UNIVERSAL HEALTH CARE
Foundation *of* Connecticut

October 20, 2020

Victoria Veltri
Office of Health Strategy
P.O. Box 340308
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Hartford, CT 06134-0308

Re: Public Comment on *Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team*

Dear Ms. Veltri

I am grateful for the opportunity to serve on the Stakeholder Advisory Board of the Cost Growth Benchmark project. I write to offer public comment, on behalf of Universal Health Care Foundation of Connecticut, on the draft recommendations of the Technical Team.

Our Foundation has been aware of the benchmark process in Massachusetts and its positive impact on slowing the growth of health care spending. We applaud Connecticut's effort to establish a similar effort, augmented with attention to both improving quality and enhancing spending on primary care.

Cost Growth Benchmark

The Technical Team has taken a thoughtful approach to establishing the initial benchmark. The challenge is to balance consumer affordability with provider sustainability.

The Office of the Healthcare Advocate has raised a concern in both Stakeholder Advisory Board meetings and in their public comment that the methodology may not be focused enough on the affordability side of the equation. I would suggest that the Healthcare Affordability Index, currently under development by the Office of Health Strategy (OHS) may be useful in testing how the benchmark may affect families of different incomes and health risk status.

The Technical Team has also emphasized the need to ease into using the benchmark and to make adjustments should circumstances require it. This flexibility is important. For example, as noted in the report, 2020 will not have been a "normal" year, due to the COVID-19 pandemic. So, adjustments are likely to be needed in future calculations of the benchmark, once 2020 data is available.

As has been pointed out in the report, the benchmark is not a cap. It is not setting a limit on any given provider's price or cost increases. Therefore, it should pose no threat to an individual provider's financial viability or be used as a reason to cut needed services in a given community.

At the same time, the draft report indicates that performance will be measured at the "state, payer, market and large provider entity" level. Making this information public will be crucial, particularly since no enforcement mechanism is currently anticipated when entities appear to be having a disproportionate impact on health system costs.

Regarding hospitals, a focus on prices will be key. I would hope the analysis would be done at the individual hospital level, not at the hospital system level, as hospital pricing can vary greatly between each hospital in a given system. In addition, an analysis of a given hospital's prices relative to overall health costs should include drilling down to both outpatient and inpatient revenues.

The recent RAND study of hospital prices paid by commercial payers as a percent of Medicare rates illustrates just how important such an analysis could be. The report shows wide variation between hospitals relative to Medicare and between each hospital's outpatient and inpatient prices. Here are just a few examples:

Inpatient and Outpatient Prices Paid by Commercial Insurers as a Percent of Medicare Prices
Selection of Connecticut Hospitals

Hospital	Health System	Outpatient prices 2016-2018	Inpatient prices 2016-2018
Stamford Hospital	Stamford Health	349%	197%
Hospital of Central Connecticut	Hartford Healthcare Corporation	262%	201%
Norwalk Hospital	Western Connecticut Health Network	254%	191%
Yale-New Haven Hospital	Yale New Haven Health System	246%	211%
Windham Hospital	Hartford Healthcare Corporation	241%	121%
Saint Francis Hospital	Trinity Health	213%	171%
Bridgeport Hospital	Yale New Haven Health System	196%	176%
Griffin Hospital	N/A	191%	139%
Manchester Memorial Hospital	Prospect Medical Holdings	186%	165%

Source: Nationwide Evaluation of Health Care Prices Paid by Private Health Plans, RAND Corporation, September 2020

Even if overall system cost growth remains under the benchmark, there will still be outliers that should be raised up, questioned and open to public review. Sometimes price increases will be easily explainable, sometimes not so much. In that way, the benchmark can be used, at least partially, as an accountability tool, to address price increases based on pure market power – something that has gone on for far too long in our current system.

Also, I would like to see pharmaceutical companies, or certain high cost/high utilization drugs added to the list of entities where performance will be measured. While prescription drugs are a smaller piece of

the larger pie of total health care costs, they account for around 30% of insurer premiums, at least in the private insurance market. So, they should be addressed in some form in the performance analysis.

Equally important will be performance measurement at the entity level based on the quality metrics which are about to be developed. And the findings from the underservice monitoring discussed in the recommendations should also be at the entity level, when possible. Holding hospitals accountable for continuing to meet the needs of their community should be enhanced, not hurt by this process.

Primary Care

It is not clear why the Technical Team felt the need for a broad definition of primary care that includes "routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery". Connecticut's problem with insufficient spending on primary care appears to be based mainly on an overutilization of specialists and a lack of primary care practitioners. So, an expanded primary care definition that includes OB/GYN practitioners may paper over the root causes of the problem we are trying to solve.

OB/GYNs are specialists. Their residency periods are longer and their practice expenses are likely to be higher. From a cost perspective, if on average an OB/GYN visit is reimbursed at a far higher rate than a visit to a DO, MD, NP or PA, as these providers are described in the narrow definition, the broad definition works against the cost growth containment goal of this project.

The analysis of primary care expense increase will be crucial. We will need to understand if these expenses are correlated with improved value, better outcomes and enhanced access to care. And, as mentioned in the report, it will be vital to see if there is any decreased spending elsewhere in the system that can be tied to higher primary care spending.

Data Use Strategy

Some of the comments in the first section of this letter may be relevant to the data use strategy. In addition, I would like to highlight a few key points mentioned in the report.

- The impact of higher prices paid by commercial insurers to hospitals and unexplained variation in those prices should be a major focus of data reporting.
- There must be a focus on trends with regard to out-of-pocket payments by consumers.
- I applaud attention to underservice, but would also like to note that that underutilization could be due to the burden of consumers' out-of- pocket fees. If overall system costs are dropping because people are afraid to seek care because of the bills they will receive, that is not a win for cost containment. For example, a recent survey conducted by Altarum's Healthcare Value Hub, *Connecticut Residents Struggle to Afford High Health Care Costs*, notes that 24% of those surveyed struggled to pay their medical bills and 44% experienced one or more cost barriers to care, including:
    - 19% cut pills in half, skipped doses or did not fill a prescription
    - 24% delayed going to the doctor or having a procedure
- Earlier in the report, (page 13) measuring social risk is emphasized. The data use strategy should focus on the impact of social risk factors and whether the needs of marginalized populations are being hurt by providers cutting expenses in the wrong lines of service. Incorporating data from
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hospitals' Community Health Needs Assessments and the nature of their community benefit investments could be very useful in this analysis.

In addition, this process could be useful for other regulatory functions related to health care costs. For example, the benchmark and the data collected should be incorporated into the health insurance rate review process.

Next Steps

It will be important to maintain consumer input as the cost growth benchmark project continues to be developed and is implemented. The emphasis on running a transparent process, including annual public hearings, and engaging the public at large in this work will be crucial to its success.

Please do not hesitate to contact me if you have any questions regarding this feedback.

Sincerely,

Jill B. Zorn

Jill B. Zorn
Senior Policy Officer