CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Tuesday, March 1, 2022

HB 5042, An Act Concerning Health Care Cost Growth

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5042, An Act Concerning Health Care Cost Growth.** CHA is committed to working with the legislature and Governor to address healthcare affordability and access in Connecticut and is interested in working with all parties to ensure that this legislation provides the appropriate pathway for that work.

Since early 2020, hospitals and health systems have been at the center of Connecticut's response to the COVID-19 public health emergency, acting as a vital partner with the state and our communities. Hospitals expanded critical care capacity, procured essential equipment and supplies, and stood up countless community COVID-19 testing locations. Hospitals have been an essential component of the statewide vaccine distribution plan including efforts to reach and serve historically under-resourced communities disproportionately affected by the virus. Through it all, hospitals and health systems have continued to provide high-quality care for everyone, regardless of ability to pay. This tireless commitment to the COVID-19 response confirms the value of strong hospitals in Connecticut's public health infrastructure and the well-being of our communities and reinforces the need for a strong partnership between the state and hospitals.

HB 5042 places in statute language implementing Governor Lamont's Executive Order No. 5 (EO 5), which requires the Office of Health Strategy (OHS) to implement, beginning in 2021, an annual cost growth benchmark, an increase in primary care spending (as a percentage of total spending), and development of quality benchmarks.

CHA is committed to sustaining and improving access to high quality healthcare services across our state. We appreciate that affordability is central to that commitment and every actor in the system, i.e., provider, payer, pharmaceutical and device manufacturer, employer, and government, has an important role to play in this work.

It is why CHA and hospital leaders from across the state have worked directly with OHS for nearly two years now on the establishment of the cost growth benchmark, primary care targets, and quality benchmarks.

While we have been engaged in this process, hospitals and health systems have been consumed by the response to the COVID-19 pandemic, which we know has had unprecedented impact on hospital and health system financial health, patient volumes and utilization, and workforce availability and cost. In addition, we are contending with the fastest pace of rising inflation in 40 years.

We have been guided by a set of principles as we engage with OHS and other stakeholders. **First and foremost, we strive for a healthcare system that is accessible to all patients, provides the type of care they need when and where they need it, is affordable, and is high quality.** Further, the pandemic has taught us that strong hospitals and health systems are key to the state's response to a public health emergency and weakening that infrastructure would harm public health response in the future. We also consider the following specific to the construction of the benchmarks and targets:

- Preserve and expand access to care
- Memorialize robust stakeholder participation and full transparency in the development of the benchmarks and subsequent periods of evaluation
- Develop spending targets that appropriately reflect and promote healthcare's important role in the state's economy
- Implement a non-punitive assessment and evaluation process
- Define the parameters by which measurement of performance against the benchmark will be determined, including what costs will be excepted
    - Excepted costs should include state spending agreements (e.g., Medicaid rate increases); exceptional circumstances (e.g., public health emergency, novel therapies, pharmaceutical price increases, financial recovery); and costs not within a provider's control
- Allow for exceptional activities (e.g., service-line expansion)
- Provide that all healthcare spending (physician, hospital, long-term care, pharmaceutical, device, payer, government, etc.) is captured in the benchmark calculation
- Include appropriate adjustment factors (e.g., risk adjustment)
- Accommodate alternative payment models (e.g., risk contracts, shared savings arrangements, etc.)
- Ensure appropriate access to and protections for data and information submitted and used for benchmark purposes

We have consistently highlighted these principles with OHS and other stakeholders.

We have also encouraged the need to understand and consider the costs associated with providing care, including the significant impact inflation is having and will have into the future, the overwhelming labor costs that have increased dramatically over the last year, pharmaceutical costs, and the continuing effects of COVID-19 on resource utilization and care delivered outside the four walls of the hospital, such as vaccination and testing.

We have sought a process that is fair to all stakeholders, highlighting the need to use comprehensive data over what is convenient or supports a chosen narrative. We have asked

that information not be presented in silos, understanding, for example, that underpayment by public payers like Medicare and Medicaid influences commercial payment rates.

