Transit Employees'

HEALTH AND WELFARE PLAN

metro

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John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC 2016 Hospital Update Factor

Dear Mr. Colmers and Ms. Kinzer:

I want to thank the commissioners and the Commission staff for allowing me the privilege of participating in the Payment Models Work Group and to provide comments on the staff recommendation to the Update Factors. The staff and the other members of the work group have been very patient with me as I gradually get up to speed with this rate setting process.

I am the Executive Director of the Transit Employees' Health and Welfare Fund. We are the entity that pays the health and other benefits for the 12,000 active and retired members of ATU Local 689 employed by the Washington Metropolitan Area Transit Authority, about 70% of METRO's workforce

I represent a minority voice in this process: the voice of those plan sponsors that write the checks that provide the funds for carriers like CareFirst, United Health Care and Kaiser to pay hospitals. We are the ones whose bottom lines take the hit from increasing health care costs. We are the ones who must deduct increasingly larger amounts from our employees' pay checks in order to pay those health care bills.

Employers and workers across Maryland have for decades absorbed increases in health care costs that far exceed the rate of inflation and the rate of growth in the economy. It is partly because these increases are unsustainable that Congress passed the Affordable Care Act and that Maryland embarked on this pioneering effort to restructure the way that hospitals are paid

I have often repeated to others the words of an early story in the Washington Post. This is the most significant state initiative in the country next to Vermont. Now that Vermont's efforts to evolve into a single payer system have unfortunately floundered, the eyes of the nation are on Maryland

Those on the Payment Models Work Group have heard me say that I think the 3.58% allowable growth rate is far too generous and I applaud the efforts of the hospitals in Maryland to come in well under that target in its first year under this new model. We in the plan sponsor community face cost pressures from several directions. Just this past year the cost of our prescription drug program increased nearly 30% from first quarter 2014 to fourth quarter of 2014.

Those increases are largely attributable to new specialty medications for Hepatitis C that are expected to reduce long term inpatient and outpatient treatment costs for that disease. We are warned that many more very expensive treatments and cures are in the pipeline. Next up is PCSK9 a revolutionary drug to treat high cholesterol.

If we are spending more money on medications to reduce long term hospital costs, then we expect to see reductions in hospital costs, not just slower increases. In a recent article in the Journal of the American Medical Association (JAMA)[1], Don Berwick challenged the provider community to become leaders in making the changes necessary to achieve the goals of the Triple Aim. And he very specifically challenged those leaders to bring total spending on health care to under 15% of GDP.

From where I sit, Maryland is doing an outstanding job of bringing the provider community to the table to assume a leadership role in this process. But allowing hospital costs to track the growth in the Maryland economy will not reduce per capita spending and will never allow it to do Maryland's part to get health care spending below 15% of GDP.

Additionally a major concern of the employer community is the impending excise tax on so called "Cadillac Plans". This 40% marginal tax rate will eventually hit every single employer in Maryland, including the state of Maryland, perhaps the largest single group health plan in the state – unless total spending is reduced to below the rate of inflation – something that I don't think has happened to employer health care costs in my life time. The only way employers can avoid this tax is by shifting point of service costs on to their employees. Discussions at the Payment Model Work Group reveal that hospitals are having difficulty collecting these higher patient out of pocket expenses and it is affecting their bottom lines and the rate setting process.

In the first year of the waiver the hospitals have done an outstanding job of reducing revenue, improving quality while also enhancing their bottom lines. Who could ask for more? I see no reason, therefore, why the full .59% infrastructure allowance is necessary and ask the Commissioners to reconsider its inclusion in the final rate setting factors. Maryland hospitals have proven that they can meet their cost and quality targets without the additional money. Countless publications have described overuse and inappropriate volume in the system. Reducing those related costs should be sufficient to fund the necessary infrastructure improvements.

I would call attention to a slide presented at the last meeting of the Commissioners in April that showed that the median profit margin for Maryland hospitals increased by 1.18% - double what the commissioners are being asked to add to the rates for 2016 infrastructure improvement. So why is this additional money necessary?

However, if the infrastructure allowance is allowed to remain, then I ask that the Commissioners and staff to be vigilant to ensure that it is used to actually lower per capita health care costs in Maryland. I ask the Commissioners and the staff to expand its scope of unnecessary and inappropriate admissions by looking at population based metrics and benchmarking themselves against the best in class elsewhere in the nation.

That is the only way that Maryland will truly get the attention it deserves.

Thank you and I do hope that you will continue to involve the voice of the plan sponsor community in this process as you move forward.

Sincerely,

James L. McGee, CEBS
Executive Director

[i] Berwick DM, Feeley D, Loehrer S. Change From the Inside Out: Health Care Leaders Taking the Helm. *JAMA*. 2015;313(17):1707-1708. doi:10.1001/jama.2015.2830.