UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Health Care Cabinet

Straw Model Comments

Introduction

The Connecticut General Assembly asked the Health Care Cabinet to submit recommendations for:

- Improving value in our health care system, with an emphasis on lowering costs and
- Addressing high and variable health care prices, particularly in light of the increasing consolidation occurring in the health care industry.

Universal Health Care Foundation (UHCF) applauds the extensive work that has gone into the Cabinet's development of a straw proposal, which has included studying the strategies followed by other states and learning about the initiatives underway in Connecticut. UHCF offers these comments on the straw model in the spirit of providing constructive feedback as the proposal continues to evolve.

Concerns about the straw model

In general, we find the recommendations place too much faith in Accountable Care Organizations (ACOs). ACOs are relatively young organizations and the evidence, to-date, is not strong that they are able to control costs, and any progress they have made in improving quality is not significant.

The proposal focuses mainly on the state employee health plan and Medicaid contracting with ACOs, and requiring a separate governance body that includes consumer input. As it happens, the state employee health plan has already enrolled over 40% of employees in ACOs. It seems premature to require the Office of the State Comptroller (OSC) to pursue an ACO strategy for all employees, without knowing more about whether it is producing desired results. Furthermore, ACOs are only one of several different strategies OSC is pursuing to control costs and improve quality care and overall health for state employees. Meanwhile, one known area of cost concern is the increasing price of pharmaceuticals, a problem that ACOs do not address. With regard to consumer input, a labor-management committee meets regularly to guide the health plan.

With regard to Medicaid, it's not clear that an ACO strategy would make a significant difference in promoting value. The ACO examples from other states cited in the straw proposal don't seem that different from the current Connecticut Medicaid strategy, which is focused on enhanced primary care and intensive care management for complex patients. The Medical Assistance Program Oversight Council (MAPOC) provides ample opportunity for consumer input.

The proposal includes adding in down-side risk – if and when ACOs are truly ready to take it on – as the literature gives some indication that this approach produces better results. But the literature also seems to indicate that having the right organizations ready to jump into the ACO market is also crucial, with large, sophisticated medical groups performing better than hospital-based ACOs. Connecticut does not have many independent medical groups with the size and technological and analytical capability to take on down-side risk right now. Consolidation among these groups is continuing to occur - so we may have even fewer of them soon. Also, many physician groups are being absorbed by hospitals. Furthermore, it's not clear that the same ACOs would bid on serving both Medicaid and the state employee health plan, so opportunities for synergy may be lacking.

The straw model isn't clear about how ramping up the ACO market by serving state employees and Medicaid would be sufficient to move the rest of the commercially insured into ACOs. This is partly because most of those with private health coverage receive it from self-insured companies, a very fragmented market.

Another concern is the proposal does not do enough to address pricing power, a major source of cost excess in private health spending per the information presented by Professor Zack Cooper to the Cabinet. While the proposal attempts to bake in some monitoring and limiting of ACO cost increases, this process appears to be administratively complex and it isn't clear that this would be easily accomplished. Creating large, too-big-to-fail ACOs, many of which may be based in hospital systems, could simply add to our current problem of monopoly pricing in the private insurance market.

Other recommended strategies

Agreement on a vision for our health system

The most recent version of the straw model listed goals which are very helpful in analyzing the proposal. In order to fully evaluate the proposal, it would also be helpful if the Cabinet agreed on a shared vision for our health system. One possible vision statement to consider is that of Connecticut's SIM project:

> Vision: Establish a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing healthcare costs.

Address provider and pricing power and price variation

As mentioned above, the straw model lacks sufficient focus on limiting price variation and unwarranted pricing power (e.g. prices that are unrelated to costs or quality). The hospital market in particular, is dominated by several large systems, that include large physician groups, that can not be excluded from insurance products. This dysfunctional market means consumers and employers have insufficient protection from provider power to set prices. Further regulation is needed, beyond extending the Attorney General's subpoena power to collect and report on pricing information. Here are some suggested recommendations to consider:

- Price and quality transparency for accountability
    - Ensure that the price transparency requirements of PA 15-146 are met, so that price variation, by payer and by provider for common procedures becomes visible.
    - When possible, match quality measures to price information.
    - As very little of health care is actually "shoppable", this information would be intended to give greater negotiating power to insurers or self-insured companies, who would have the information they need to explain why certain providers might be excluded from their networks. The goal would be to encourage price reductions and quality improvement.
- Require that pricing conditions be included in Certificate of Need decisions, as was done in the recent OHCA decision to allow Yale New Haven Health System to acquire Lawrence + Memorial Hospital.
- Add more "teeth" to the proposed process of setting a cost cap, or at least make explicit that the cost cap will eventually be enforced at the provider level.
- Return to reviewing hospital budgets and setting rates, as was done in Connecticut from 1976-1994, along the lines of what is done in Maryland and Vermont.
- Forge closer linkages between hospital rate setting and insurance rate setting as is done in Vermont.

