New Mexico Banker's Association

Barbara McAneny MD

CEO New Mexico Cancer Center

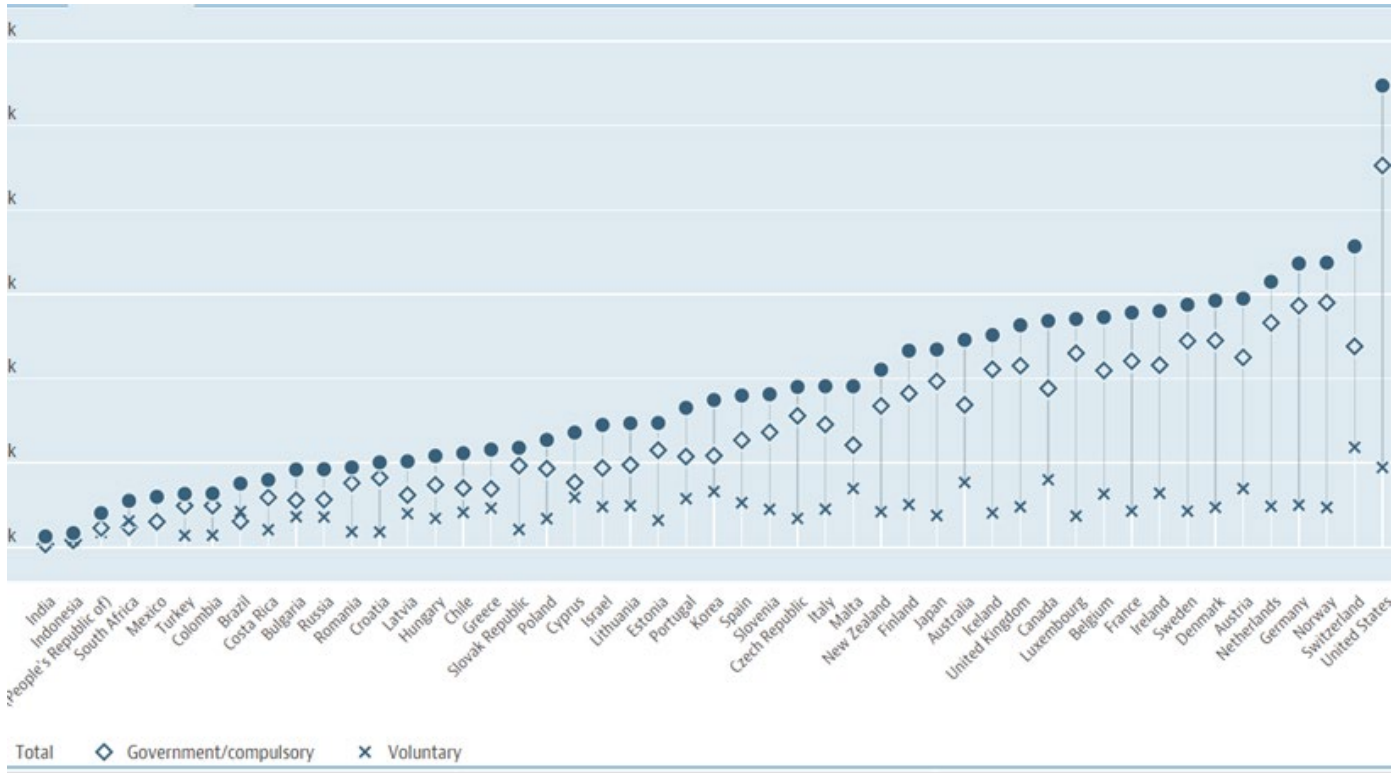
Former President, NMMS and AMA

NMCC

New Mexico Cancer Center

New Mexico Oncology Hematology Consultants, Ltd.

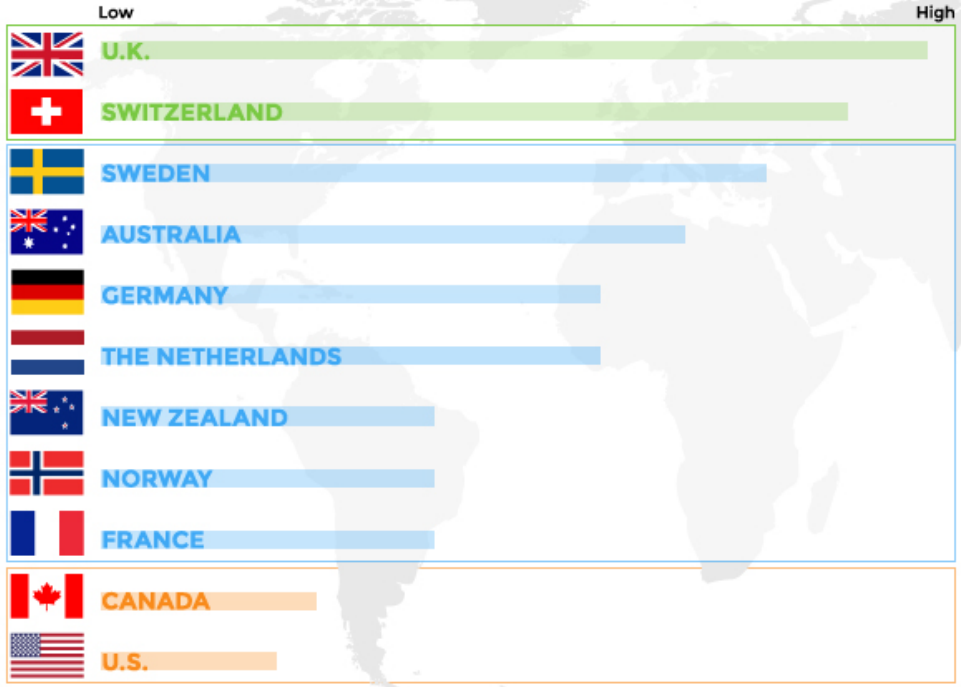
Cost of Health care in the USA: OECD 2022

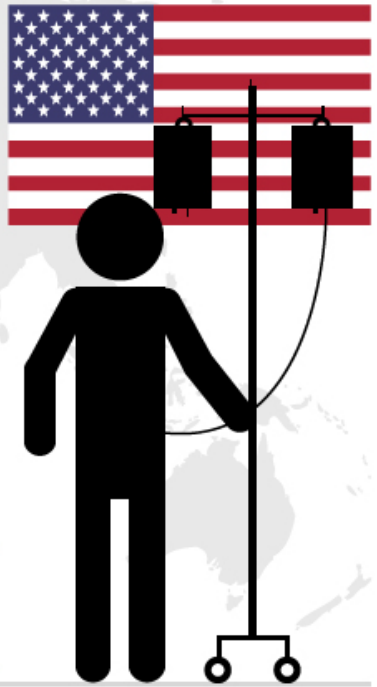


U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking



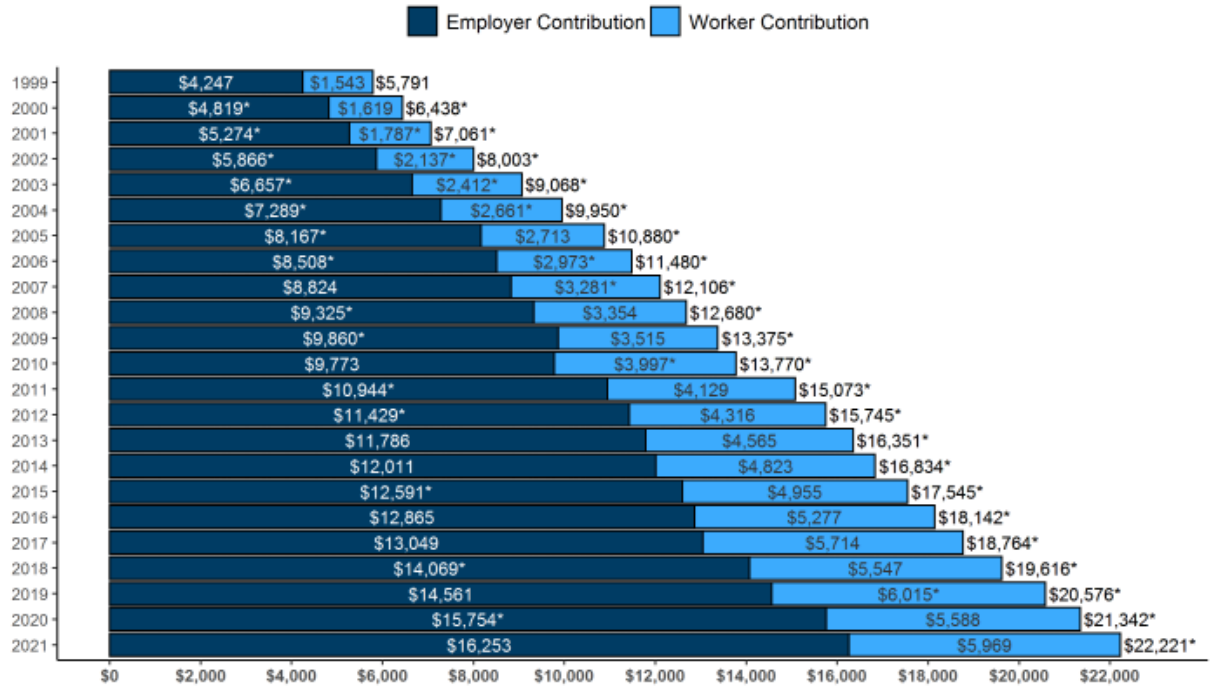


Source: K. Davis, K. Stremikis, D. Squires, and C. Schoen, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update*, The Commonwealth Fund, June 2014.

