

Access, Quality & Transparency:
The Forgotten Issues in the Healthcare Debate
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What's happened? What's next?

The ACA remains the Law of the Land...*for now!*

- Republican efforts to “repeal & replace” are on hold
- “Electeds” seem more concerned about the insurance marketplace than care delivery choke points
- Question of the day: How do we change the direction and the tone of the national healthcare reform conversation?

What's happened? What's next?

Issues around healthcare will not go away:

- Cost increases continue to grab a disproportionate share of budgets
- Our employees are ill equipped to navigate the healthcare delivery maze
- Too often we pay too much for care with no clarity as to what we are paying for
- Questions of medical appropriateness and quality rarely enter the equation!

The Big Topics for Today

- Three big issues which we believe require greater attention:
 - Access to Insurance AND Access to Care
 - Provider reimbursement that incents quality not volume
 - Transparency in pricing

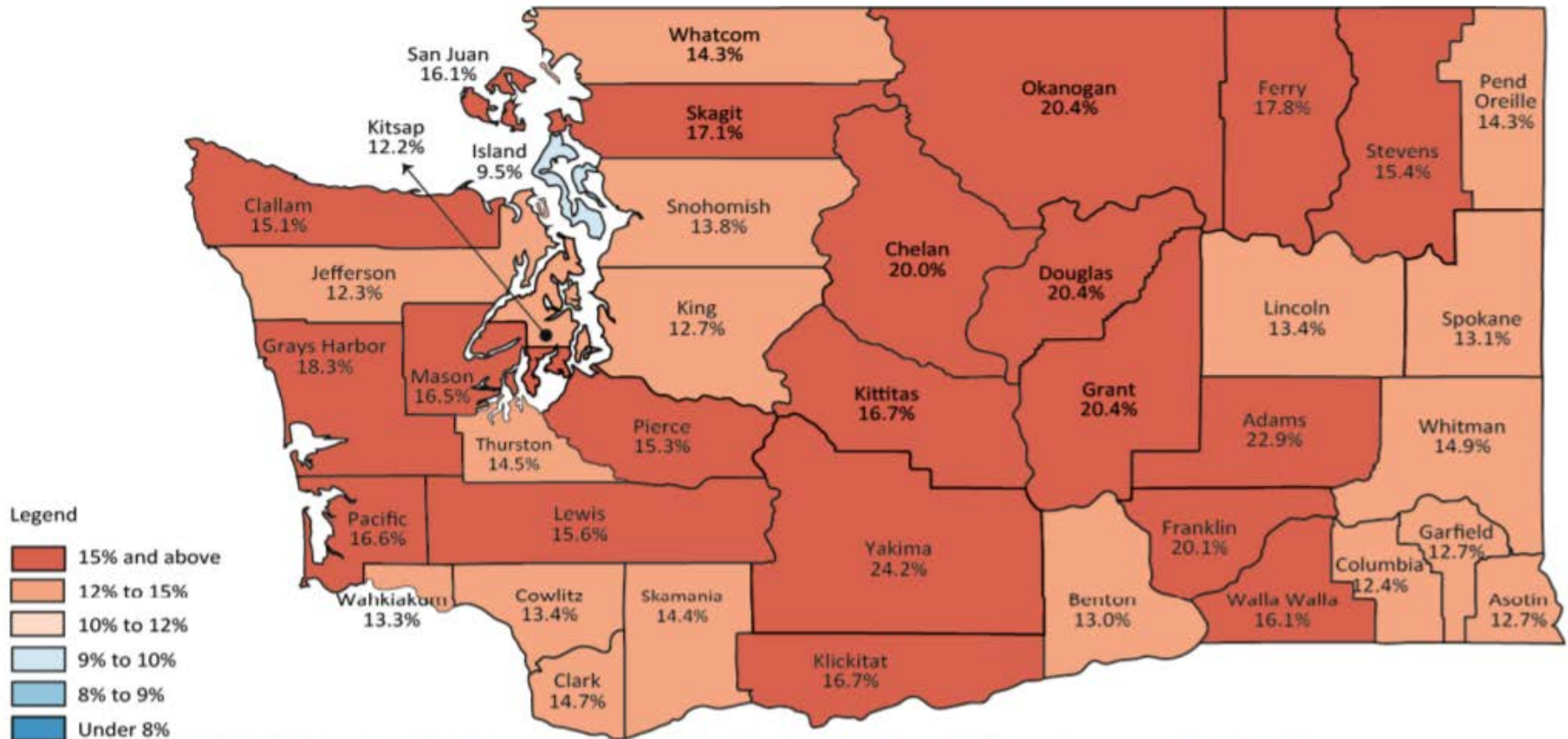
Expanded Insurance Coverage/ Access to care

