Comments Regarding KNG Health Consulting Fiscal Analysis of the NM Health Security Act Preliminary Report May 22, 2020

Submitted by Mary Feldblum, Ph.D.,
to the Legislative Finance Committee on 6/9/20

Prior to moving to New Mexico in 1986, Dr. Feldblum had an academic career. She was a member of Hofstra University's faculty and ultimately directed the university's Institute of Applied Social Science. From 1992 to 2002, she was under contract with Consumers Union, the publisher of *Consumer Reports*, to lead their New Mexico Health Care Project. The Project focused on a variety of health care issues, such as patient protection in managed care settings, hospital sales and conversions, and state plans for universal health coverage.

In 1993, State Representatives Max Coll and Lucky Varela introduced New Mexicare, legislation that would have enabled New Mexico to create its own health plan covering all residents. Since that time, Dr. Feldblum, who is currently the executive director of the Health Security for New Mexicans Campaign, has collected and researched almost all publicly available studies that have produced cost analyses of national and state plans for universal coverage.

The attached written comments describe what the Health Security for New Mexicans Campaign has concluded are critical issues of concern regarding the Preliminary Report. The comments include an introduction by Max Bartlett, Chair of the Health Security for New Mexicans Campaign.

Both Max Bartlett and Josette Haddad, Health Security Campaign Communications Coordinator, have provided critical input into these comments as have others.

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Introduction
Max Bartlett, Chair, Health Security for New Mexicans Campaign

Our healthcare system was already in trouble prior to the pandemic. As a result, and in accordance with action by the 2019 New Mexico Legislature, the New Mexico Legislative Finance Committee commissioned a fiscal analysis of the New Mexico Health Security Plan. A draft preliminary report was released on May 22, 2020, by a team led by Maryland-based KNG Health Consulting. KNG seeks public input so that a corrected report can be released by the end of June.

The Health Security for New Mexicans Campaign has identified numerous errors, omissions, and shortcomings. These written comments present a number of the problems with the draft report. ***There are three critical shortcomings*** in KNG's report that relate directly to their finding that there would be insufficient funding to fully pay for the Health Security Plan during the first five years.

These comments are written with the expectation that the problems presented will be addressed in the final report. The three critical shortcomings are briefly explained in the following paragraphs. They are described in more detail in our comments, along with explanations of the other problems that the Campaign has identified.

1. $3 Billion Discrepancy in Preliminary Report.

One of the most important objectives for the analysis was to determine the cost of the Health Security Plan (HSP). However, there is a critical $3 billion discrepancy in the report in this regard.

The discrepancy arises from two tables that indicate vastly different amounts for total health care spending on benefits and administration under the Health Security Plan. One table says the cost of the HSP for 2024 is $12.317 billion, while the other states that it is $9.259 billion. The accompanying text provides no explanation for this discrepancy, which amounts to up to one third of the projected cost of the program.

The KNG report needs to provide a clear picture of the estimated cost of the HSP during each of the five years covered in the report. This cost information is necessary for two reasons: (1) to compare the cost of the HSP with projected revenues to ensure that the HSP is affordable, and (2) to compare the costs of the HSP with the costs of the existing system, to see how much is saved with the HSP reform and to compare the affordability of the two systems.

2. Preliminary Report Ignores That Health Security Plan Costs Less Than Current System

KNG projects that the current system will cost $12.113 billion in 2024, while the HSP will cost $9.258 billion. In the first year alone, the difference between the current system and the HSP is $2.854 billion. Over the course of the first five years, the HSP saves over $16 billion compared to the current system.

This confirms what two other studies have concluded: the Health Security Plan costs less than the current system.

How is it possible that the HSP costs less but is not affordable? This calls into question KNG's assumptions, methodology, and conclusions.

3. Preliminary Report Does Not Justify Revenue Projections

The preliminary report alleges that the Health Security Plan, according to KNG's microsimulation modeling and assumptions, would end up with a "funding shortfall" of approximately $7 billion over the first five years of the program (figure 5.7).

However, the alleged shortfall depends not only on the cost of the HSP (for which we have been given two different figures), but also on KNG's revenue projections. We found both erroneous assumptions and lack of data and explanations in their revenue calculations. They do not demonstrate that they are able to verify the claims that they make.

For starters, the report needs to provide a list of all state and federal programs that provide existing funds that can be used to pay for the costs of the HSP, and the projected amounts for each funding stream. It does not. (Tyler Taylor, MD, identified $6.8 billion more than the report in federal funding for the HSP during the first five years.) There are also serious problems with other calculations of revenue, including employer contributions to the HSP and enrollee premiums.