The COMMONWEALTH FUND

Kaiser Family Fund: payment for family insurance

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2021



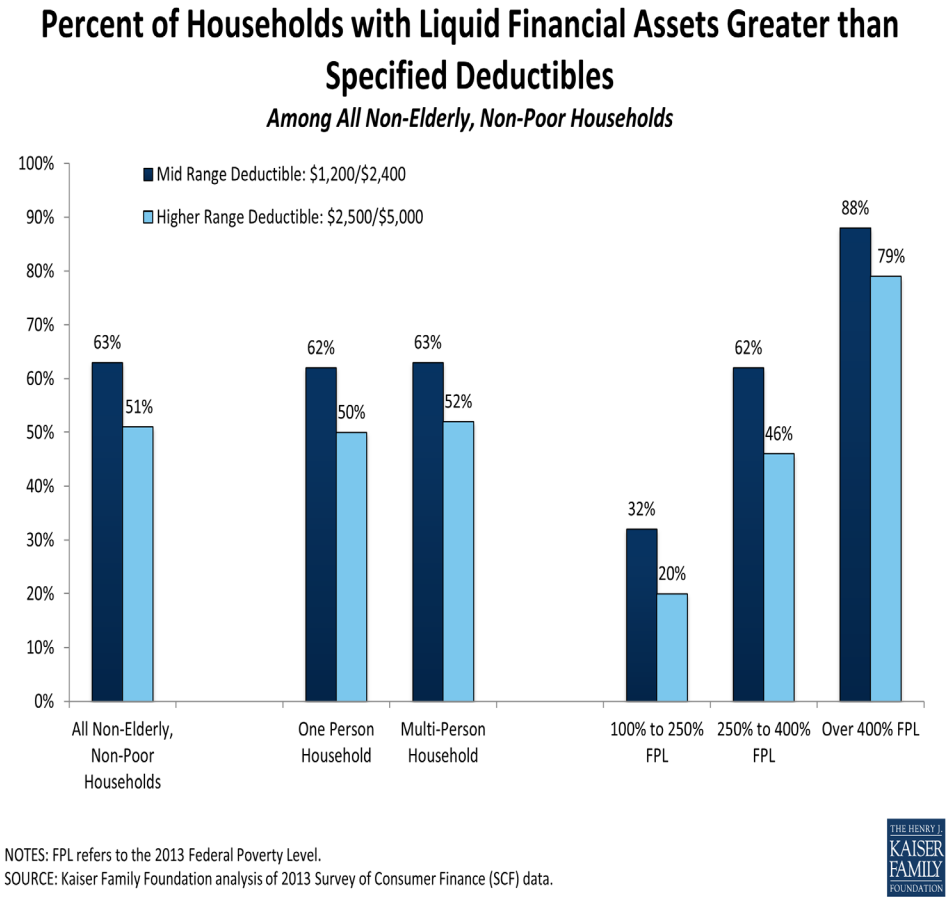
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Patient's Inability to pay

- 62.1% of Bankruptcies are from Medical bills : 48% of the bills are from Hospitals, 18% drugs, 15% physicians
- Annual Health Care Costs $16,771
- Cancer patients are twice as likely as other patients to enter bankruptcy
- 2/3 of patients declaring bankruptcy have insurance

Only one third of low-income households have sufficient financial resources to cover mid-range deductibles

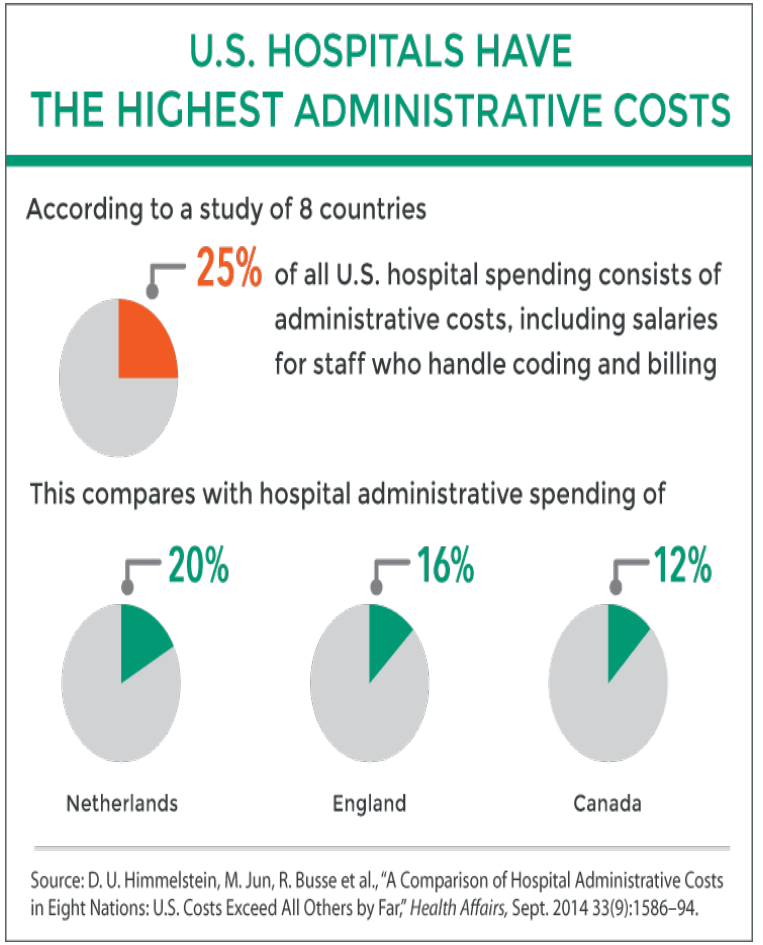
Figure 4



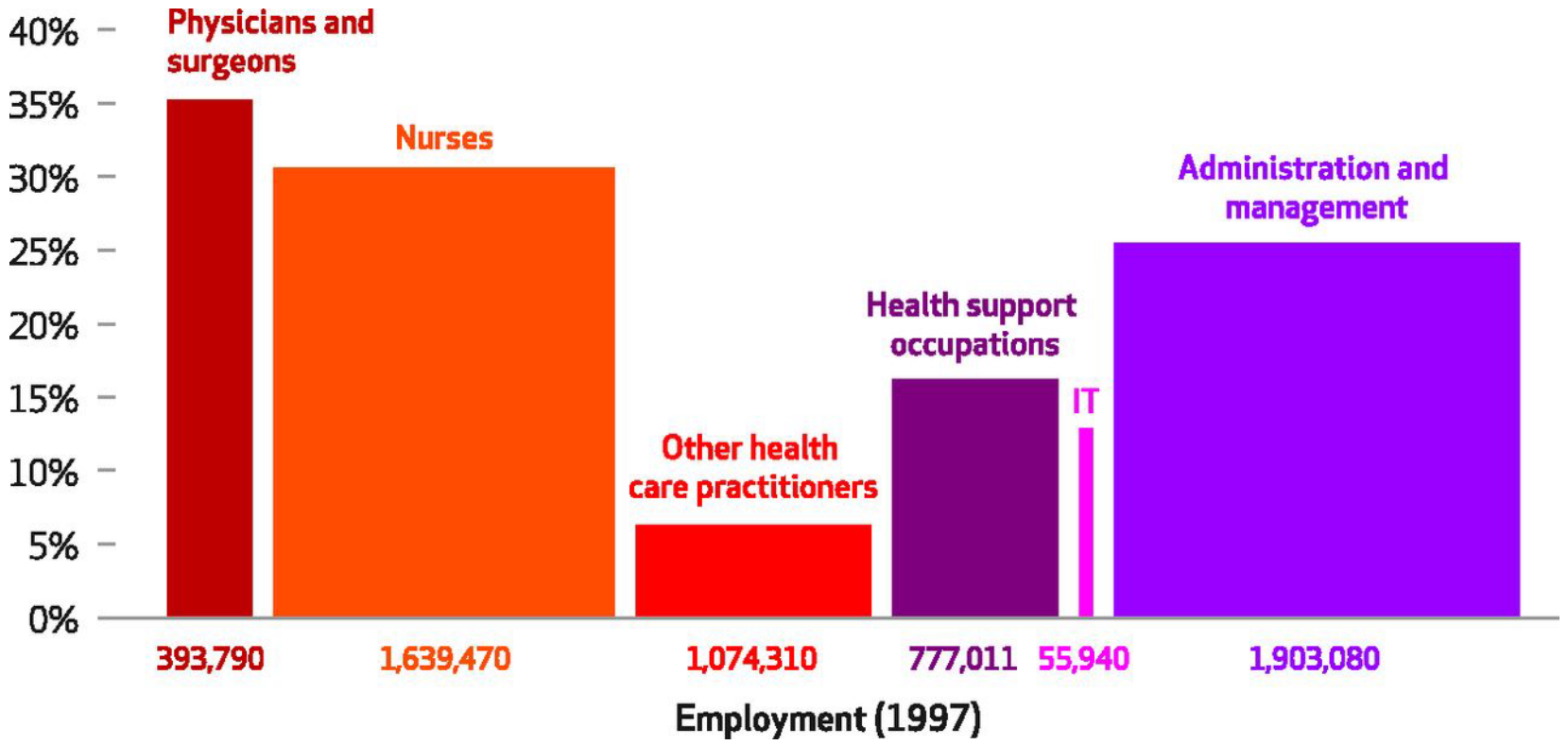
NOTES: FPL refers to the 2013 Federal Poverty Level.
SOURCE: Kaiser Family Foundation analysis of 2013 Survey of Consumer Finance (SCF) data.

Administrative costs too high

- Overall, administrative costs are 8 percent of spending on health care in U.S.
- OECD average is 3 percent. (Source: OECD)
- Figure to the right is a comparison by The Commonwealth Fund of hospital administrative costs in several nations.



Growth in earnings for health-sector occupational groups from 1997 to 2012.



Sherry Glied et al. Health Aff 2016;35:1197-1203

HealthAffairs

Summary

- Medicare Trust Fund projected to be insolvent 2026
- Commercial insurance is increasingly expensive and fewer employers are purchasing fully insured plans
- Medicare pays under the cost of care for most states, including NM
- Drug prices are increasing to 14% of health care costs
- Fee for service is blamed for increased volume
- More middlemen making a great living

What needs to be done, according to CMS?