The ACA expanded healthcare coverage by:

- Expanding original Medicaid from 100% of the Federal Poverty Level to 138% of the FPL
- Created a federal Exchange (and allowed for state exchanges) that would provide a central place:
 - Where individuals could enroll in Medicaid coverage
 - Where individuals between 138% and 400% of the FPL could enroll in health plans and receive significant premium subsidies

Expanded Insurance Coverage/ Access to Care

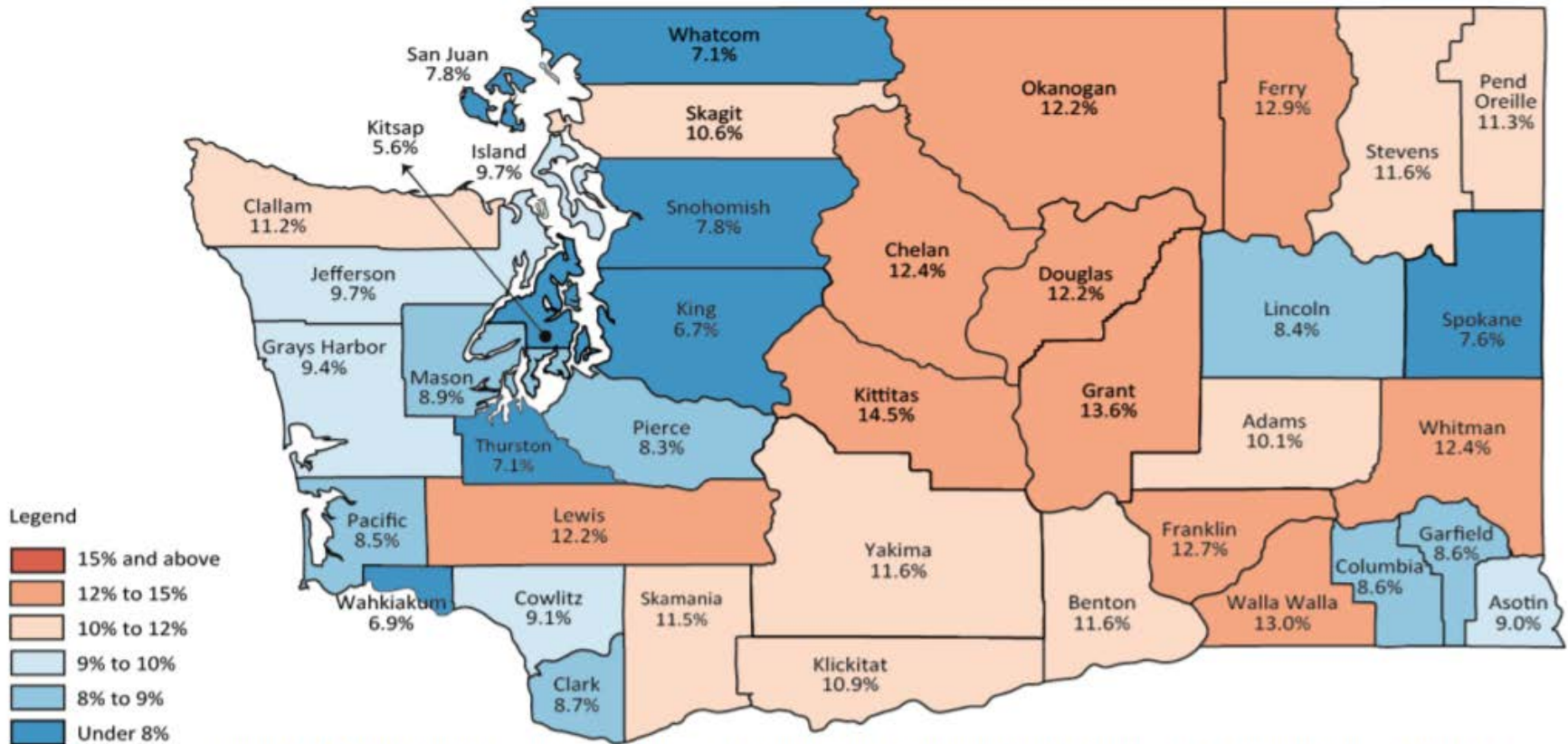
Figure 2-2. Uninsured population by county, 2012



Source: OFM, Population Estimates, 2013; U.S. Census Bureau, 1-Year ACS 2012; U.S. Census Bureau, SAHIE 2011.

