UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Testimony in Support of
Senate Bill 444: An Act Requiring the Health Care Cabinet to Study Establishing a Health Care Cost Growth Target and
Report on Total Statewide Health Care Spending
Submitted by Frances G. Padilla, President
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I come before you as President of the Universal Health Care Foundation of Connecticut. In this capacity I also serve as a member of the Connecticut Health Care Cabinet and a member of the Steering Committee of the State Healthcare Innovation Model. In addition, I serve as co-chair of the CT Choosing Wisely Collaborative, and as a board member of Qualidigm (a leader in health care quality improvement and innovation), and on the board of Planned Parenthood of Southern New England. My comments today are offered from what I understand by looking through these various lenses.

I respectfully testify that enactment of S.B.444 is one of the most important outcomes the Public Health Committee and General Assembly should achieve in this legislative session. Health care costs are a major proportion of the state budget, comprising 25 to 40 percent of expenditures. But public spending on health care is only a part of the full health care cost picture. Total health care spending in the private market in Connecticut is also a large segment of the state's economy, and costs to employers and consumers continued to escalate over the past decade. Health care premiums and out of pocket costs, particularly drug costs continue to rise faster than median income in Connecticut. Employers trying to contain their costs have adopted coverage strategies that limit their exposure by increasing cost-sharing requirements on their employees. A silver lining is an uptick in helping public and private sector employees benefit more from prevention and early detection of treatable or avoidable conditions.

While controlling utilization of low value care and incentivizing the right care through various payment reform strategies is important and should continue, payment reform alone will not fully contain costs. As most of you know, price and cost are two different things in health care. Negotiated discounts between providers and payers make the price paid for a service or product in health care far removed from the actual cost of it. As you also know, CT hospitals complain mightily about this with respect to Medicaid reimbursement rates, which they consider to not sufficiently compensate for costs, if at all. To some extent, they are justified.

Public Act #15-146, Section 17, enacted in June 2015, instructed the Connecticut Health Care Cabinet to make recommendations on health care cost containment strategies for Connecticut. We examined model strategies in other states including Massachusetts, Maryland, Oregon, Rhode Island, Washington and Vermont. Massachusetts and Maryland are two states that have adopted policies to better understand the "total cost of care" and implemented a specific target for statewide health care cost growth as one strategy. In each instance, these states align the targeted rate of growth in total cost of health care to an external economic indicator such as the gross state product (a measure of productivity) or the Consumer Price Index.

In those states, setting a cost growth target has focused the attention of policymakers, providers, payers and the public on containing cost growth, and thereby necessarily considering both service prices and utilization of services. It has spurred action on prices and changes required in care delivery to contain cost growth. For example, in Massachusetts, hospitals must submit annual reports on their spending against budget to the Massachusetts Cost Containment Commission. If their expenditures exceed the target, they must propose a remediation plan to which they are held accountable.

The goal should be to establish a cost growth rate target that is affordable to consumers, employers and taxpayers, and that is simultaneously fair to hospitals' and other providers' solvency requirements. Maryland has similarly adopted a cap on cost growth. Connecticut SIM's goal is to achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) using primarily a value-based alternative payment methodology.

It is important to emphasize that Massachusetts and Maryland consider the target to apply to total private and public health care costs, not only Medicaid. The rate of growth in Connecticut Medicaid spending in recent years is considered within normal expectations. While there is always room for improvement, it should not be the sole target of a cost growth cap. This would be potentially very harmful to low income people in Connecticut, and may justify an alternative target (or none at all). Hospital and drug prices contribute significantly more to health care costs and affordability in the private market than they do in Medicaid. Privately insured consumers need relief from these costs.

As the final report submitted to the Legislature on January 5th states, the Connecticut Health Care Cabinet concluded that more transparency regarding the rate of health care cost increases and key drivers of those increases is needed to start changing the state dialogue on how to control rising costs. To further this goal, the Cabinet recommended reducing cost growth by setting a statewide target on annual total cost of care, and assessing performance at the state, payer and large provider level.

The Cabinet further recommended that it be charged by the Legislature with a follow-up assignment to further analyze and recommend more precisely how best to define and implement a statewide health care cost growth target.

We learned from the experience of other states how important it is that all relevant stakeholders be involved in such an exercise if it is to ultimately come to fruition. "Change happens at the speed of trust", one leader from Maryland told us at the Universal Health Care Foundation in 2015. Accountable care organizations, hospital systems, independent hospitals, post-acute providers, doctors and other health care providers, safety net providers, public and private health care purchasers and payers, consumers, economists, and health care policy experts should all be assembled into a working group of the Cabinet to conduct the analysis and develop further recommendations.

When considering a cost growth target, our report identifies 8 specific issues on which the work group should recommend:

1. Study the methodology of Massachusetts and other states that have adopted or implemented a state-level cost growth target, including their relative public and private reimbursement environment.

2. Identify what data various Connecticut agencies have, and what data are needed to define baseline spending and assess state, payer and provider performance relative to the target.
3. Recommend a state entity that should assume responsibility for computing state, payer and provider performance relative to the target.
4. Define the minimum number of provider-attributed lives for a provider to have its performance assessed relative to the cost growth target.
5. Identify what external economic indicator should be used to define the cost growth target, with consideration given to the Prospective Gross State Product and the Consumer Price Index for All Urban Consumers (CPI-U).
6. Recommend an implementation timeline for the cost growth target that spans several years' time and defines the time period during which performance relative to the cost growth target should be reported publicly without penalties or sanctions for meeting or exceeding the target. The recommendation should specify the timing for setting each year's cost growth target.
7. Recommend how the results of the cost growth target are reported publicly, and what steps payers and providers must take to explain their performance if they exceeded the target.
8. Recommend the frequency with which the cost growth target should be assessed for its effectiveness.

The work group should make its recommendations to the Cabinet in a timely manner to allow the Cabinet to make its final recommendations to the Governor and Legislature by December 15, 2017.

I started this testimony by stating that enactment of this legislation is one of the most important outcomes of this session. I will conclude by saying that Connecticut consumers and businesses cannot afford health care costs today and the federal health reform environment makes it even more crucial that state policymakers assertively and strategically move to strengthen Connecticut's economic position. This is a start in that direction for which your constituents will be grateful.