- 1. move patients from FFS to value- based care
  - CMMI: Center for Medicare and Medicaid Innovation
  - Medicare Advantage
- 2. Put practices and hospitals at risk for the cost of care
  - Start with pay for performance then 1-sided then 2-sided risk
- 3. Negotiate drug prices by CMS
- 4. Cut the physician fee schedule! (pushes practices into hospitals)

CMMI Value based Care: 5/55 models saved money and spent $10B *

- COME HOME *
- Oncology Care models
- Accountable Care Organizations
- Medicare shared savings programs
- ESRD programs
- Joint replacement bundles *

COME HOME

Innovative Oncology Business Solutions, Inc.

COME HOME: CMS/CMMI Grant 2012-2015

- $19.8M
- 7 practices
- Significant savings associated with Oncology Medical Home through reduced ED & IP use
- Improve quality of care through triage protocols, team care and clinical pathways
- Increase delivery of patient-centered care through after hours clinics, same day appointments, patient education

COME HOME results The Community Oncology Medical Home

Overall Impact of COME HOME (all on per quarter basis)

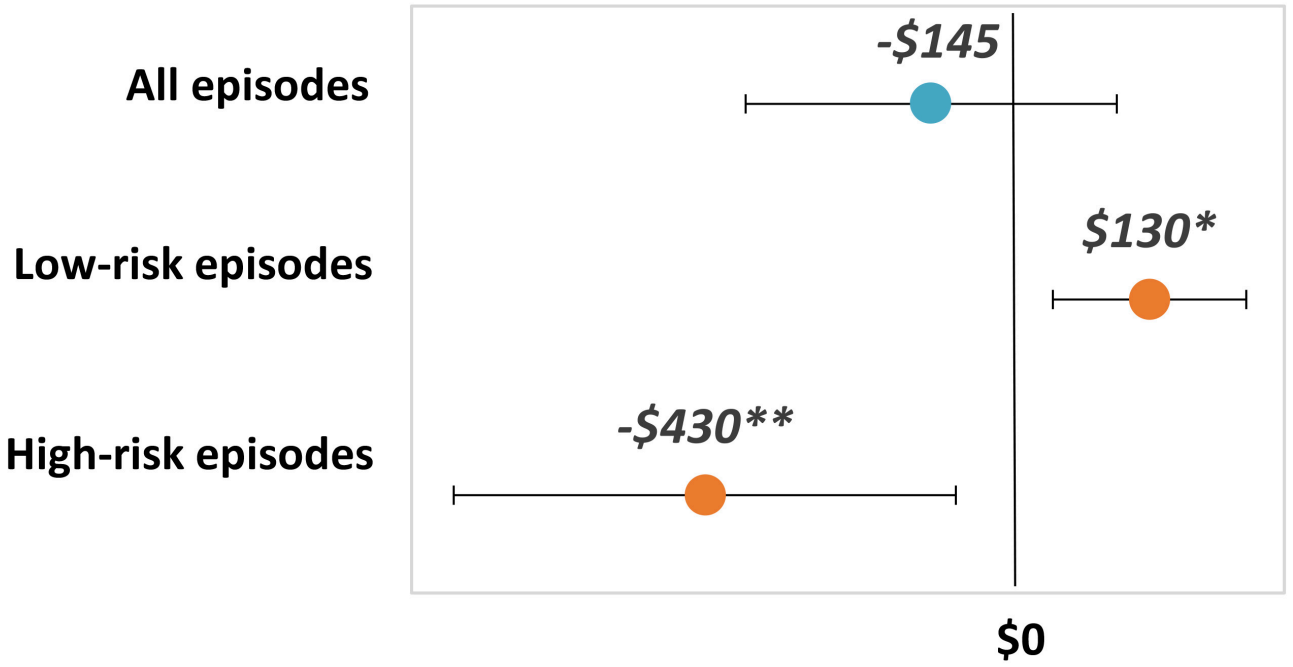
- ED visits reduced by **13** per 1,000 patients
- Ambulatory Care Sensitive (ACS) hospitalizations reduced by 3 per 1000
- Average Cost lowered by $612 per patient
- Significant decreases in costs of care in last 30-180 days of life:
  - $959 **lower** in last 30 days,
  - $3346 in last 90 days,
  - $5790 in last 180 days of life

Oncology Care Model 2016-2021

- All Episodes: OCM resulted in a non-significant relative **$145 (0.5%) decrease** in per-episode payments.
- Low-Risk: Per-episode payments i**ncreased** by **$130 (1.8%)** for low-risk episodes. Low risk episode payments averaged $7,395.
- High Risk: Per-episode payments **decreased** by **$430 (1.1 %)** for high-risk episodes. High risk payments averaged $44,538.

Oncology Care Model

Estimated relative change in per episode spending



● Non-statistically Significant ● Statistically Significant **p<0.05 *p<0.1

Medicare ACOs falling short of projected savings

- Medicare Shared Savings Program (MSSP), enacted as part of the *Affordable Care Act*, is Medicare's largest Alternative Payment Model (APM)
- MSSP *increased* federal spending by $384 million from 2013 – 2016, counter to CBO projection of $1.7 billion in net savings.
- Upside-only model (MSSP Track 1) **increased** federal spending by $444 million.
- Downside-risk ACOs (MSSP Tracks 2 & 3) **reduced** federal spending by $60 million.
- ACOs in their fourth performance year produced net savings of $152 million to federal budget, suggesting numbers could improve in future years.
- Source: Avalere, March 2018

Next Generation ACOs

- Percentage impact was 0.42% in 2016, -0.01% in 2017
- In 2016 CMS paid out out $216.7M after achieving savings of $38.60M
- In 2017 CMS paid out$177.39M after saving $114.37M
- Most of the money went to large systems adding IT infrastructure
- NORC data published 2020 and presented to CMS

Consolidation: Creating a system designed to maximize profits

ACOs have increased consolidation

Hospitals that are consolidated into systems increase costs, decrease access without improving quality

Health plan consolidation increases costs and control of medical decisions

Pharma Consolidations allows monopoly profiteering

FTC is now looking at systems for anti-competitive behavior

Chart: Community Health Access and Rural Transformation Model

- COMMUNITY TRANSFORMATION TRACK:
- Capitated payment based on volume
- 15 communities
- Must have 10,000 MedicareFFS recipients and deliver 20% if their care
- 15% of hospitals qualify

- ACO TRANSFORMATION TRACK:
- Join the Medicare shared Savings Program as an ACO
- 20 communities
- Accept financial risk
- Advanced shared saving payments for inpatient and outpatient
- Lose CAH payments

What would I do to save money for CMS (without impacting access or quality)

Just my ideas

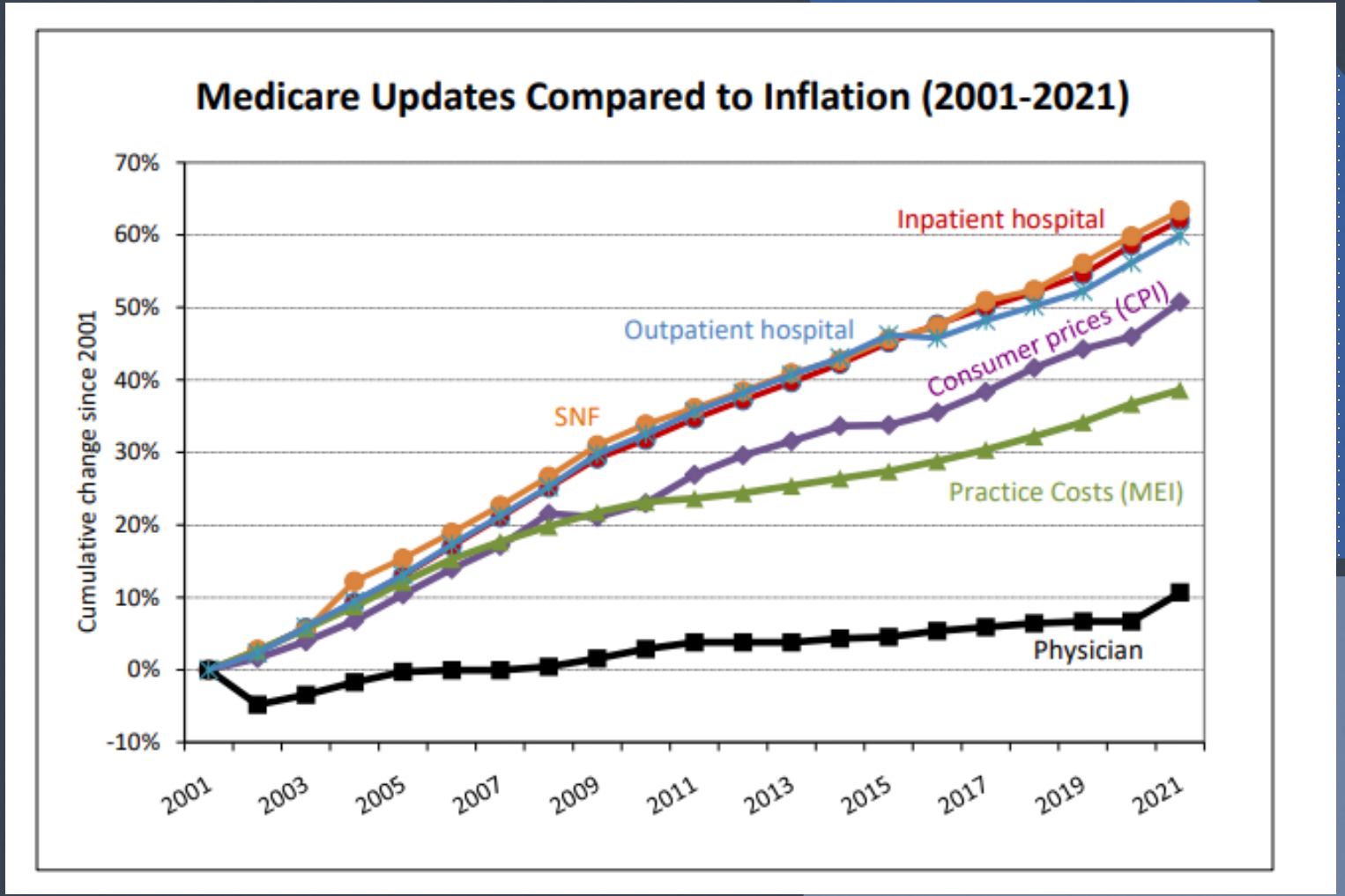
- Restructure care delivery on the medical home ideas
- Site of service Support the low cost high quality options
- PBM reform for drugs
  - Limit rebates and discounts and share them with payers and patients
  - Modify 340b to go to poor people
- Pay primary care doctors differently
- Stop cost shifting from commercial plans to Medicare and Medicaid
- Transparency especially for MA plans
- Not for profit insurance designs
- Lower administrative burden
- Stop having practices take risk