Expanded Insurance Coverage/ Access to Care

Figure 2-3. Uninsured Population by County, 2014



Source: OFM County Population Estimation Model, January 2016 update using the 2014 American Community Survey, adjusted for Medicaid undercount

Expanded Insurance Coverage/Access to Care

Selected Counties Uninsured Rates

County	2012	2014	Change % Points	% Change
<u>West Side</u>				
King	12.7%	6.7%	-6.0%	-47.2%
Pierce	15.3%	8.3%	-7.0%	-45.8%
Pacific	16.6%	8.5%	-8.1%	-48.8%
Thurston	14.5%	7.1%	-7.4%	-51.0%
<u>East Side</u>				
Kittitas	16.7%	14.5%	-2.2%	-13.2%
Yakima	24.2%	11.6%	-12.6%	-52.1%
Spokane	13.1%	7.6%	-5.5%	-42.0%
Stevens	15.4%	11.6%	-3.8%	-24.7%
Franklin	20.1%	12.7%	-7.4%	-36.8%

Expanded Insurance Coverage/Access to Care: Who will care for us?

Provider Shortages: the elephant in the room

- Nationally, by 2030 the shortage of providers will be between 40,800 and 104,900*
- Primary Care provider shortage will be 7,300 to 43,100 and does not include any ACA impact
- While Physician extenders are increasing they do so in non-primary care specialties and favor urban settings as opposed to suburban or rural ones

**Source: The Complexities of Physician Supply and Demand: Projections from 2015 to 2030 (2017 Update) by IHS Market 2/28/2017.*

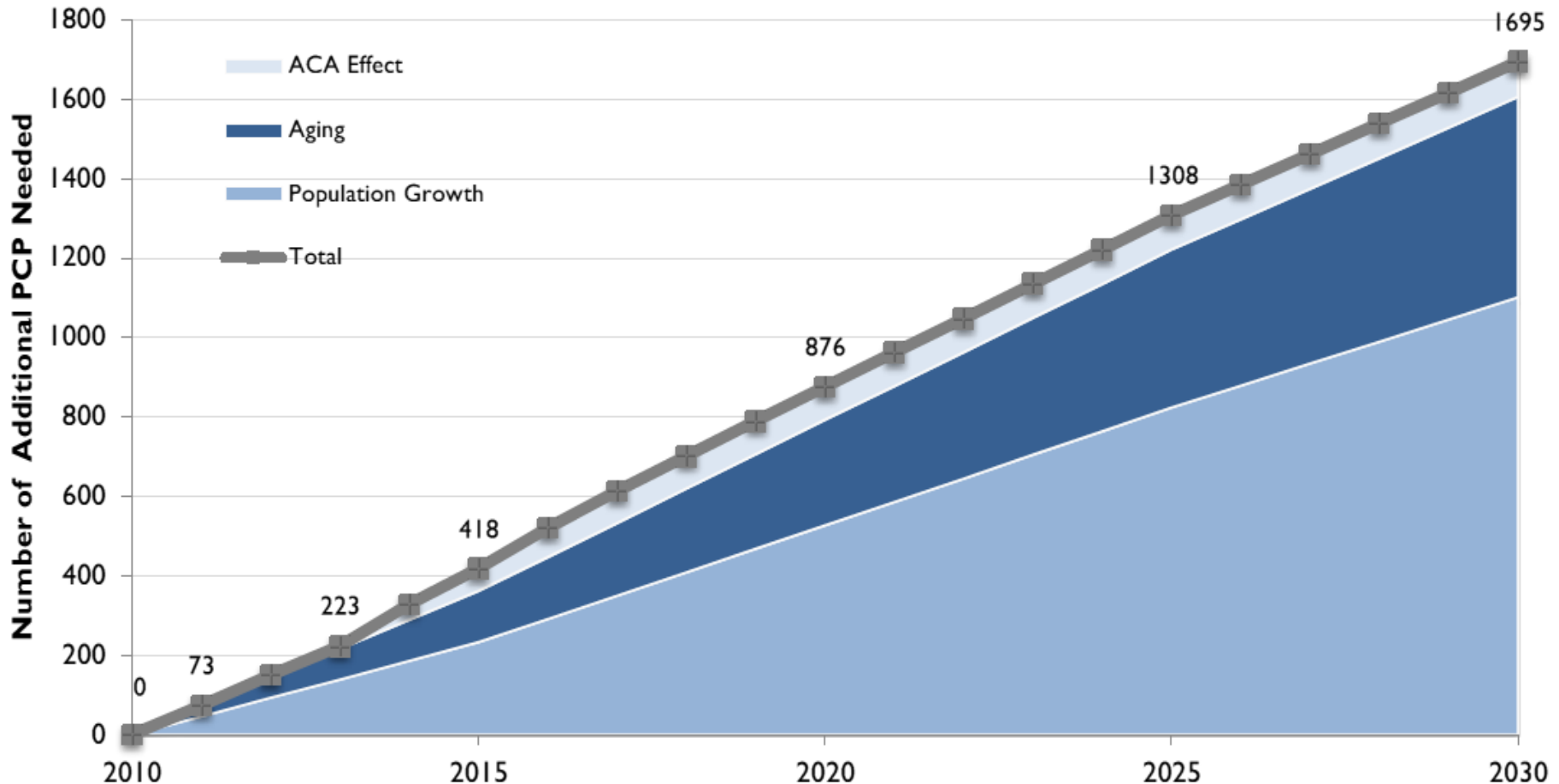
Expanded Insurance Coverage/ Access to Care