- Study more closely Maryland's and Vermont's movement toward all-payer global budgeting and determine what initial steps Connecticut could take to move in this direction.

Pharmaceutical prices

The amount of the health care dollar spent on pharmaceuticals is growing rapidly. The straw model includes a recommendation for trying to maximize the state's purchasing power through coordinating formularies. We agree with the added recommendation to increase the Attorney General's subpoena power to include investigation of prescription drug prices.

Here are some additional recommendations to consider:

- Institute co-pay protections, as was done in California.
- Enact pharma pricing transparency legislation, as is being considered in multiple states.
- Ban direct-to-consumer pharmaceutical advertising from Connecticut's airwaves.
- Enact a therapeutic substitution law that would empower a pharmacist to substitute a less expensive but equivalent brand name drug for another.
- Pursue multi-state prescription drug purchasing alliances.
- Use the state's influence to pressure Congress to address pharmaceutical pricing excesses.

Addressing Medicaid cost drivers through payment or delivery reform

In contrast to the discussion above, high prices are generally not a cost driver for Medicaid. (Note: this is less true for pharmaceutical prices, although Medicaid still is able to obtain far lower prices than private insurers). Instead, the literature points to the need to better manage the care of high cost/high need recipients, as well as to prevent the development of chronic diseases.

SIM's Medicaid Plus pilot project is an example of this approach. Another example is the CT Practice Transformation Network project funded by a federal grant awarded to the Community Health Center Association of Connecticut (CHCACT).

- An 1115 waiver combined with a DSRIP program may be another important way to fund the building of needed care coordination infrastructure. States with the right motives - e.g. to improve care not limit care - have found 1115 waivers to be a useful tool. However, these waivers clearly come with risks, as they cap federal Medicaid payments. Also, some states can benefit from them more than others, based on technical factors such as how their federal funding formulas are structured. We await further technical analysis from Bailit about the tradeoffs between pursuing 1115/DSRIP or using alternative approaches such as state plan amendments.

It's important to note that movement away from fee for service payment is already happening in the health care system, driven largely by Medicare's movement to MACRA, which emphasizes the adoption of alternative payment methods. These changes come with serious risks of undertreatment, that require zealous monitoring and accountability measures to ensure patient care isn't compromised.

But changes in payment can also have a beneficial impact, not as a provider payment incentive, but to provide more up-front and flexible funding to support care coordination, community health workers or other needed connections between the medical care system, public health and social services. In any event, there is no doubt that effective care coordination is going to require major delivery system changes. We recommend:

- Explore Vermont's Blueprint for Health community-based teams and Colorado's Regional Care Collaborative Organizations as possible models for improving care coordination and medical care-community supports connections.

Focus on individual affordability

Too much of the health care spending burden is being shifted onto individuals, essentially punishing people who are ill, and discouraging people from addressing health problems. Evidence is beginning to emerge that underinsured individuals are avoiding getting care, which will only lead to greater expense down the road.

- Consider legislation that would limit co-pays and deductibles, perhaps starting with monthly limits on pharmaceutical co-pays, as mentioned above.
- Set limits on out-of-network provider charges, as is done in Medicare Advantage.
- Pass legislation to give the Connecticut Insurance Department statutory authority to consider affordability to individuals and employers when reviewing and approving insurer rate requests.
- Build on the work done for SIM by the Value Based Insurance Design (VBID) Consortium, determining ways to get more widespread adoption of VBID across the private insurance market.

Aligning state efforts within the state

It is important for the state to maximize its purchasing power, as well as its collective influence on delivery system improvements and cost containment, by aligning payment and delivery efforts across all state agencies as much as possible. It would be hypocritical for the state to impose new regulatory requirements on the private sector without getting its own house in order. We support the creation of an Office of Health Reform, that would have the authority to carry out the tasks described in the straw proposal, including setting an annual health care cost cap and monitor its achievement. In addition, we recommend:

- The office be clearly empowered to analyze and oversee health reform across the administration, including collecting cost data and setting quality metrics across all state agencies.
- The office should complete the study of rising health care costs mandated in section 19 of PA 15-146 which has yet to be conducted.
- The office should begin the process of moving Connecticut toward all-payer global budgeting, as discussed above.
- The office should have the authority to convene all health-related agencies, the Comptroller's office, plus SIM and Access Health CT on a regular basis.
- The office should have a duty to report regularly to the legislature and the public.
- The legislative leadership should consider a reorganization of the committee structure to centralize all health-related legislation and oversight, including Medicaid, public health and insurance, into one committee in order to achieve better alignment between the efforts of the administration and legislature.

Aligning state and private efforts

Beyond coordinating within the state, there is a need to have a body with stakeholder and consumer representation align state and private efforts around better care, lower costs and population health.

- Reexamine the current Cabinet structure and functions to maximize its effectiveness, using the current SIM Steering Committee structure as a guide.
- This entity would serve as a board to the Office of Health Reform to provide oversight and thought leadership.