The site-of-service dilemma (reports and studies)

- **Avalere, 2017**: Analysis finds that applying MIPS adjustments to Part B drug reimbursement will have very significant effect on income of some specialties
- **Avalere, 2016**: 340B hospitals often don't provide charity care
- **Milliman, 2016**: The shift of cancer care from physician office to hospitals is one factor driving up costs
- **Berkley Research Group, 2016**: Rapid growth in 340B expenditures due to hospital acquisition of physician practices
- **Avalere, 2015**: 340B hospitals are more heavily engaged in physician acquisition than other hospitals


RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)
The difference between what is paid (blue) vs breakeven price (green) is the potential opportunity for payers to negotiate with hospitals to help contain prices.
Total Facility
NASHP Breakeven Price
750
500
250
0
GUADALUPE COUNTY HOSPITAL

Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics



According to data from the Medicare Trustees, Medicare physician pay has increased just 11 percent over the last two decades, or 0.5 percent per year on average. And roughly one-third of that increase is the temporary 3.75 percent update for 2021 that will expire in 2022. In comparison:

- Medicare hospital updates totaled roughly 60 percent between 2001 and 2021, with average annual increases of 2.4 percent for both inpatient and outpatient services.
- Medicare skilled nursing facility (SNF) updates totaled more than 60 percent between 2001 and 2021, or 2.5 percent per year.
- The cost of running a medical practice increased 39 percent between 2001 and 2021, or 1.6 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, increased 51 percent over this period (or 2.1 percent per year).

As a result, Medicare physician pay doesn't go nearly as far as it used to. Adjusted for inflation in practice costs, Medicare physician pay declined 20 percent from 2001 to 2021, or by 1.1 percent per year on average.

American Medical Association, Economic and Health Policy Research, October 2021

Exhibit 5.

Herceptin Markups Across Settings and Payers

(one year of therapy)

Community Practice or non-340B Hospital Treating a Medicare Patient

Purchased for $66,107

Reimbursed at $70,073

Margin **$3,966**

340B Hospital Treating a Medicare Patient

Purchased for $43,168

Reimbursed at $70,073

Margin **$26,905**

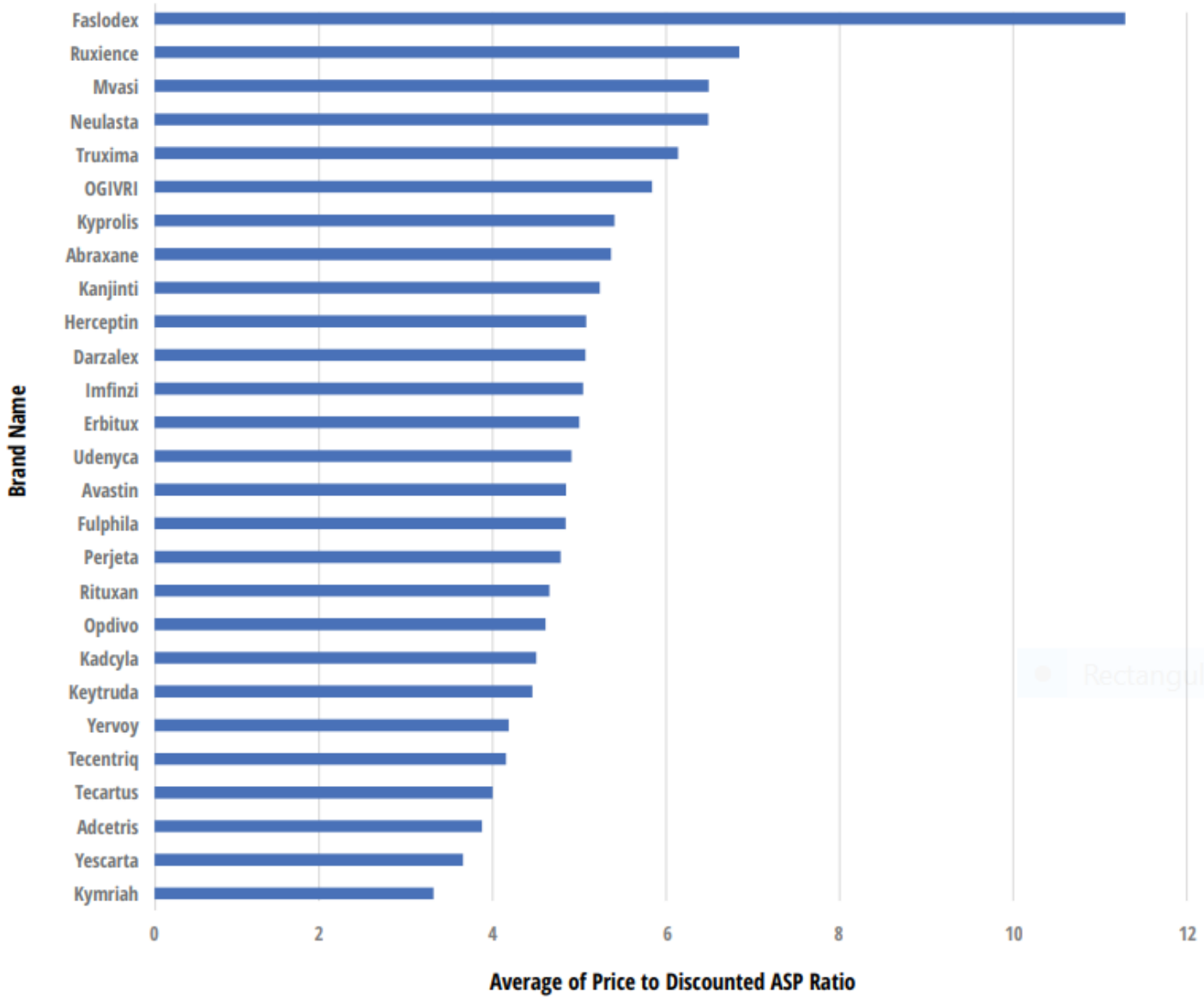
340B Hospital Treating a Commercial Patient

Purchased for $43,168

Insurer Charged $217,122

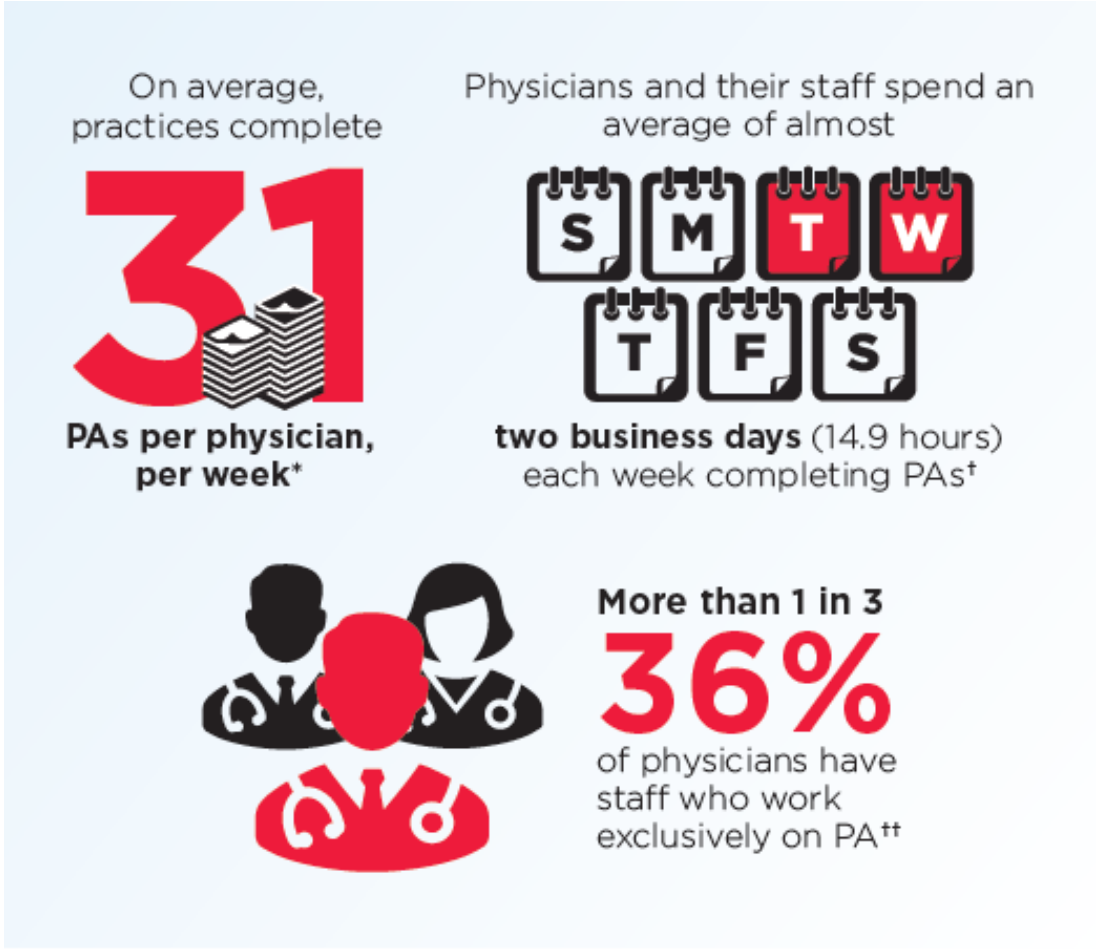
Margin **$173,954**

Exhibit 3. **Average 340B Hospital Markup vs. 340B Hospital Discounted Acquisition Cost**