- Other issues driving the shortage of physicians
 - Many physicians who had delayed retirement from the recession are now leaving their practices
 - Overall population demographics between 2015-30:
 - Population will grow from 321M to 359M*
 - The <18 population will grow only 4% while the 65+ population will grow 55% (73% for 75+)*
- Panel size: the next big issue!

**Source: The Complexities of Physician Supply and Demand: Projections from 2015 to 2030 (2017 Update) by IHS
Market 2/28/2017.*

Expanded Insurance Coverage/ Access to Care

Washington Projected Primary Care Physicians Need



Source: WHAA: An Assessment of Primary Care Capacity in Washington State, 2016 and the Robert Graham Center, Washington: Projecting the Primary Care Physician Network, 2016

Expanded Insurance Coverage/Access to Care: Washington State Challenges

- Our average physician age is 52
- We will need to increase our current 5,141 primary care work force by 32% in 2030 to maintain current patient panel ratios...1,307:1
- The shortage is greatest in the already underserved rural areas of the state and particularly in populations of color

Source: WHAA: An Assessment of Primary Care Capacity in Washington State, 2016 and the Robert Graham Center, Washington: Projecting the Primary Care Physician Network, 2016

Expanded Insurance Coverage/ Access to Care

Strategies for meeting the challenges:

- Understand that social mores and culture change is as critical as expanded insurance coverage
- Emphasize primary care residencies and rural physician placements
- Incentivize both physicians and extenders to stay in primary care and in more rural settings
- Remain nationally patient during the process

Cost & Quality Concerns

The current fee for service model tends to:

- Incentivize the # of services performed rather producing positive outcomes
- Deliver care that is poorly coordinated
- Produce higher costs and lower quality outcomes

The patient population is left largely unaware how to navigate the system or judge if the care they receive is proper, necessary or affordable!

Cost & Quality Concerns: Where's the Incentive?