In sum, there is insufficient information to judge the validity of the revenue estimates they project to pay for the HSP on page 51. This calls into serious question their claim that there is a $7 billion shortfall.

Technical Overview

Mary Feldblum, Ph.D.
Executive Director, Health Security for New Mexicans Campaign

These comments highlight some problematic issues with the KNG preliminary report. The LFC's request for proposals included a requirement that the consultants develop various scenarios. That means there should be several Health Security Plan (HSP) cost possibilities, not just one, based on varying assumptions. The scenario requirement also applies to how the Health Security Plan could be paid for.

Therefore, what is perhaps the biggest flaw in this report is that it only presents one baseline HSP cost (Table 5.2) – a figure that is in conflict with annual cost estimates of the HSP in Table 5.3. Furthermore, the numbers that are used to arrive at the annual cost estimates for the HSP in Table 5.2 are based on assumptions that in all too many cases are not substantiated or explained.

As will become clear in the following comments, it is disturbing, to say the least, that in every case in which there is a possibility for HSP cost reductions (provider administration savings, global budgets for hospitals, bulk purchasing of pharmaceutical drugs, billing simplification), reductions do not seem to be considered as a possible scenario when producing the cost estimates for related services under the HSP, such as drug costs or the cost of physician visits. We actually do not know how KNG arrives at the estimates for different services in Table 5.2.

This is also a problem with the revenue estimates to pay for the Plan. While KNG comes up with several funding alternatives, nowhere do they provide the data and information we need to judge their original suggested option or the five alternative options that were briefly described toward the end of the report (pp 52-54).

Throughout the report, too many of the estimates are based on unknowns. There are simply too many leaps of faith required. In essence, this draft report is only providing us with one view of a picture that requires other ways to view it.

Finally, it must be stated that both Sen. Carlos Cisneros and Rep. Bill Pratt, who were instrumental in achieving the funding for this fiscal analysis, were interested in seeing a range of ways to ascertain the cost of the Health Security Plan, a plan that they so deeply believed in. They wanted an objective analysis. This draft report, unfortunately, fails that important test for the many reasons cited in these comments.

1. $3.0 billion discrepancy questions validity of entire analysis.

We developed a chart that shows the different KNG cost estimates for the Health Security Plan (HSP) and how these costs change year to year from 2024 to 2028. Not only is there a $3 billion difference in cost in the first year that the HSP is in operation (2024), but over the 5-year fiscal analysis this amounts to the difference between a plan that costs $50 billion and one that costs $66 billion.

KNG Preliminary Report Fiscal Analysis May 22, 2020	Health Security Plan Cost Estimates Table 5.2 (p. 47)	Health Security Plan Cost Estimates Table 5.3 (p. 51)	The Difference
Year	*In billions of dollars*		
2024	12.317	9.259	3.058
2025	12.756	9.549	3.207
2026	13.140	9.997	3.143
2027	13.543	10.104	3.439
2028	13.947	10.793	3.154
Total	**65.703**	**49.702**	**16.002**

This difference is so critical that we need to explain the numbers used in this chart. The data are derived from two separate tables. Table 5.2 (p. 47) provides us with the estimated "total health care spending" numbers for the HSP along with the corresponding numbers for the current system. Table 5.3 (p. 51) provides the total "HSP benefits and administration" figure. This discrepancy between these two numbers is a very serious problem for KNG.

Which is the correct number? According to the KNG preliminary report, the number in Table 5.3 is the one to rely on. The numbers in Table 5.3 are the estimates they used when they constructed their dramatic chart to demonstrate what they considered to be a $7 billion shortfall. (The difference between the total cost of the HSP over 5 years [$50 billion] and their revenue estimate totals of $43 billion – which, as our comments will demonstrate, are as questionable as their cost estimates.)

As you can see in the table above, the estimated cost for HSP benefits and administration in Table 5.3 is $9.259 billion. We have totaled the cost for each year and come up with the $50 billion that is reflected in the large blue column of Figure 5.7, which is clearly labeled with "$50 Billion" and "Proposal Costs." The text on page 50 also corroborates the HSP cost listed in Table 5.3. "In 2024, we estimate total state benefit spending and administrative costs for HSP enrollees would be $9 billion."