Right-sizing prior authorization

- Working with national partners and the insurance industry to “right-size” prior authorization.
- Pushing state legislation to address prior authorization and step therapy and advocating to national policymaking organizations for regulation of these programs.
- Creating new resources to help practices streamline prior authorization.
  - Visit **FixPriorAuth.org**



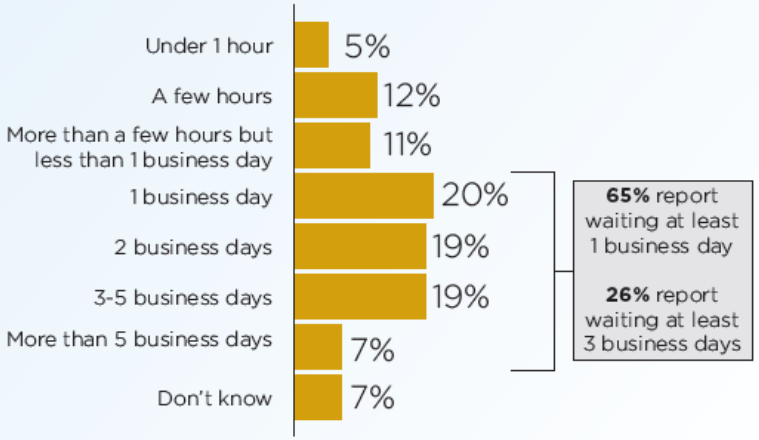
Source: 2018 AMA Prior Authorization Physician Survey

AMA | MEMBERSHIP MOVES MEDICINE™

Impact of prior authorization on clinical outcomes

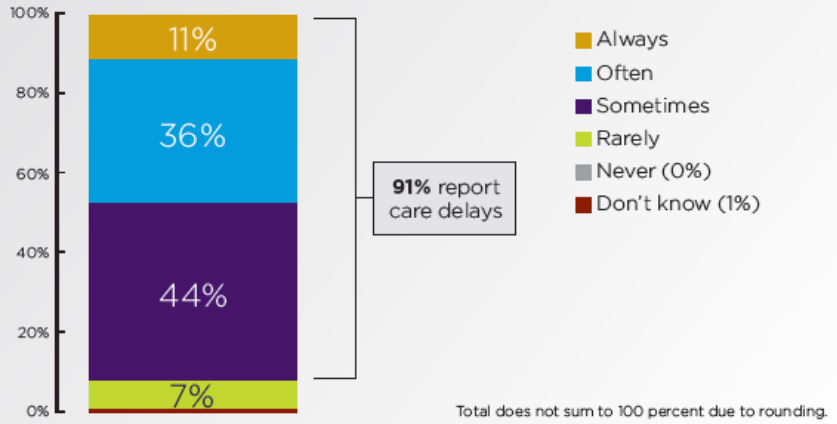
Average wait time for PA responses

Q: In the last week, how long on average did you and your staff need to wait for a PA decision from health plans?



Care delays associated with PA

Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



In your experience, has the PA process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?

28% reported PA led to a serious adverse event

Source: 2018 AMA Prior Authorization Physician Survey

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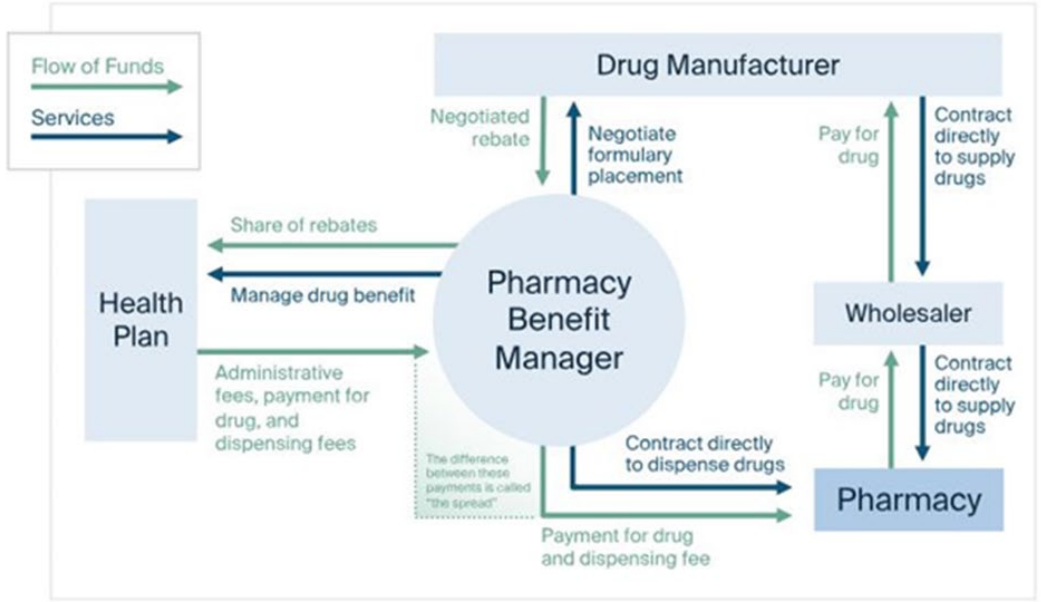
NMCC is spending $380,000/year for a 98% prior authorization approval rate!! Why??

EXHIBIT 2

The Flow of Services and Funds in the Pharmaceutical Distribution Chain



Data: Adapted from Elizabeth Seeley and Aaron S. Kesselheim, *Pharmaceutical Benefit Managers: Practices, Controversies, and What Lies Ahead* (Commonwealth Fund, Mar. 2019).

Source: Elizabeth Seeley and Surya Singh, *The Role of Pharmacies in Making Drug Purchasing More Efficient and in Promoting Access to Preventive Care* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/g749-h298

Inflation Reduction Act

- No limitation on Launch price
- Delay of the drug board action for 9-13 years
- 10 drugs in 2026, 15 in 2027 and 2028, 20/year after that
- Ceiling price is 75% of AMP years 9-12 65% 12-16 and 40% for >16 years on market
- CBO: $62.3B from decreased spending +$38.4 B on revenue impact
- $2000 max OOP for 2025 with increase depending on cost of the program
- in catastrophic phase $0 for 2024

Drug Boards, unintended consequences

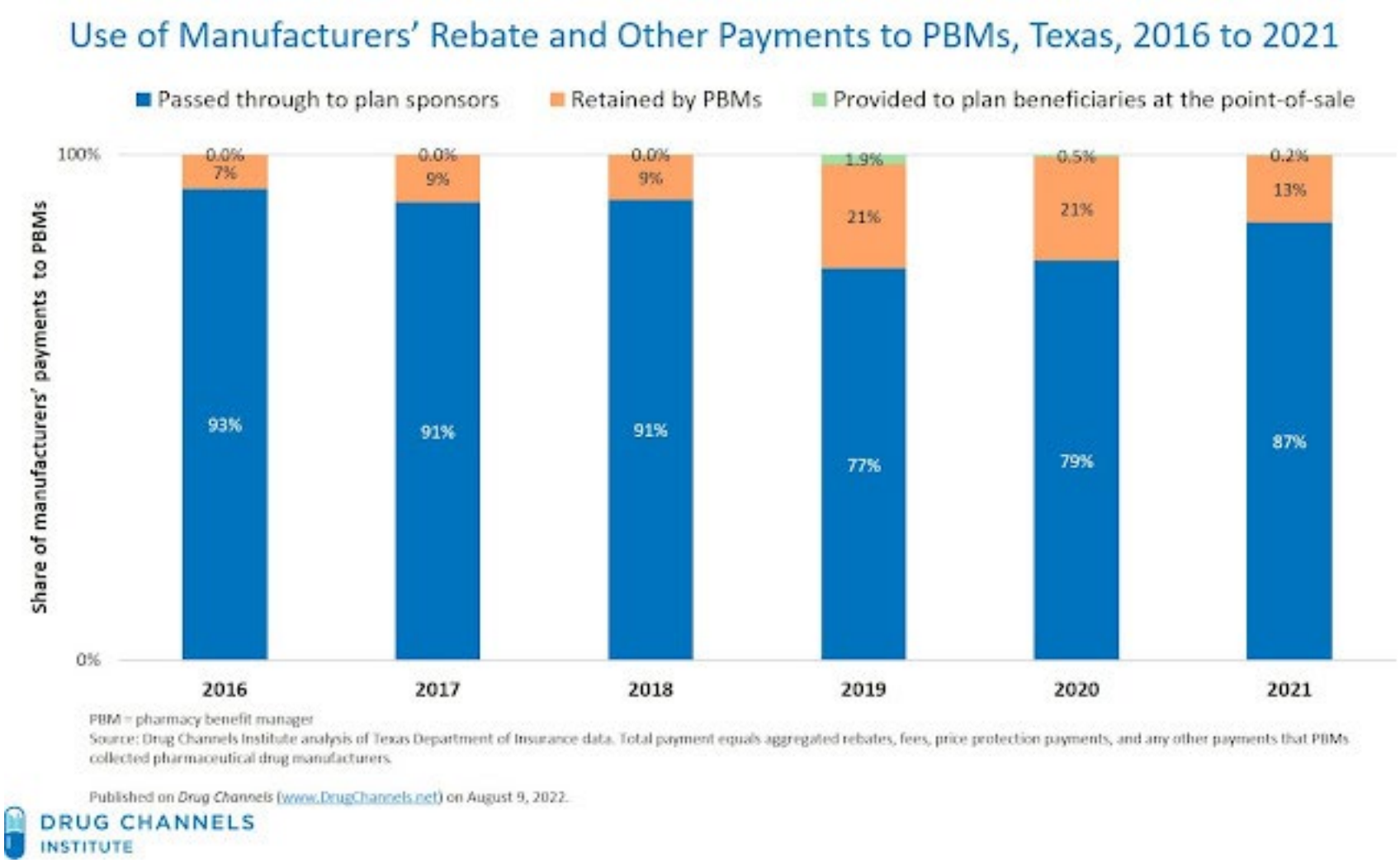
Any determination of Maximum Fair or List Price that is higher than purchase price hurts the practice or hospital who bought the drug to administer, not the manufacturer.