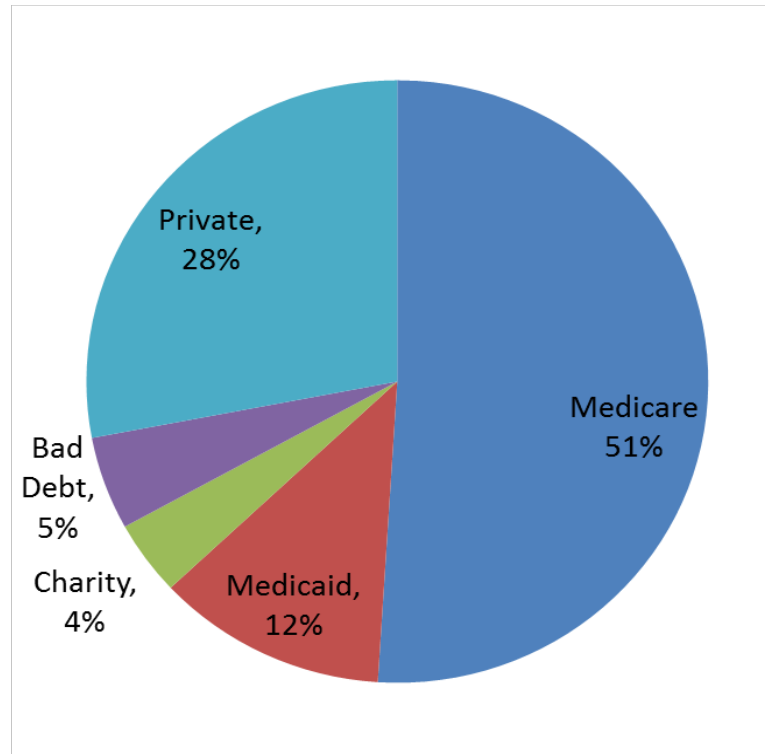
Little incentive to change the status quo:

- Providers are using private payors (like you) to subsidize their reduced revenues from Medicare & Medicaid programs
- Insurers try to negotiate preferred pricing but are met with resistance from customers when that negotiation leads to reduced access to the healthcare systems
- Healthcare leaders publicly support changing the status quo, privately they fret over losing the predictability of fee for service revenue.

Cost & Quality Concerns: The Economic Model

Hospital Payor Mix (by admissions):

- Medicare = 51%
- Medicaid = 12%
- Charity = 4%
- Bad Debt = 5%
- Private = 28%



Cost & Quality Concerns: What are the trends?

- CMS is changing reimbursement on Medicare to place greater emphasis on quality outcomes and population health
- Forces providers beginning to look at their world from a “continuum of care” perspective!
- Insurers are beginning to alter payments to providers based on quality metrics as well...providers don't like it!
- Clinically, we see primary care practice changes that emphasize team approaches over the traditional clinic models

Cost & Quality Concerns: What's the end game for Providers?

Make the mindset about quality rather than volume:

- Emphasis on right care/right time/first time mentality
- Focus on patient experience...think about care continuity
- Become community engaged: know the needs and understand the disease burden

Cost & Quality Concerns: What can we do?

- Demand more transparency from your local healthcare providers
- Encourage your healthcare leaders to purposely engage with the community to talk about:
 - Physician shortages
 - Quality issues
 - Community Disease Burden
- Lean heavily on our “electeds” to broaden their perspectives on healthcare issues

Transparency in Healthcare

“Transparency is just like the weather...everyone complains about it but no one ever does anything about it”

- In healthcare the lack of transparency is not always purposeful...it’s just complex!
- However, there is one segment of healthcare where the lack of transparency is simply part of the business model

Transparency:

The PBM as a case study

What is a PBM?

- PBM = Pharmacy Benefit Manager
- They provide both clinical and financial management services to plan sponsors
- Serves as intermediary between plan and drug manufacturers, retail pharmacies and at times with your employees

Transparency: What a PBM Is & Isn't

IS	ISN'T
Third-party administrator of prescription drug programs	Pharmacist
Financial Benefit Source	Dispensaries or network of dispensaries
Clinical Benefit Source	In routine communication with members <i>(although this is changing)</i>

Transparency:

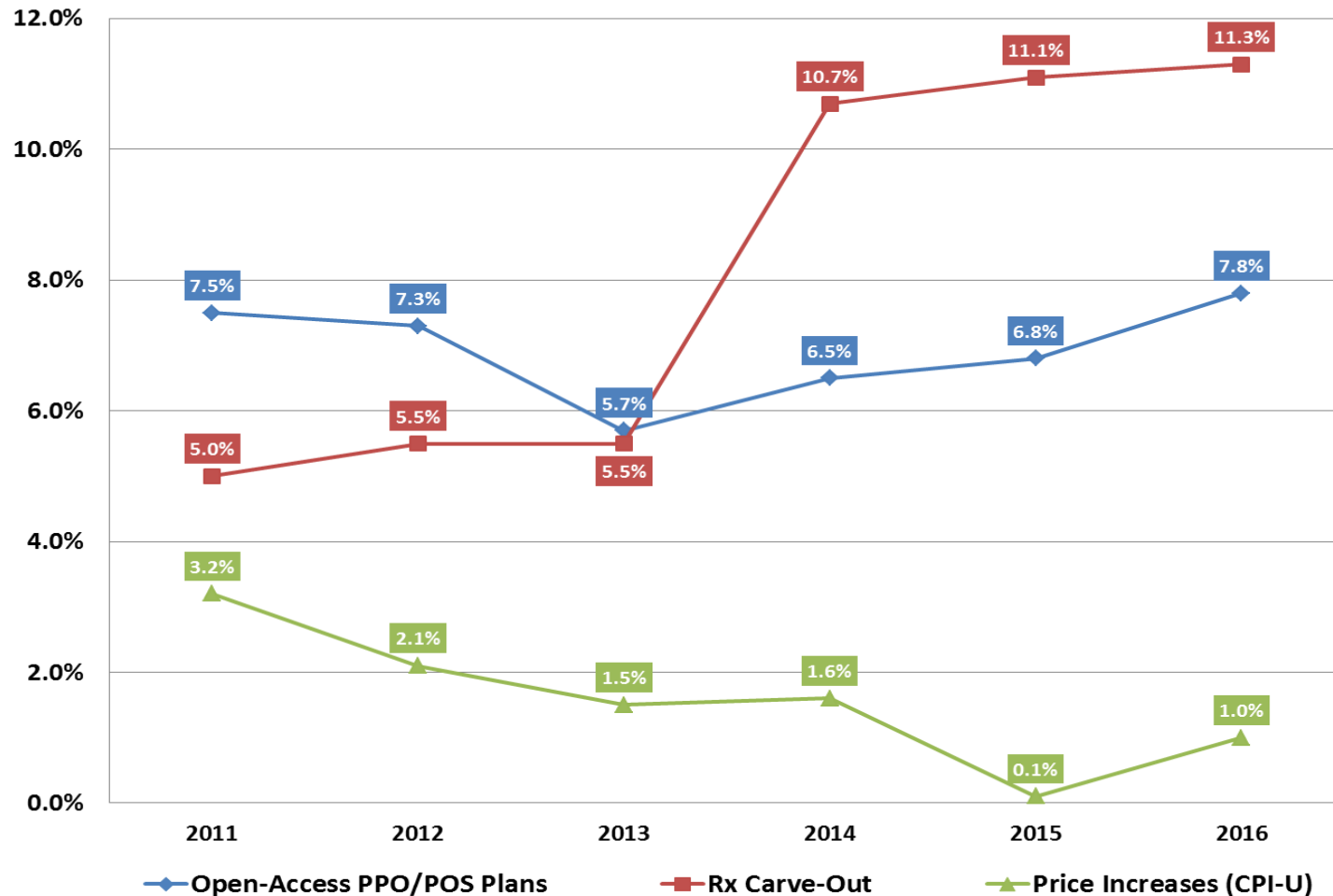
The PBM as a case study

PBMs provide a great example of how non-transparency in pricing and contractual terms:

- Drives plan costs upwards
- Can influence clinical protocols
- Creates enormous market inefficiencies that inevitably benefit the PBM and the manufacturer!

