October 21, 2020

Re: Comments on the Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team

We write to comment on the preliminary recommendations of the Healthcare Cost Growth Benchmark Technical Team and to again urge the Office of Health Strategy to reconsider its plans to pursue its health care cost containment program as currently formulated. We note that this is not the first time we have written to express our concern with the inclusion of HUSKY programs in the strategy and with the proposed initiative generally. We recently received a response to our letter of September 17, which has helped our understanding of OHS's position, but many of the concerns expressed in our original letter remain. That letter is attached to these comments, which expand upon the concerns previously expressed.

Benchmarks Developed without Regard to Equity Issues Can Increase Health Disparities

As a general matter, we remain concerned that the cost containment strategy may result in greater health disparities, and erect greater barriers to health care access, for Black and Latinx residents of Connecticut. The plan is silent on the many issues that lead to health disparities in Connecticut. Failing to address those issues when developing a plan to address cost growth runs the very real risk that a cost benchmarking program will incentivize behaviors and practices by medical providers and insurers that will exacerbate health disparities. This is particularly true for HUSKY enrollees who are unlikely to see any tangible benefit from the plan as currently envisioned. The plan targets costs at the provider and payer level, in order to assess where savings can be realized. As a practical matter, because Medicaid enrollees do not pay premiums or cost sharing, any realized savings will not be passed on to patients who are Medicaid enrollees.

OHS stresses that the program is only to develop benchmarks, not cost caps, but the purpose of a benchmark is to establish a standard metric by which all subsequent measurements can be assessed, placing pressure on the providers to obtain that benchmark, and negotiations conducted behind closed doors to bring the private parties into compliance with OHS's desired targets, apparently still are intended. While the cost growth benchmark may not be a cost cap *per se*, OHS's stated intention is to use the benchmarking program to save money as compared to current medical expense. In order to achieve the benchmark cost savings, it is likely that providers and payers will be forced to cut services or access to low income patients, who will be unable to afford to pay out of pocket for denied services.

We understand that OHS is attempting to help address the growth of medical costs in the state. But even the best of intentions often result in unintended consequences if safeguards are not built in from the beginning. Experiments in controlling medical costs across the country have revealed that many programs often have the perverse result of dis-incentivizing hospitals and medical professionals from providing care to the most disadvantaged and medically needy populations.[i] Programs that blindly tie quality metrics to financial incentives without accounting for the social risk factors to health experienced by these populations can inadvertently penalize medical providers. For example, a study of Medicare's Hospital Readmission Reduction Program found that "safety-net" hospitals (those hospitals required to provide

care regardless of ability to pay) had higher readmission rates than more affluent hospitals. The study found that poverty, disability, housing instability and residence in a disadvantaged neighborhood were associated with the higher readmission rates, but when those social risks were accounted for the difference in readmission rates was cut in half.[ii] As a result, over half the safety-net hospitals saw reduced (and in some cases no) penalty.[iii] Another example is New York's use of a Coronary Artery Bypass Graff Report Card as a way to improve quality through the use of benchmarks and incentives for providers. [iv] Researchers found that rather than improve quality, the CABG report cards led surgeons to avoid patients they perceived as high risk, so fewer of these surgeries were done on the sickest patients, leading to even worse outcomes for these patients.[v]

The stories of the unintended consequences listed above along with so many others underscore the importance of fully exploring how measuring one element of quality health care could impact how that health care is provided. As such, these potential unintended consequences should be fully explored in advance of developing a set of metrics, not as an afterthought. On pages 13 and 14, the report acknowledges that members of both the Technical Team and the Stakeholder Advisory Board raised concerns that a cost growth benchmark may incentivize providers to reduce services provided. The report's answer to this concern is not to fully vet the ways in which benchmark measurements can go askew, but to apply the inadequate underservice utilization monitoring strategy for PCMH+ as a stopgap. OHS should *first* develop robust proposed monitoring measures and then use program management techniques to identify the ways in which these measures are likely to incentivize not only the desired behavior but also potentially incentivize behavior that would be counterproductive to achieving health equity. At a minimum, no cost control measures should be implemented until such monitoring measures are already fully developed.