If the manufacturer does not lower the price, practices and hospitals will stop offering the drug

New Mexico Marketshare is not sufficient to persuade manufacturers to lower prices

Patients don’t get the drugs they need.

PBMs: Where do the Rebates go?



Insurers Determine Patient Out-of-Pocket Costs

The Congressional Budget Office (CBO) recently acknowledged that "it is unlikely that the average net price of a prescription has increased considerably in recent years...," [17] yet patients face growing cost-sharing (or out-of-pocket costs) obligations because of insurance benefit design, and in some instances, are getting less access to needed medicines.

Commercial insurers and PBMs often, and more increasingly, base patient cost-sharing on list price and not the lower net price negotiated with drug companies. Commercial insurers and PBMs are also implementing more restrictive utilization management programs. [18]

One example of more restrictive utilization management programs is the increasing use of

"Exclusion Lists"

which in some instances, prevents patients from accessing a growing list of medicines.

Since 2014,

these "exclusion lists" have grown more than **675%**[15] to include more than **846 unique products**.[16]

References 15. Xcenda. "Skyrocketing Growth in PBM Formulary Exclusions Raises Concerns About Patient Access." September 2020 link. 16. Fein, A. "Five Takeaways from the Big Three PBMs' 2022 Formulary Exclusions." Drug Channels Institute. January 19, 2022. https://www.drugchannels.net/2022/01/five takeaways-from-big-three-pbms-2022.html. 17. The Congressional Budget Office, "Prescription Drugs: Spending, Use, and Prices." January 2022. https://www.cbo.gov/publication/57772 18. Howell, S., Yin, P. and Robinson, J. "Quantifying The Economic Burden Of Drug Utilization Management On Payers, Manufacturers, Physicians, And Patients." Health Affairs. August 2021https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00036.

CO Pay Accumulators

Manufacturer funds 501cs Foundations to pay patients copays or coinsurance until the total out of pocket amount is reached, and the insurer is to assume the total cost
With accumulators, Insurers designate the Foundation donation as not part of True Out Of Pocket Expense
The patient, if they can afford it, must then pay the second round of copays until (and If)the out of pocket Maximum amount is paid.
Patient Adherence drops
Payers get the benefit of 2 rounds of copays.

Co Pay accumulators in New Mexico Courtesy of The Aids Institute

- Federal rules allows insurers to keep the copay assistance provided to patients by PhRMA Foundations
- 4/5 NM Insurers have a copay accumulator
  - BCBS, Molina, Truehealth, Western Sky
- Other states have laws that require insurers to count donated copays toward the true Out Of Pocket expense

Industry Myth: Banning Copay Accumulator Programs will drive up premiums

Fact Check: States that have passed laws banning copay accumulators saw premium rate increases/decreases comparable to other states

- VA had an overall premium rate decrease of 6.9% in 2021 with 5/8 issuers decreasing rates[5]
  - AZ had an overall premium rate increase of 5.45% with 2/5 issuers decreasing rates[6]
- No issuers attributed rate increases to having to count copay assistance toward a beneficiary's cost sharing

[5] Louise Norris, *Virginia health insurance*. December 16, 2020. https://www.healthinsurance.org/virginia/
[6] Louise Norris, *Arizona health insurance marketplace: history and news of the state's exchange*. December 16, 2020. https://www.healthinsurance.org/arizona-state-health-insurance-exchange/

CO Pay Maximizers

- Plans designate specialty drugs as “non-essential health benefits” thus removing these drugs from the ACA essential Health Benefit requirements for out-of-pocket maximums
- PhRMA Foundations pay until the maximum value of the copay is reached
- Patients’ Out-of–Pocket maximum is defined to equal the value of the Foundation contribution but is spread evenly over the entire year.
- The insurer gets the benefit of the Foundation support
- Some plans do not require copays by patients
- Carve outs of specialty drug coverage allows manufacturer foundations to pay, but usually there is a requirement to buy from PBM’s SP.

Prevalence

- 80% commercial insured have a plan with an available copay accumulator in the design.
- 61% of commercial insureds have a plan with a maximizer in the design.
- 43% of plans have implemented the accumulators
- 45% of plans have implemented the maximizers

Manufacturers: Transparency report 1/16 companies

- Net price declined 2.8% in 2021, 5th year in a row
- Rebates discounts and fees paid $33.9B (15.2% increase year over year)
- Rebates Discounts and fees 55% of list prices
- R&D is double the amount spent on marketing $11.9B

WHAT COULD BE DONE FOR DRUG PRICES AND INSURANCE COSTS?

Limit Pharmacy Benefit manages to a transparent flat fee service

- No copay maximizers or accumulators
- 340b payments to the patients
- Stop the profiteering
- Stop steering patients to the affiliated pharmacies owned by PBMs

Read my Task Force Report!

Value based insurance design

- Why do we have copays?

Encourage transparency reports from PhRMA

Avoid consolidation of the market of PBMs Insurers and PhRMA

Why can’t you find a doctor?

Medicare pays under cost of business

48% Medicaid

Gross receipts tax on medical goods and services

Lack of opportunity for spouses

Educational system for children

Aging physician population

Hospital employment of physicians

Coping with Professional Burnout

- **54%** of all U.S. physicians have experienced burnout – AMA and Mayo Clinic 20% considering leaving
- EHRs a major source of frustration and burnout
- Physicians spend **2** hours on EHRs for every **1** hour with patients – AMA and Dartmouth
- **6** hours of every physician workday consumed by EHRs, paperwork

Coping with Professional Burnout:

- Moral injury
- COVID
- Trauma
- Criminalization of medicine
- Angry people threatening
- Feeling responsible for the social determinants of health

NEW MEXICO IS MOSTLY RURAL OR FRONTIER

- 6 COUNTIES ARE URBAN
- 40% OF AMERICANS LIVE IN RURAL AMERICA

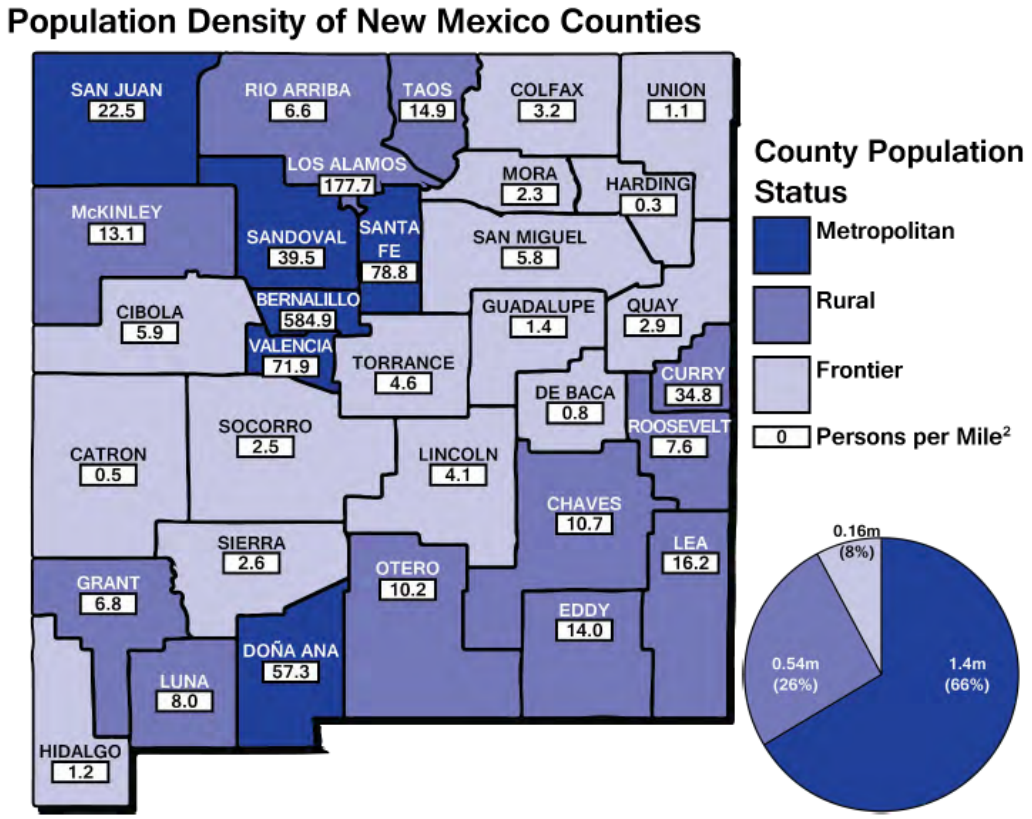


Figure 1.1. Each county's color indicates its classification as frontier (light), rural (medium) or metropolitan (dark); the white boxes show the population density (persons per square mile). The pie chart shows the proportion of the state's population residing in metropolitan, rural or frontier counties.