We also note the concerns raised about potential effects on access to care and believe those concerns need to be front of mind as we continue with this process. We must not allow benchmark implementation to result in diminished access for patients to healthcare providers and services.

We appreciate the opportunity to share these principles and our ideas with the Committee and ask that you consider them should this legislation move forward. Consistent with these principles, we suggest the following amendments be considered.

Require Reauthorization

The legislation should authorize the benchmarks and targets through 2025 and require their reauthorization by the legislature for implementation beyond that date.

As we continue the work of implementing the benchmarks and targets, we should acknowledge that we cannot be fully aware of the impacts of their implementation. We do not know yet their full effect on patient access, care innovation, care delivery, and care and service line expansion.

It is also too early to identify how the pandemic will affect the future of healthcare delivery in our state. There is no analogue for attempting to implement a statewide healthcare spending target in the midst of a global pandemic.

The legislature should acknowledge both the potential promise of benchmark implementation, while being thoughtful in planning that implementation.

Section 1

- Line 20, page 2, strike "directing"

- Line 28, page 2, strike "facilitate adherence with" and replace with "meet"

Section 3

- Line 154, page 6, after "inflation," strike all through line 156 and insert "(iii) the adequacy of public payer provider reimbursement rates, (iv) labor costs, (v) medical inflation, (vi) costs of breakthrough treatments and medical advances, (vii) impact of the COVID-19 pandemic and future public health emergencies, and (viii) the most recent report, if any, prepared by the executive director pursuant to subsection (b) of section 4 of this act."

- Line 157 page 6, strike "may" and insert "shall"

- Line 169, page 7, after "target." insert "If the executive director, after the informational public hearing held pursuant to this subparagraph (C), determines that no such modification is required, the executive director shall issue a public report describing the reasons for not making such modification."

- Line 170, page 7, after "(iii)" insert "The executive director shall review the current and projected rate of inflation and assess the impact on healthcare costs and spending."

- Line 175, page 7, after "benchmark." insert "Should the executive director determine no such modification is required, the executive director shall issue a public report describing the reasons for not making such modification."

- Make the above amendments to the quality benchmark provisions

Section 4

- Line 235, page 9, insert after (1) and renumber "(2) Payer and provider input costs, including pharmaceutical costs; (3) Adequacy of Medicare and Medicaid payment rates as they relate to the cost of care; (4) Impact of the rate of inflation and rate of medical inflation; (5) Impacts on access to care, medical service expansion, pursuit of medical innovation; (6) Patient acuity; (7) Response to public health crisis"

Section 5

- Line 265, page 10, insert after the period "The names of the payer or provider entities identified under this subsection (a) shall remain confidential and not be made public and only made public should the executive director be permitted to disclose the payer or provider identity as part of the public hearing described in Section 6."

- Line 269; page 10, after "be" insert "confidential and"

- *Process for Contesting OHS Findings* – insert as new (3)

  Each such payer or provider entity shall have the opportunity to meet with the executive director within 30 days of the transmission by the executive director to discuss the factual basis for the executive director's finding, provide information to dispute or contextualize such finding, and request that the executive director amend the finding.

  The executive director shall consider the information provided by the payer or provider entity and consider whether to amend the finding based on that consideration. Should the executive director determine that the finding should be amended, the provider entity should not be required to participate in the public hearing described in Section 6.

Section 6

- Line 304, page 11, strike "The expenditures of provider entities and payers, including, but not limited to,"capitalize "health," and after "expenditures" add "at the state, market, and provider type levels"

- Line 310, page 11, after "(2)" strike "The" and add "Subject to the requirements of paragraph 3 in section 5, the"

- Line 342, page 12, require the executive director's report to the legislature to also include an analysis of the benchmarks and targets' impact on access to care, medical service expansion, and pursuit of medical innovation. The executive director's report should also include the report required under the amended section 4.

We are happy to discuss further our ideas and amendment suggestions at your convenience.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.