Objection to Including HUSKY in Cost Growth Benchmark Initiative

We understand that there is legitimate concern about the increase in the cost of health care in the state, but not all health care coverage is created equal. The cost drivers at the provider, insurer, and consumer levels in private and employer-sponsored health insurance are very different from those for public health insurance. Indeed, HUSKY's impressive track record in controlling those costs, with average per member per month annual increases approximately 1.35% from SFY 2015 to SFY 2019,[vi] underscores the very difference between management of costs across a decentralized spectrum of private insurance options and a centralized government run insurance program. The report includes the HUSKY health programs (Medicaid and HUSKY B) along with all other health plans in the state that would be subject to the benchmarking program. We think including HUSKY in the program is misguided for several reasons.

HUSKY Health Costs are already well-monitored and tracked, and programs like PCMH have been very successful in ensuring efficient provision of services that often go beyond strict "health care" definitions. Innovations like the CHESS program, which begin to address the key social determinates of care by connecting select HUSKY enrollees with housing and social services providers, and the Diabetes Prevention Pilot, illustrate not only the inventiveness and dedication to obtaining optimal health outcomes within the framework of HUSKY, but also the inherent differences between the market and employer-provided insurance programs, and public health care like HUSKY. In addition, the HUSKY population as a whole faces many more complicating issues affecting health, such as substandard housing, food insecurity, and additional stressors, that are best addressed in a holistic wrap-around approach.

By regulation and statute, in partial recognition of this reality for Medicaid enrollees, HUSKY provides services that are not typically provided by private or employer-sponsored insurance, such as nonemergency medical transportation, long-term care, and other services. These additional services require more upfront expenditures than the average private health care provider must spend to achieve positive outcomes for patients, and are not fully comparable to the services provided by other insurers.

Further, HUSKY enrollees include populations that as a rule tend to be less healthy than the population covered by private and employer-sponsored insurers, with higher incidence of obesity, depression, and high cholesterol.[vii] Despite the hurdles to good health facing the average Medicaid enrollee, an extensive literature review of studies related to Medicaid expansion indicates that Medicaid does improve the health and economic of its patients.[viii] Medicaid is able to do this because of the expansive nature of the program, providing targeted services not provided by private insurers. Incentivizing the cutting of Medicaid expenditures, when major efficiencies have already been obtained in Connecticut through thoughtful affirmative investments, would be the greatest threat to enrollees' health[ix]. Because HUSKY serves patients facing higher health challenges than those enrolled in private insurance programs, and because it provides services those insurers do not, it is inherently different from private insurance. Including HUSKY costs in benchmarks evaluating private insurers in Connecticut would be like including oranges in an assessment of apple varieties.

The goals of benchmarking for HUSKY and for state-employee and other employer provided coverage should be very different. OHS says that the purpose of the cost benchmarking program is to make health care more affordable for the consumer. This is of no moment for HUSKY enrollees who don't pay out of pocket costs. Apart from a few HUSKY B enrollees, there are no premiums, copays or other cost sharing for HUSKY enrollees. Given this, HUSKY enrollees would not experience a financial gain from any cost savings in the way private enrollees in private insurance plans might see a reduction in their premiums and cost-sharing, while these enrollees would experience lost access to services through the incentivizing of arbitrary cost control beyond what has already been cautiously obtained in the program. We note, however, judging from Massachusetts' experience (upon which Connecticut has based its plan), the savings may instead simply be retained as profits by commercial insurers and providers. (See below.)

Given the success of cost control of Medicaid in Connecticut, HUSKY should not be the target of this cost containment program, and indeed, if the program is to proceed at all, HUSKY should be excluded from the benchmarking project. Unfortunately, the state has little leverage in controlling the costs of health care paid for through private insurance, apart from negotiating the insurance plans for state employees. Thus, HUSKY, which the state *does* control, is the most likely program to be enlisted as the state's laboratory guinea pig for this benchmark experiment, with inappropriate savings extracted from this already very efficient program credited to the all-payer aggregate cost reduction goal to the benefit of hard-to-control private insurers, giving a false appearance of overall success.