SHORTAGE OF PHYSICIANS

Table 1.3. Summary of Statewide Health Care Professionals Since 2013

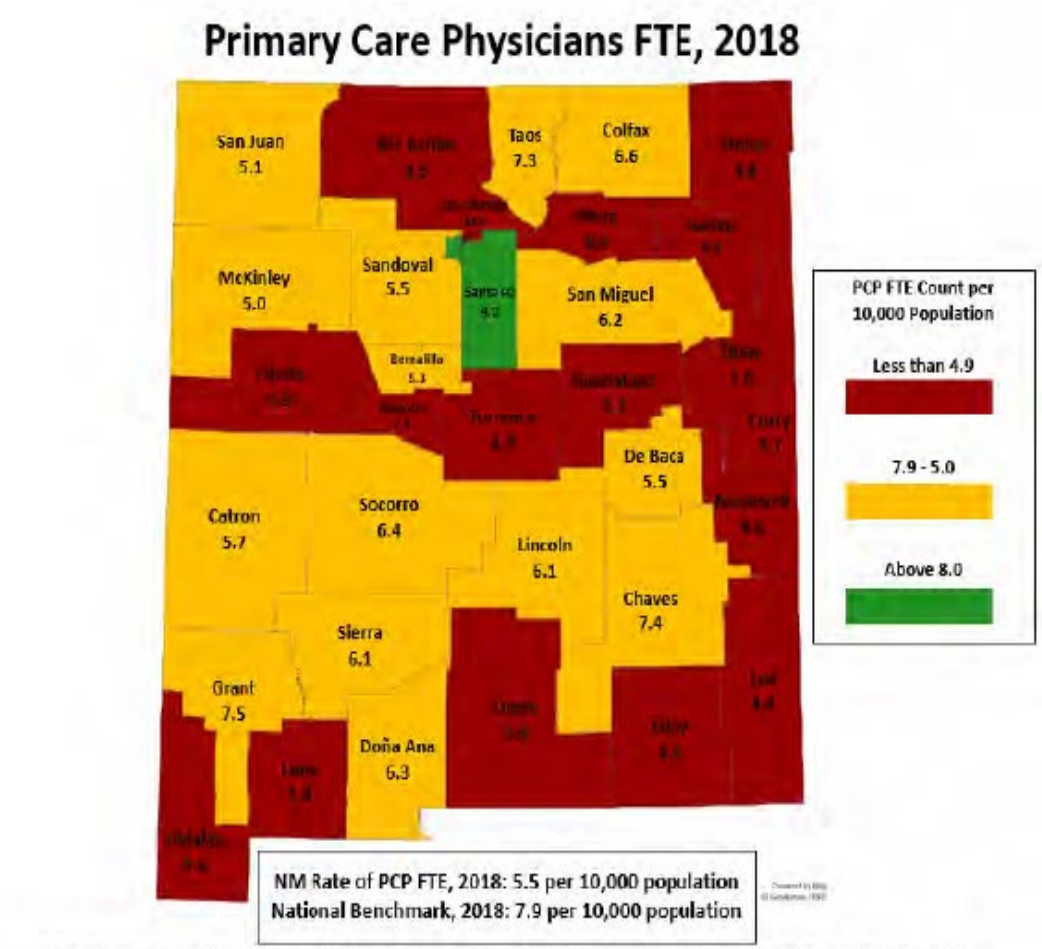
A. Physicians

Profession Metric	2013	2014	2015	2016[b]	2017	2018	2019[c]	Net Change Since 2013
PCPs								
# in New Mexico	1,957	1,908	2,073	2,076	2,360	2,162	1,581	-376
Total Below Benchmark[a]	153	145	125	139	126	136	336	183
Counties Below Benchmark	23	22	17	22	16	18	26	3
OB-GYNs								
# in New Mexico	256	236	253	273	282	279	230	-26
Total Below Benchmark[a]	40	43	36	31	30	39	59	19
Counties Below Benchmark	14	14	12	9	11	15	17	3
General Surgeons								
# in New Mexico	179	162	177	188	194	188	155	-24
Total Below Benchmark[a]	21	18	16	14	12	11	11	-10
Counties Below Benchmark	12	8	8	7	7	6	5	-7
Psychiatrists								
# in New Mexico	321	289	302	332	332	317	296	-25
Total Below Benchmark[a]	104	109	111	106	111	108	106	2
Counties Below Benchmark	25	26	26	26	26	26	26	1

[a] Total below benchmark reflects the number of providers needed to bring all counties below benchmarks to national provider-to-population values without reducing workforce in counties above benchmarks.

[b] This is the first year for which DO specialties were analyzed, correcting prior years' overestimation of DOs in primary care and underestimation in OB-GYN, general surgery and psychiatry.

[c] The benchmark for PCPs and OB-GYNs was changed with 2019. Non-practicing providers for all professions were excluded beginning with 2019.



Source: Data obtained from University of New Mexico Health Sciences Center, 2019. UNM HSC obtains licensure survey data from the New Mexico Regulation & Licensing department. calculations of need based off HRSA Need designation calculations for FTE PCPs for population with unusually High need. NM 2050 population projects obtain from UNM Geospatial and Population studies at https://gps.unm.edu/pru/projections. NM Healthcare Workforce Report, 2019: https://www.nmms.org/2019-nm-healthcare-workforce-report-released/

PRIMARY CARE

- NOW YOU KNOW WHY YOU CANNOT FIND A PRIMARY CARE DOCTOR

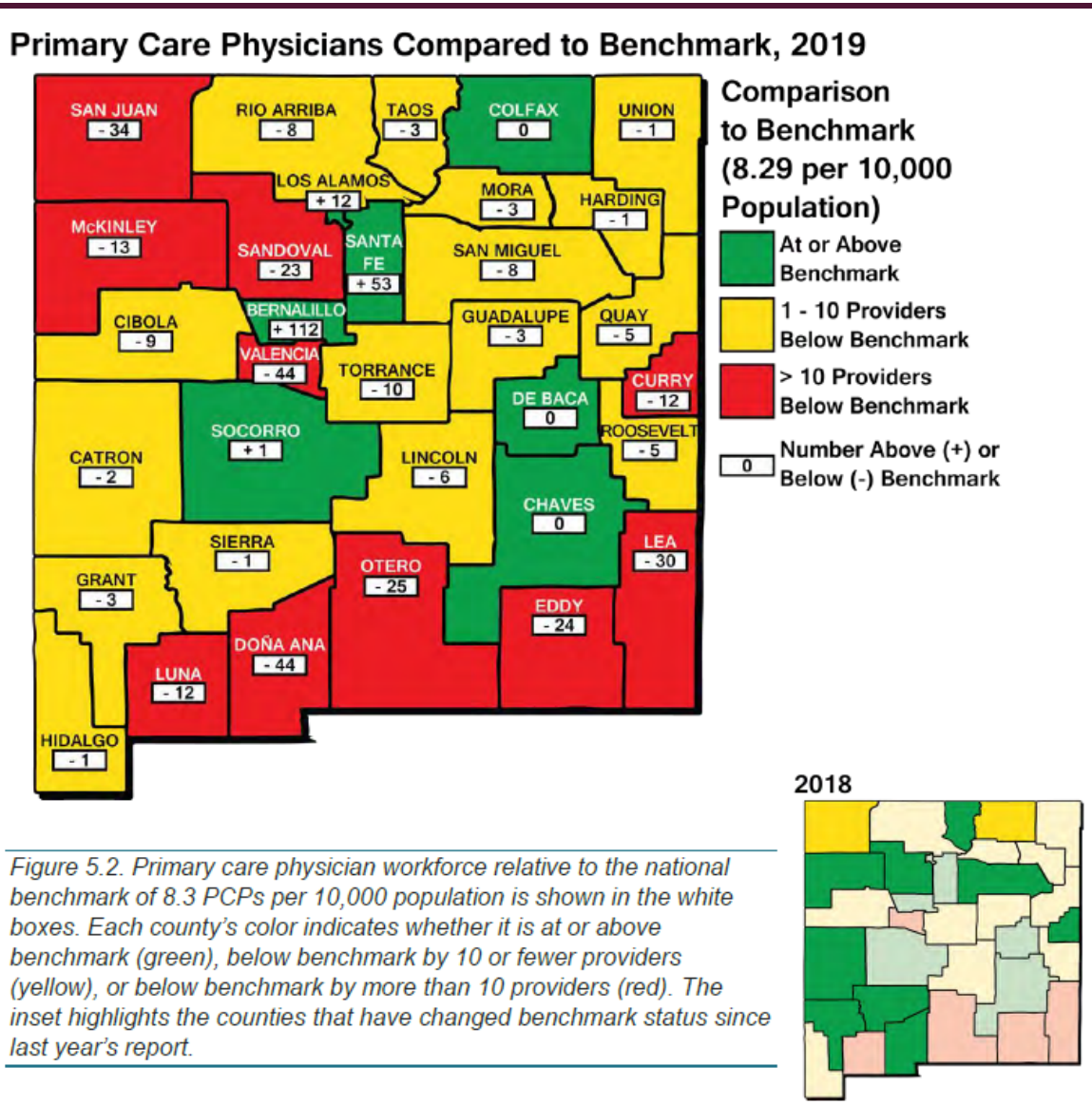
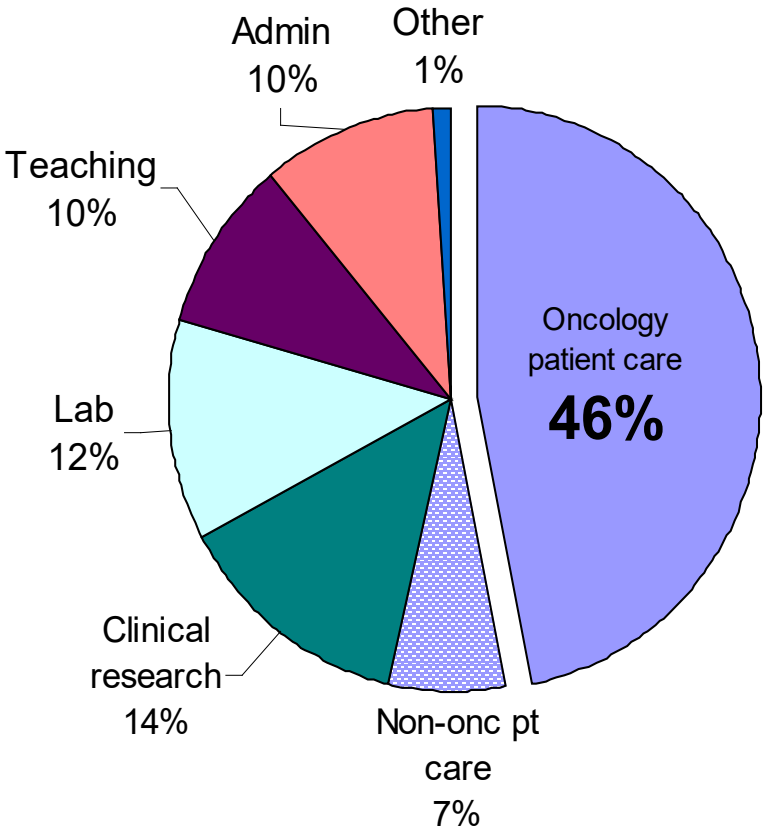
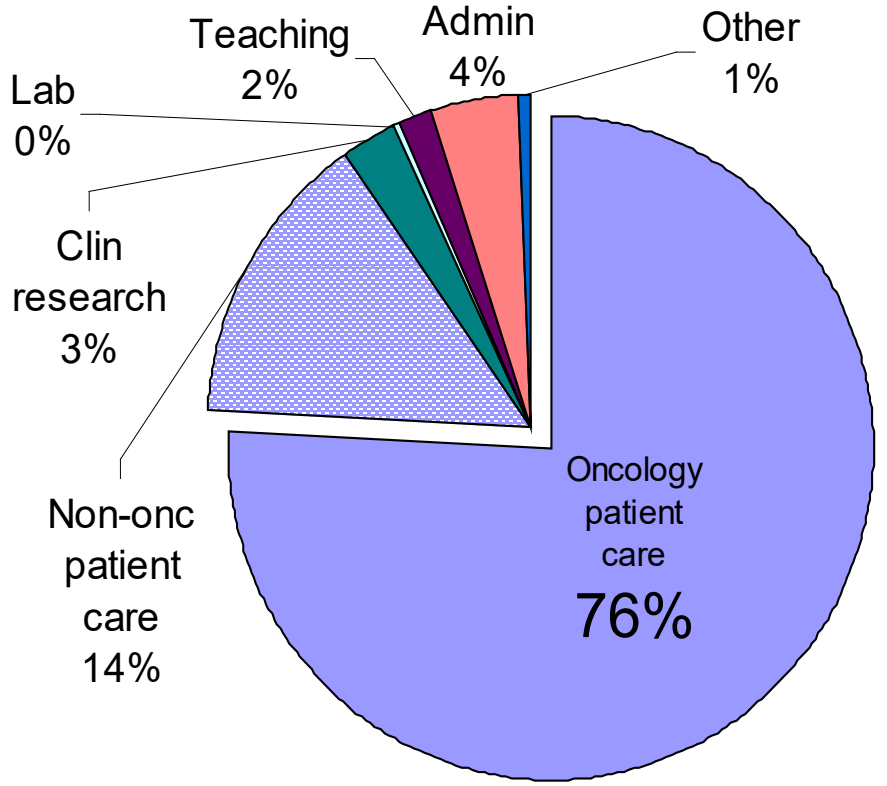