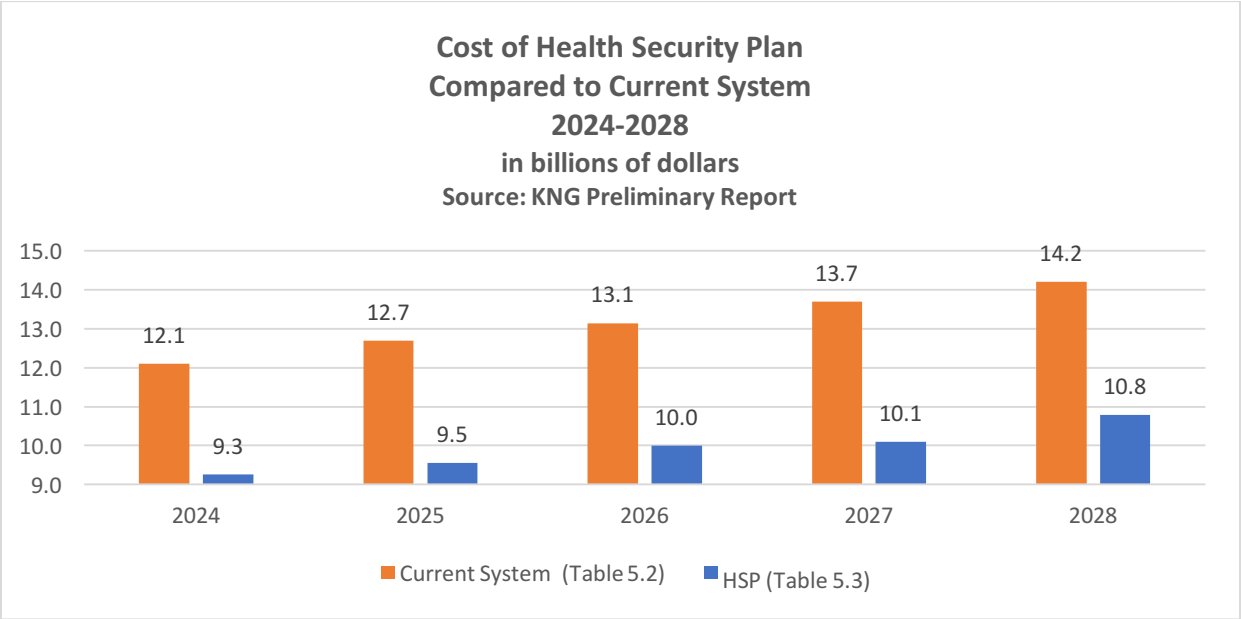
Thus, it seems reasonable to rely on the HSP cost data provided in Table 5.3 as the total cost of the HSP, rather than the cost data listed in Table 5.2.

And, this 2024 $3 billion discrepancy amounts to $16 billion over 5 years.

2. Report shows HSP has lower costs than current system.

We also constructed a chart based on KNG's estimates of what total health care spending would look like from 2024 to 2028. Given the information we presented above, we relied on Table 5.3 for the cost estimates of the Health Security Plan. KNG provides cost estimates for the current system in Table. 5.2.

The chart below shows a dramatic difference between KNG's estimated cost of the current system (Table 5.2) and the cost of the HSP (Table 5.3).



This chart clearly demonstrates that the HSP costs less than the current system, an estimate that was confirmed by two other New Mexico studies (Lewin and Mathematica). This chart presents a different view to the cost picture.

From this chart, we can calculate the yearly difference in cost between KNG's estimates for the Health Security Plan and the current system. In 2024, the difference amounts to $2.8 billion (12.1 - 9.3 = 2.8). By subtracting the difference in each year's costs, we end up with a total of over $16 billion that should be described as **savings** due to the HSP's lower rate of increase in health care costs compared to the current system.

How, if the HSP costs billions of dollars less than the current system, can KNG claim it is not economically viable, especially when compared to the current system?

There are two major issues that need to be addressed: (1) how KNG calculates the cost of the Health Security Plan, their assumptions, and the data they use, and (2) how KNG determines the revenue sources to pay for the cost of the HSP.

3. Revenue Issues and Assumptions
3.b. Federal and State Funding Estimates

If the cost projections for the HSP pose problems, so do the revenue projections. The same issues arise. The draft report provides us with totals for each revenue source category, but there are no justifications for the amounts listed in Table 5.3 (p. 51). This extraordinary lack of supporting documentation brings into question the validity of these estimates.

Federal/state funding sources: Since Medicaid recipients are assumed to be included in the HSP, it makes sense to include those dollars as a funding source. The HSP, however, does not include long-term care, which Medicaid funding covers for those qualified to receive it. (While KNG acknowledges that the HSP does not cover long-term care, we have no way of knowing whether the portion of Medicaid funding going to long-term care has been excluded from their calculations.)