Objection to Focus on Primary Care Spending Instead of Access

We also remain concerned about the focus on primary care spending, rather than access, particularly in the Medicaid program. The narrow definition of primary care ignores the reality that for many individuals, their primary medical relationship is with a medical provider who does not fall under the primary care definition. For example, many healthy women consider their obstetrician/gynecologists as primary care providers, who would be excluded from the narrow definition.[x] The model also presupposes access to primary health care providers, which has been decreasing over several decades. A 2014 study of the largest U.S. metropolitan areas by the Pittsburgh Post-Gazette/Milwaukee Sentinel found that, since

the 1970s, physicians and hospitals have been moving out of lower income areas, where the population is more likely to be sick, to wealthier areas.[xi] The 2016 Agency for Healthcare Research and Quality Disparities Report found that poor people experienced worse access to care compared to high-income people in 19 of 20 access measures, and Black people had worse access than white people in 10 of 20 measures. In no measure did poor people or Black people have better access than high-income people or white people.[xii]

Focusing only on primary care spending, without doing more to establish primary care providers in underserved areas, has the potential to cut spending for the medical providers on whom HUSKY enrollees rely and also privileges medical doctors over physician assistance and nurse practitioners who can in many cases provide the necessary care at a lower price point. Given the smaller numbers of M.D.s as compared with P.A.s and nurse practitioners, the focus on spending rather than access could incentivize medical practices and insurers to privilege doctors, further reducing access to care. Furthermore, the report anticipates that it might not be possible to collect these costs across all medical systems. HUSKY costs, of course, are readily available to the state, more so than any other data set, so inclusion of HUSKY in the cost containment benchmark runs the real risk that HUSKY costs will be a disproportionate component of the primary care spending metric. Because HUSKY costs are uniquely controllable by the state, there is also the risk that HUSKY would be the primary target of any cost adjustment in fulfillment of keeping to an aggregate cost growth benchmark.

Another problem with the focus on costs at the insurer and provider level is that it encourages cost cutting which can increase real costs for HUSKY enrollees who can least afford them. People without primary care providers rely on local clinics, which often suffer as a result of health care system consolidation and cost cutting. For example, in New Haven, the creation of the "primary consortium" of Yale New Haven Health, the Cornell Hill Health Center, and Fair Haven Community Health Care, the latter two FQHCs, and the location of the consortium in the YNHH Long Wharf facility moved three clinics in minority-majority residential neighborhoods to a location that is not only not a residential area, but is also not easily reachable by foot or public transit. Yale New Haven Health has proposed addressing the transportation issue by providing Uber rides, but local advocates have dismissed this arrangement as inadequate.[xiii]

The consolidation of the New Haven FQHCs illustrates the disconnect between cost savings at the institution level and cost at the patient level. Assuming for the sake of argument that this arrangement is wildly efficient financially with the three clinics sharing administrative and overhead expenses, despite the higher Medicaid reimbursements required for the same services when provided by an FQHC versus a hospital, patients will nevertheless face increased costs, depending on their local clinics.

Getting to the clinic at a remote location will cost the patients, either for the cost of transportation or for the additional time required to travel to the new location. Even if the proposed Uber program is implemented, it adds another level of complexity for patients in getting to the clinic for appointments. Patients may be discouraged from seeking care because of the difficulty in traveling to the clinic. Consolidation will likely reduce the number of appointments available or, at a minimum, make it more difficult for a patient to make an appointment with a specific provider. Thus, it is likely that patients will have to go through their history with a new provider each visit. Further, all practitioners have been informed that all appointments will be scheduled for 20 minutes only, regardless of the medical issue being treated or whether the patient is a new patient. Indeed, it is not unreasonable to predict that this consolidation will lead to greater use of the Emergency Departments at Yale New Haven Hospital's main

and Saint Raphael's campuses, both of which are more centrally located to low-income residential neighborhoods than is the Long Wharf location.

These impacts will disproportionately fall on racial and ethnic minorities, who make up 62.99% of the patient population of FQHCs nationally.[xiv] Black and African Americans specifically make up 21.69% of the patient population. One in four people in poverty relies on FQHCs, as compared to 0.6% of people with incomes more than twice the federal poverty level.[xv] Limitations to access to FQHCs will also directly impact access to health care for Medicaid recipients as more than 17% of Medicaid recipients receive care at an FQHC.[xvi] These patterns hold true in Connecticut, with 50% of patients at state FQHCs identifying as Hispanic/Latino and 24% identifying as African American.[xvii]

Objection to Benchmarks which Measure Cost Savings without Regard to Savings by Consumers

In addition to our concerns about the cost growth benchmark proposal for our clients on HUSKY, we have concerns regarding this proposal for our low-income clients who rely on private coverage purchased through the state insurance exchange. Even for these health insurance consumers, the program as designed is less likely to improve their ability to afford health care than to reduce the costs for insurers and providers. We come to this conclusion by examining the experience of consumers in Massachusetts, the site of the model upon which Connecticut has developed its plan.

