employers, communities, government, and households forcing sacrifices in other priorities.

We are concerned that the cap chosen by OHS and their Technical Team to reduce aggregate healthcare cost trends by almost half will cause harm to state residents, especially those with significant healthcare needs. We are concerned that resulting limits to care could further harm underserved populations, who struggled to access care before the pandemic. Since the pandemic, the sharp disparities in health and healthcare for racial and ethnic minorities have been laid bare, disparities which will likely worsen by cutting health care costs. We are further concerned that the very ambitious cap will undermine the state's healthcare system that is reeling from the pandemic and its impact.

We are concerned that there is no plan or timetable to develop a meaningful monitoring system to detect both anticipated and unanticipated harms. Ignoring the serious potential for unintended consequences, OHS and the Technical Team have only allowed for a rise in inflation to trigger a reconsideration of the Cost Cap. Direct harm to consumers wasn't considered by OHS or their committee as a prompt to reconsider and mitigate the harm. We urge you to delay implementation of the Cost Cap until that robust monitoring system is in place and functioning, and to require a reconsideration of the cap if harm is found.

We are concerned that OHS's plans to address Connecticut's disappointing quality of care will be delayed at least a year after the cap is in place. This invites cost control by lowering access and quality of care. OHS has devoted years and significant federal funds to set standards for quality measurement, without success. According to OHS, the project was unsuccessful because providers could not come to consensus on metrics. We are concerned that providers, who would be held accountable for their performance, were able to halt quality improvement. We urge you to delay implementation of the cap on healthcare costs until a robust quality monitoring system is in place and investments in quality improvement are working.

We are also concerned about OHS's stated plans to enforce the Cost Cap with agreements reached in confidential negotiations with high-spending entities. In secret negotiations, profit motives, rather than the best interests of Connecticut residents, could drive the outcomes. Advocates have raised concerns with OHS's past policy decisions affecting consumers, specifically selling access to sensitive medical records and reducing access to primary care for over 25,000 low income New Haven area residents. Transparency is key to increasing trust across the healthcare system. It is critical that the people affected by these agreements are part of the negotiation and have input into them to highlight the impact on communities and patients. We urge you to work through an open policymaking process using existing levers in law and regulation to lower healthcare costs responsibly.

Finally, we are concerned that the basic data necessary to measure healthcare costs against the cap and make good decisions is not available. Unlike Massachusetts and other states now considering a Cost Cap, Connecticut has little healthcare data capacity or analytics. Without those costly resources, the state would be flying blind trying to control costs, risking serious unintended consequences. In 2015, the General Assembly's Office of Fiscal Analysis estimated that a similar effort to develop a Cost Cap would be $3.3 million. The budget for the agency that sets Massachusetts' cost cap is $8.5 million this year, not including data costs. We urge delay of implementation of the Cost Cap until sufficient funds can be devoted to developing adequate data and cap development systems. As the state is facing a serious recession, there are better uses for those funds. We understand this is unlikely to happen soon, but doing this right is more important than doing it quickly.

While we have many concerns that must be addressed, advocates and providers stand ready to work with you and other policymakers to lower the burden of healthcare costs on our state, as Connecticut has done very successfully under the Medicaid program working with advocates. We have worked productively with state policymakers in the past to responsibly control costs and we stand ready to share innovative ideas for the future.

Thank you for your attention and we look forward to working with you and your administration to improve the affordability of healthcare in Connecticut.

Respectfully yours,

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cc: Victoria Veltri, Office of Health Strategy
Commissioner Deidre S. Gifford, Department of Social Services Representative Catherine F. Abercrombie
Senator Mary Daugherty Abrams
Representative Jay M. Case
Senator Kevin C. Kelly
Senator Matthew L. Lesser
Senator George A. Logan
Senator Marilyn V. Moore
Representative Cara Christine Pavalock-D'Amato Representative William A. Petit
Representative Sean Scanlon
Senator Heather S. Somers
Representative Jonathan Steinberg

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May 27, 2020

Governor 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 January 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 proposal 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 succeed 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 months, 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 impossible 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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Luis Perez
Mental Health Connecticut

Elaine Burns
President
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Karen Roseman
Chair
CT State Independent Living Council

Ann Pratt
CT Citizen Action Group

Bette Marafino
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Stephen A. Wanczyk-Karp, LMSW Executive Director NASW/CT

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Win Evarts, Executive Director The Arc of Connecticut, Inc.

Sharon J. Heddle
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Melissa Marshall JD
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Connecticut Cross Disability Lifespan Alliance

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Victoria Veltri, OHS Commissioner Deidre Gifford Legislative Leaders