KNG's report needs to provide a specific list of each and every federal and state program that can be assumed to help cover the cost of the HSP, what KNG describes as "repurposed federal and state spending." *It does not do this.* It needs to inform us of the status of these funds as of 2019 or, if possible, 2020. *It does not.* Since the HSP begins to operate in 2024, what assumptions are they making about the availability of the funds in 2024 and afterwards? Will they increase? Or decrease? KNG calculations need to be transparent and explicit explaining these estimates.

Tyler Taylor, MD, has been working on this issue and is separately submitting some very different calculations and higher revenue estimates for federal funding available to the HSP. In fact, using data projections from the NM Human Services Department, he has identified a total of **$6.8 billion** in additional federal dollars to help fund the HSP during the first 5 years.

3. Revenue Issues and Assumptions
3.b. Employer Contributions

KNG's approach to the employer contribution side assumes an 8% payroll requirement for all employers who do not provide coverage for their employees through a self-insured plan. First, it is important to understand how this 8% figure was established. Second, it is important to estimate the numbers and characteristics of the employers whose employees will now be covered by the HSP.

1. How is the 8% derived? "First, we estimated the amount of money contributed towards premiums by employers for fully insured plans." (Does this include public plans? It's unclear.) Then "we calculated total premium contributions as a percentage of total payroll across all employers that do not offer a self-insured plan. This fixed percentage was established as the contribution required for employers who participate in the HSP." (pp. 9–10)

There are two problems with this approach: (1) The Health Security Plan requires an employer contribution based on payroll and number of employees, with a cap. The report lacks NM data on these employers (including the self-insured, the fully insured, and those that don't provide insurance) that includes size of firm, payroll information, and the number of employees. Without this data, we cannot judge the impact of the 8% and whether there are other possible scenarios beyond the draconian ones presented as alternative sources of funding at the end of the draft report. (2) There are questions about their estimates regarding self-insured employer participation in the HSP, as decisions to participate will not simply be based on payroll costs but will also factor in lower workers compensation and lower auto insurance – both of which the report states will be lowered under the HSP – as well as the administrative costs that an employer takes on when providing health care to employees.

2. Which employers are required to make contributions?

"For the purpose of our model, we assumed that the HSP could develop an ERISA-compliant approach to obtain payments from all employers whose employees are enrolled in the HSP and who do not offer a separate self-insured plan." (p. 9)

Here it appears that all employers whose employees are enrolled in the HSP would be required to contribute, with the exception of companies that remain self-insured. (And, of course, those employers enrolled in the HSP would see lower workers' compensation and commercial automobile premiums.)

3. Self-insured employers (those who collect premiums themselves and pay a company to process employee claims) can voluntarily join the HSP. This is a provision that is not new to the Health Security Act, as mistakenly asserted on page 9 in the draft report, but has in fact been included in the bill since 1993 when it was first introduced by Reps. Max Coll and Lucky Varela in the state legislature.

Does KNG modeling think that they will join the HSP?

3. Revenue Issues and Assumptions
3.b. Employer Contributions

Option 1. On page 23, KNG comes up with a formula that, if we understand it correctly, would result in a firm dropping its self-insured plan and joining the HSP if there is a 5% difference in payroll costs. Thus, if an employer's health care costs amount to 13% of payroll and the contribution required by the HSP is 8%, that presumably would lead to a preference to join the HSP. There is no explanation for how this 5% is derived.

Option 2. On page 30, KNG writes, "We modeled the decision of self-insured firms to continue offering their own plan or having its employees gain coverage through the HSP." While a firm may choose to remain self-insured, and here KNG seems to indicate that their modeling assumes they will, there may be **employees** in a self-insured firm who would join the HSP. (An issue that we address later on).

What are we able to learn from this?

Table 4.1 (p. 31) provides us with the number of employees in self-insured firms and in fully insured firms. In addition, the table breaks out the number of employees with ESI (employer sponsored insurance) by firm size. The table does not break out employees by firm size according to whether they are self-insured firms or fully insured firms. Nor does this table separate out public employees, who account for almost 36% of those who have insurance – if indeed they are even included in this table (see p. 30, where public employees are noted as "not shown" in Table 4.1). Moreover, it does not tell us whether these are full-time employees, part-time, or contract employees.