This initiative has largely been justified by the need to address high costs for private and employer-sponsored health insurance consumers. However, according to the Technical Team's own report, Massachusetts' cost cap has not saved consumers' out of pocket costs. Indeed, premiums and other out-of-pocket costs there have actually grown at twice the rate (or more) of the benchmark.

For low-income consumers of health insurance, such cost increases are likely to discourage their purchase of health insurance, both increasing the number relying on public health insurance options (to the extent they are eligible) and the number of uninsured. The Urban Institute found that a moderate increase in insurance premiums for low and middle-income (with incomes between 133 and 400 percent of the federal poverty level) consumers resulted in a 4.1% increase in the number of uninsured in this group, and an increase of 0.9% of enrollees in public health coverage.[xviii] The National Bureau of Economic Research has found that an increase in insurance premiums not only increases the ranks of the uninsured, but also increases unemployment, pushes more people into part-time work, and forces employees to sacrifice wages and other benefits in order to maintain coverage.[xix] For individuals and families at the lower end of this income band, the effect of increases are magnified. Research by the Kaiser Family Foundation has found that the effect of premium increases is the largest for those with the lowest income.[xx]

Because there is a real need to provide relief to consumers enrolled in private and employer-sponsored insurance, particularly for low-income consumers, any savings generated through these insurance plans under this proposal should go to those consumers, especially given the likely harm to them from incentivized under-service. The experience in Massachusetts should give the state pause and delay the initiative at least until it can be assured that any savings will go to consumers and not to private payers and providers. It also underscores the need for a robust system for measuring resulting harm. This may be difficult to do, as acknowledged by OHS's consultants, but that is not a reason to ignore the initiative's originally-stated goal of lowering cost growth for consumers, nor the danger of such an initiative in terms of restricting access to quality health care for Connecticut consumers.

Objection to Moving Forward with This Initiative during the Pandemic

Finally, while we believe that HUSKY should not be a part of any general cost containment initiative by OHS, and that there are serious concerns with moving forward with a model unlikely to benefit the health insurance consumers, we note that, as many other advocates and providers have already pointed out, attempting to implement any cost growth benchmarks in the midst of a pandemic, with grossly altered medical expenditures, is inappropriate. A benchmark's value is in the extent to which it represents a standard measurement. Nothing about medical costs in 2020 can be described as "standard." We recognize that the Governor signed an executive order stating that benchmarking would begin this year. However, he signed that order well before the pandemic hit Connecticut and the state's health care system.

The state's providers are reeling from the impact of COVID-19, with high costs related to actual COVID patients and extra infection control measures, at the same time that other health care usage has dramatically dropped, resulting in artificially depressed expenditures and revenue for providers. For example, Community Health Network of Connecticut reported at the September 10 MAPOC meeting, "FQHC, Medical billing and billing by other practitioners such as physician assistants and nurse practitioners, decreased by 28.7% in Q2 of 2020 compared with the same period in 2019."[xxi] While Connecticut has significant difficulty in accessing relevant data, whatever current data is available is going to be greatly skewed as a result of excessively depressed use of non-COVID health care, and thus not a basis for any rational cost containment calculation based on current expenditures, as intended.

Conclusion

We applaud the efforts of OHS to make health care more affordable for the residents of Connecticut, but we request that OHS not do so during a pandemic, and not do so at the expense of those least able to afford increases in costs for accessing healthcare, including people of color, whether directly or indirectly through reduced access to care incentivized by cost caps. We also urge that any such efforts directed at saving money for commercially insured individuals, including low income individuals purchasing insurance on the exchange, not be implemented unless, contrary to the Massachusetts model upon which this effort is based, it can be assured that any savings generated by this initiative will go directly to those consumers.

Sincerely,

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