Figure 5.2. Primary care physician workforce relative to the national benchmark of 8.3 PCPs per 10,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 10 or fewer providers (yellow), or below benchmark by more than 10 providers (red). The inset highlights the counties that have changed benchmark status since last year's report.

Private practice oncologists spend 90% of time on patient care; academics - 51%





Key Findings

- **Supply of oncology visits will rise about 14%**
  - Aging workforce
  - Limited plans for new training slots
- **Demand for visits will be up about 48% by 2020**
  - Aging population (48% increase in incidence)
  - Increased cancer survivorship (81% increase)
- **Challenge for entire oncology care system**
  - Project a shortfall of 2,550 to 4,080 oncologists by 2020
  - Assuring access and quality care will require a concerted and multi-faceted effort and significant changes to practice of oncology
- **Study with alternate methodology confirmed findings**

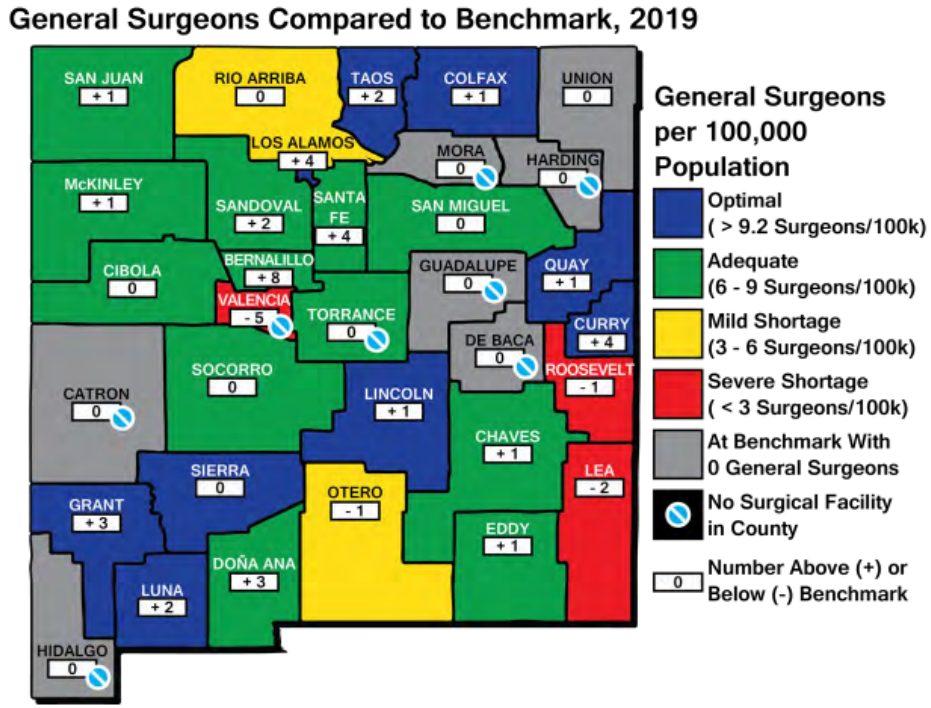
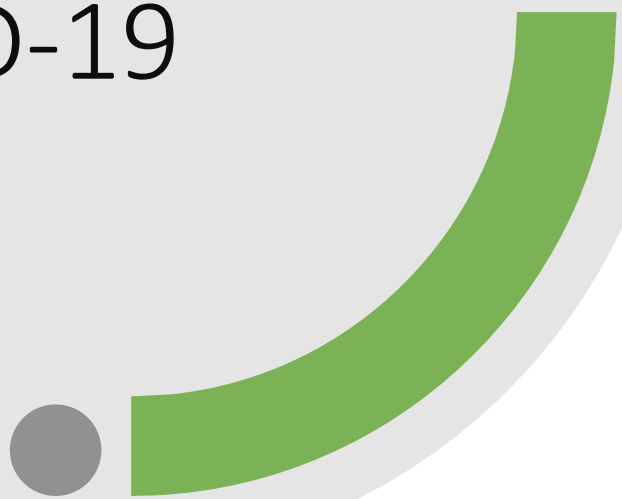


Figure 5.10. General surgeon workforce relative to the national benchmark of 6.0 general surgeons per 100,000 population is shown in the white boxes. Each county's color indicates whether the count of general surgeons per 100,000 population is considered optimal (blue), adequate (green), a mild shortage (yellow) or a severe shortage (red). Gray counties have no providers and benchmark values of zero. Blue "no" symbols denote counties without surgical facilities. The inset highlights the counties that have changed benchmark status since last year's report.

The impact of COVID-19

1. Practices saw decreased volume and revenue since March 2020
    a. 47% practices have reduced hours or closed (NMMS survey)
    b. 41% furloughed staff
    c. 18% furloughed physicians
    d. 38% reduced salaries or benefits
    e. 17% closed
2. Lack of PPE and expense
3. Expense of screeners
4. Expense of cleaning
5. Costs of Telemedicine



WHAT COULD BE DONE FOR HOSPITALS?

Decide what the role of a rural hospital should be.

Create transparency of costs and payments

Community support of a health care system

what is local and what is transferred

Pay MORE not LESS for rural health care

Determine the actual cost and pay that with a reasonable margin

Stop the vertical integration and consolidation

WHAT COULD BE DONE FOR PHYSICIANS?

Support Independent Practices: Determine the actual cost and pay that with a reasonable margin

Philanthropists could build small rural clinics, with $1/year rent

Exempt rural systems from Stark law.

Pay MORE not LESS for rural health care

Create transparency of costs and payments

Loan repayment or subsidize medical education

Decrease administrative burden

Reconsider risk as a strategy

WHAT COULD BE DONE FOR INSURANCE COMPANIES?

Transparency of premiums and costs

Not for profit insurance companies, reasonable margin

Subsidize premiums inversely related to income, advanceable refundable tax credits

Use copays and deductibles to guide behavior rather than cost shift

Require each type of coverage to cover its own costs

Return PBMs to their original functions

Stop the vertical integration and consolidation of the market

WHAT COULD BE DONE BY YOU?

Educate yourselves and your clients on alternative models for insurance

Choose where you get your care: which site of service?

Read my Report from the Governor's Task Force on Drug Pricing

Insist on transparency including fees for PBMs and insurers.