Based on the information provided by this table, KNG assumes (p. 38) that "about half (52%) of individuals enrolled in an employer's self-insured plan would work at firms **that stopped offering independent coverage**."

Since Table 4.1 does not tell us the number of firms but only the number of employees who work in those firms, we have no way of judging how many self-insured companies would stop offering coverage and join the HSP. In addition, payroll information for these firms is not provided. Without this information, we cannot evaluate KNG's assumption that those self-insured firms that opt to join the HSP are doing so because they would be paying 5% less of payroll in health care costs under the HSP. (A 2017 Mercer survey indicated that 14% of payroll goes to health care for what are assumed to be large firms.)

Payroll information should be available for all NM firms, even those that are not providing coverage. Such information would make it possible to examine alternatives that comply with the Health Security Act requirement that employer contributions need to consider payroll, number of employees, and caps.

In a discussion of the financial impact of the 8% on employers (p. 44), KNG describes three types of firms and the accompanying impact:

1. The ones who currently do not provide coverage now would have a cost.

2. The ones who currently provide coverage and whose employees are now in the HSP would pay less.

- These HSP contributions would be less than what these firms would have paid toward employee premiums in the baseline, as the burden of replacing forgone employer contributions is also being shared by firms that would not have offered coverage in the baseline. This set of firms, which includes firms of all sizes, would pay less.

3. We assume this third group, described below, refers to the self-insured. This group still offers coverage and would not be contributing to the HSP. Then comes a puzzling prediction from their model that these firms would end up covering more dependents and their spending would increase under the HSP. There is no data provided or sources given to back up this prediction.

- As other employers drop coverage, our model predicts that dual-income spouses will migrate to the employer-based plans that remain. Among those remaining firms, this will increase employee participation rates as well as the average number of enrolled dependents. Employer benefit spending among these firms, which tend to be larger (>100 workers), would thereby increase under the HSP.

What does all this mean in terms of the employer contribution?

1. We are not able to judge how much revenue will be generated with their 8% payroll requirement because there is no information provided in the report regarding the number of employers, their payroll, and the number of employees (and the source of that information).

2. We are not able to judge how much revenue will be generated, if KNG is correct in assuming that 52% of the employees of self-insured plans will be enrolled in HSP. How many firms does this estimate include? What is their payroll? How much do they estimate is available to the HSP?

3. We are not able to judge how many self-insured plans will join the plan based on the "5% less than their current payroll" standard, since no payroll numbers are provided. Many more self-insured firms, whom they are not counting as a possible revenue source, may willingly join the HSP for other reasons (such as, their health costs are rising dramatically and there is evidence that they are not saving money by being self-insured).[1] The attraction of a large risk pool, lower workers compensation and automobile insurance premiums, the reduction in

[1] "Self-Insured Companies Do No Better on Cost Control," January 27, 2020, Drew Altman, Kaiser Family Foundation, https://www.axios.com/employers-health-care-insurance-costs-57f06e79-dbb8-4233-898d-f5fd7664d201.html. See also "Employers Increasingly Open to Provider Rate Regulation," Harris Meyer, February 20, 2020, Modern Healthcare, https://www.modernhealthcare.com/finance/employers-increasingly-open-provider-rate-regulation.
Mercer Health Benefit and Plans Survey. https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercer-national-survey-benefit-trends.html

administration costs, and the ability to offer supplemental insurance, if desired, must be taken into consideration. KNG does not give us the numbers of self-insured firms that will join the HSP, but their assumptions, which are unclear, may be much too low. A larger number of firms coming into the HSP would generate more revenue.

KNG also expresses concerns "that the presence of HSP could encourage employers to design self-insured plans that limit eligibility to select workers, which would shift costs from these employers onto the HSP" (p. 10). In fact, this is already happening when companies like Walmart rely on Medicaid and Medicare for many employees, shifting the burden of paying for health care onto the public purse. (This concern also seems at odds with KNG's prediction on p. 44, which was quoted above, that these firms would end up covering more dependents under the HSP.)

4. Finally, there is another missing source of revenue. KNG estimates that based on "affordability," a certain number of employees of self-insured companies will prefer to be enrolled in the plan. By allowing employees of self-insured companies to select the HSP – based on an affordability standard of 9.5% of a family's modified gross income – the same cost shifting problem could occur *unless* the self-insured employer has to pay for any employees who are covered by the HSP – an assumption that is unclear in this report. Has KNG (1) estimated how many of these employees would join the HSP; (2) how much the self-insured employer would be required to pay for those employees who enroll in the HSP; and (3) how much additional revenue this would provide to the HSP? If so, the information is not presented.

