Quality is Our Bottom Line

TO: SIM Steering Committee (via Mark Schaefer, SIM Program Manager)

FROM: Keith Stover and Susan Halpin: Connecticut Association of Health Plans

DATE: June 26, 2015

RE: Equity & Access (EAC) Report: Recommendation 3.5

The payer community has welcomed the opportunity to participate in meaningful dialogue on the various SIM workgroups and in particular on the Equity & Access Council. While the process has been labor- and resource-intensive, the health plans continue to share the state's vision for health care reform and value the development of a coordinated strategy to bring about better quality health care services at the best possible price. We are, however, beginning to question whether there is a serious commitment to payer engagement by all SIM participants, and indeed whether there is a strategy being pursued by some participants to purposely and actively alienate payers. Given the tone of some of the "recommendations" contained in the final EAC report (and the tone included in previous iterations), it's difficult for us not to feel that we are witnessing a devolution - from working together on shared goals back to revisiting ancient invective put forth by some "advocates."

Despite repeated opposition expressed by health plan Medical Directors to recommendation 3.5 "Reinvestment of Non-Retained Savings", the provision was not only included in the draft EAC Phase 1 Report, it was also noted as a "consensus" item. After an acrimonious subsequent session, a few revisions were incorporated that at least appropriately reflect the payer position for which we are thankful.

As outlined on pages 33 and 34 of the report, a number of principal rationales were put forward in opposition to the proposal including, and expanded upon herein, that:

- Payers and self-funded employers will not support a contract provision that calls for "reinvestment" of non-retained savings into an "independent entity" that administers the funds and ensures that they are earmarked to support improvements in access and quality. Cost saving, and therefore premium savings, pay their own reward in expanding access by enhancing affordability, Cost savings are decidedly not a new pool of money to spend on subsidies for private entities who have not chosen to invest in their own infrastructures. As noted in the report, payers and employers intend shared savings programs to incent quality of care, not to underwrite infrastructure improvements of private entities;

- The dollars associated with self-funded plans belong to employers, not the payers, and carriers have a very clear requirement under federal law to spend employer dollars on actual services. Diverting funds as proposed amounts to a pre-empted tax and;

- The assertions around "preventing payers from intentionally inducing underservice in order to withhold and keep shared savings payments "are offensive on their face – any entity responsibly engaged in the reform effort is well aware of the criminal and civil penalties for this sort of behavior. We have heard

these allegations for many years from the very same people making them now. As we know, however, the simple repetition of an attack repeatedly, even over the course of years, doesn't make it true or even fair.

The statement on page 12 that "consensus does not imply that a recommendation was adopted unanimously," is appreciated, but a report can't redefine words in contradiction to their meaning. Webster's defines "consensus" as "an idea or opinion that is shared by all the people in a group," which recommendation 3.5 was decidedly not. While we appreciate that in the end the final report was changed to denote recommendation 3.5 as "non-consensus", we object to its intent and respectfully request that the Steering Committee reject its consideration moving forward. Likewise, given the reasons articulated herein, we would also suggest that the Committee revisit the use of the term "consensus" in future stakeholder deliberations.

As we state above, the plans, whose representatives have spent countless hours on SIM, have a growing concern about the anti-insurance carrier rhetoric being included not just in discussion, but within the actual documents and recommendations. As you know, plans have participated actively and voluntarily in this important effort, based upon a commitment to system change and a fond hope that this process would be different - involving a range of interests who, while coming at issues from vastly different perspectives, held the important common core belief in system changes to benefit members, patients and Connecticut's citizens. It's fair to say that our concerns are beginning to color our thoughts as we contemplate our ongoing engagement in the SIM process. Of significant additional concern, we must add, is our diminishing confidence in the assurance we were given at the beginning that future payer engagement with SIM initiatives would be voluntary – undermined by such things as the survey on whether implementation of various measures should be mandated. Once again, we'd like to state for the record that health insurance carriers are on the cutting edge of implementing value-based designs in partnership with Connecticut providers and such efforts are well down the road, functioning well, and returning benefit to members and the system.

We look forward to discussing these concerns with you anytime, and again, respectfully request rejection of recommendation 3.5.