Office of the Healthcare Advocate
STATE OF CONNECTICUT

September 30, 2020

Victoria Veltri, Executive Director
Connecticut Office of Health Strategy
450 Capitol Avenue, 1st Floor
Hartford, CT 06134-0308

Re: Comment on Technical Team Preliminary Recommendations

Dear Ms. Veltri:

The Office of the Healthcare Advocate appreciates the chance to comment on this draft. The Cost Growth Benchmark project is important to the future of the healthcare system in this state, and if implemented wisely will foster healthcare justice and combat inequality. We provide one suggestion that in our view is absolutely necessary to the success of the project as well a number of other suggestions that would be important improvements also.

The first and most critical suggestion is to key the benchmark to the 25th percentile of family income, rather than the median income. Because of the rapidly escalating income inequality in our nation and even more so in our state, even the median income level is moving further and further away from large numbers of our hardest-working families. [1] If we use median income as a benchmark, we risk leaving behind the very folks in our community that will need a strong benchmarking project the most. Healthcare providers, insurance carriers, policymakers and other stakeholders who drive cost, price and affordability in our state should measure their own progress on affordability against the economic progress being made, or not made, by the families working hardest to keep up.

Utilizing the 25th percentile income rather than the median income level as our benchmark will ensure that this project remains relevant to our entire community, not just the top half. Without this simple but critical change, the benchmarking project will not fulfill its promise, and instead actually could contribute inadvertently to a large segment of our community falling further and further behind in terms of affording decent healthcare.

Please note that we are not suggesting different goal numbers than those that may be adopted until 2025. OHA is agnostic on what the actual final target numbers are for the first few years, and even on whether or not there should be targets defined in the first few years, especially given the confounding factor of the ongoing pandemic. The most important thing is to start measuring and observing healthcare expenditures in our state, and to establish a culture, practice and norm of using a benchmark keyed to the economic progress of our families of modest means. If others have an interest in keeping the bottom-line numbers in the draft the same, it should be possible to make this switch while still holding steady any pre-arranged cost growth benchmarks for

[1] For instance, from the late 1990's to the mid-2000's, Connecticut's bottom quintile income fell by nearly 10 percent, while our middle quintile eked out a gain of 2.5 percent: https://www.cbpp.org/sites/default/files/atoms/files/Connecticut.pdf

the first years, by use of any adjustment factors needed to keep the nominal numbers stable. Rather, OHA's goal here is longer-term and more fundamental. The need now is to establish the norm of having our state use the 25th percentile as the benchmark factor in further future years, since OHA hopes, expects, and will advocate for making cost benchmarking a permanent feature of Connecticut's healthcare landscape.

It is worth noting that this simple change will help put Connecticut at the forefront of all benchmarking states in terms of recognizing and addressing income inequality, and the consequent racial and other health disparities linked to growing income inequality.

Further suggestions for improvement include:

- Data use strategy (p. 6): needs the addition of an overt, strong focus on price. There is no need to do away with the proposed focus on costs, but there is a need to add in a specific focus on price. This is in recognition of the voluminous research showing that price itself likely is the single largest contributor to America's unique health spending problem (with the price problem centered in commercial insurance, and also particularly acute in markets like Connecticut with significant provider market concentration); [2]
- Access issues (p. 6 #3): it is key that this project does not morph into utilization review for providers in this state;
- If this project is not able to convince all payers to participate in this community project, a list of those payers who don't participate should be compiled and publicized annually. Asking is not alone enough (p. 12 #C(1));
- Primary care definition should be broad (p. 14-16): segments that are not included will be at increased risk of stinting or underutilization. This is reminiscent of the unintended consequence that occurred within payers after the adoption of the ACA's Medical Loss Ratio rules that required carriers to spend either 80% or 85% of premium dollars collected on medical claims or quality-related spending. Items that are critical to consumers but that weren't on the approved list of medical care or quality-related spending, like many anti-fraud expenses, suddenly became and remain disfavored expenses;
- The project needs a formal, systematic, periodic process to compare Connecticut on healthcare prices to selected economic competitor states/countries. This should be added to the Data Use priority goals (p. 18-19);
- It is too early to discuss consequences for breaching the benchmark, but when this time does eventually come, it is necessary for these to be geared to price, not costs (*passim*);
- Payers should be compared on prices; yes payers have their own data on costs, but they need to see how they are doing vis-à-vis their competitors (consumers likewise need to see which payers have negotiated better prices) (p. 18-19; add payers to priority audiences);
- Price & cost variation (p. 20): need to add in variation among payers as well as providers to the Cost Drivers analyses;

[2] The scholarship showing that price itself must be given its own separate high rank in all discussions of the factors creating America's healthcare spending problem are too numerous to mention, but for excellent examples, *see* https://healthcarepricingproject.org/ and https://www.healthaffairs.org/do/10.1377/hblog20190111.645950/full/

- Mathematica (p. 21): their charge must include explicit reference to price tracking and analysis; and
- Massachusetts (p. 21 #c): that state's inability to control growth in out-of-pocket costs while keeping overall spending in check is a fundamental flaw – and such a result should be unacceptable here. OOP spending growth will need to be monitored as a top priority item, not buried in a checklist.

Thank you for the opportunity to comment on this extraordinary and exciting project.

Sincerely,

Ted Doolittle
State Healthcare Advocate
Office of the Healthcare Advocate