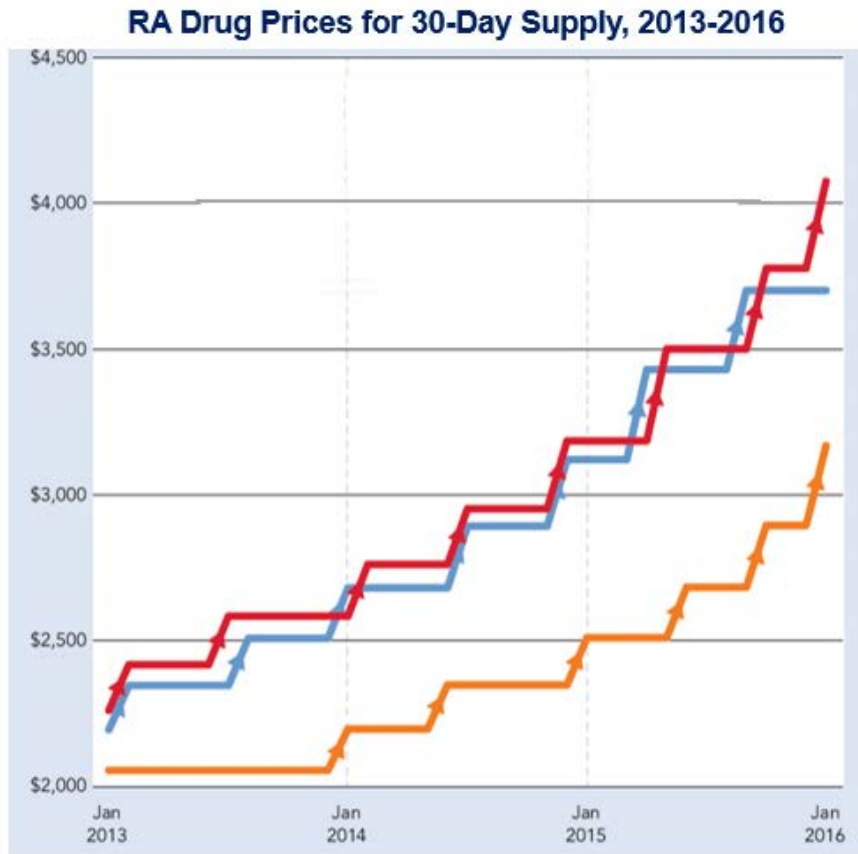
Transparency: PBMs as a Case Study Healthcare v. Pharmacy Trends

Comparison of Selected Cost Trend Rates to Price Increases



Transparency: Rising Pharmacy Costs

Increase in Rheumatoid Arthritis Drug Costs:



Enbrel

80.3%
INCREASE

Humira

68.7%
INCREASE

Xeljanz

44.3%
INCREASE

Note: Price modifications will alter the values reflected above.

Source: Alliance of Community Health Plans - Medi-Span® Price Rx®. Figures reflect wholesale acquisition cost

Transparency: Rising Pharmacy Costs

Increase in Diabetes Drug Costs:

Diabetes Drugs with Significant Percent Price Changes Over Five Years (3/1/2010 – 2/28/2015)



Note: Price modifications will alter the values reflected above.

Source: Alliance of Community Health Plans - Medi-Span[®] Price Rx[®]. Figures reflect wholesale acquisition cost

Transparency: PBM Case Study

PBMs business practices maximize market inefficiencies by

- Purposely muddling pricing & supply chains
- Changing clinical protocols to increase their profits rather than drive better patient outcomes
- Intentionally hiding transactional elements from view and using vague, imprecise contract terms

Transparency: PBM Case Study

Spread Pricing

- There are multiple pricing sources for drugs
- PBMs reimburse contracted pharmacies off one source and charge the Plan from another

Transparency: Rebates

Rebates generally are broken down into:

- **Performance Rebates – based on volume**
- **Access Rebates – dollars paid by drug manufacturer for**
 - Favorable positioning of products on the PBM's drug formulary
 - Less restricted access to drugs – no prior authorization or step therapy

When a contract says '100% Rebate pass through' to client understand that is likely only *Performance* rebates:

- PBM's can forego aggressively negotiated Performance Rebates and
- Reclassify Access Rebates as administrative or marketing fees

Transparency: Clinical Impact

PBMs also provide clinical support to assure members are getting and properly using their medication

- **Step Therapy.** requiring member to use an alternate medication before getting to the more expensive drug
- **Prior Authorization.** requiring PBM before a particular medication can be dispensed

These levers can be used more for financial gain than clinical protocol:

- Move member to medication where PBM earns greater rebate or has a better acquisition cost
- Steer members away from medications with less rebate potential

Transparency:

The PBM as a case study

How do you force a PBM to behave?

- In insured plans, you really must depend on the insurer and their ability to negotiate from their position of strength based on volume.
- Self-insured plans should (must) review their PBM contracts regularly.
- Hire a good pharmacy consultant!!

Parting Thoughts?

- All is not lost...most of the healthcare industry and even insurers want to do the right thing.
- These are challenging times...as part of WCIF you are part of an organization that has the critical mass and the will to actively participate in the “change” conversation!
- And change is coming...

Questions?

Thank you!