In sum, KNG's questionable assumptions, lack of justifications, and lack of sources ultimately raise questions about the validity of their conclusion that $9 billion will be generated from employer contributions to help pay for the HSP over the 5-year period of the analysis.

3. Revenue Issues
3.c. Enrollee Premiums

Premiums. The lack of information regarding premiums also raises questions about the projected $6 billion collected from enrollees in the HSP (Fig. 5.7, p. 51).

There are many different ways to come up with premiums schedules. Table 2.3 (p. 13) lays out four possibilities. The one KNG selected is titled "employer plan": "our base model used a common employer plan cost-sharing and premium policy, since this represents around the average generosity" (p. 12). The HSP services is modeled after those of the NM state employees. Their logic for using private employer premiums is as follows:

"An assessment of the state workers' plan revealed that its actuarial value (percent of average total health care spending that is covered by the plan) is similar to an average ESI [Employer Sponsored Insurance] plan. Thus, we assumed that the use of services under the HSP would be similar to the use of services under an ESI plan, with adjustments for waiver of cost-sharing for certain services and groups." (p. 11)

First question: We do not know whether the coverage offered by the average ESI plan offers the comprehensive set of services that are offered to the state employees. (Does this "ESI" coverage include the self-insured?) The state employee spending (the actuarial value) may in fact include services not offered by the average ESI. Given the fact that state employee health spending information is available and given the fact that the plan models its services after the state employee plan, why make this assumption? The RFP suggests that the fiscal analysis should consider "using the claims experience of state employees/educational employees to project costs for the rest of the covered population" (RFP p. 35). Why was this not done?

Second question: Premiums assume plan administration costs. State employees select from several private insurers. If, as stated by KNG, "combining Medicaid with the HSP would likely reduce administrative complexity for both the state government and the rest of the state's health care system," (p. 8), why wouldn't this assumption also apply to state employees? With lower costs, the result would be lower premiums than the ESI average that KNG has selected.

Third question: Why doesn't the proposed premium schedule reflect the requirements as outlined in the Health Security Act: premiums are based on income, with minimum and maximum levels, and caps. (KNG seems to understand "caps" as merely a limit on the percentage of income paid; instead, a cap is a dollar amount beyond which the premium would not rise, regardless of higher income.)

Another option: KNG's four options all assume the current costly private insurance system. That is certainly an option, but there are other methodologies that can be used. A premium schedule could be based on the actuarial value of the Health Security Plan, exempting those who are not required to pay premiums under current laws and regulations. Once possible cost scenarios are developed (not one baseline), the "repurposed" public dollars would be factored in. The remainder would then be generated through premiums and employer contributions.

3. Revenue Issues
3.c. Enrollee Premiums

The funding mechanisms would, however, be based on the cost of the HSP, not the cost of plans in the private insurance market.

What is missing:

A table that is based on current NM income data and shows incomes from $9,000-$9,999, $10,000-$14,999, $15,000-$24,999… all the way up to $150,000 and above. Then use that 2019 data to estimate 2024 incomes.

A table that identifies the revenue generated by income category for the estimated ESI premiums for 2024–2008.

In addition, since these premiums were based on 2024 health costs, how do they compare to today's premiums?

Finally, premiums are not the only source of enrollee revenue. Why are copays not included? Again, the state employee data would be extremely useful in calculating this revenue source, which would not apply to preventive care services.

4. The KNG Health Care Reform Modeling Approach

Health care reform models that help predict health care costs obviously contain lots of data that are adjusted for relevancy and then, through sophisticated formulas, point to potential conclusions. The model's formulas make all sorts of assumptions about the data. You don't need to be a mathematician to judge what is going into a model. What is critical is that those who use models are very, very clear and precise about the data they are using, the assumptions they make, and the adjustments they perform based on those assumptions.

Unfortunately, as the comments demonstrate, KNG is not clear and precise about the steps it takes and the assumptions it makes about the conclusions it comes to.

KNG relies on what is called a "microsimulation model" that was developed in-house. What is a microsimulation model?

Mathematica Policy Research, Inc., whose carefully researched 2007 analysis of five New Mexico health care reform options, including two versions of the Health Security Act, also used a microsimulation model for some aspects of their analysis. In their report, they provide a clear description of the limits of such a system.

> Microsimulation differs from a macro "top down" approach to developing estimates in that it involves a detailed consideration of the circumstances of individuals and families in New Mexico. Modeling individual opportunities and decisions under major reform is essential for comparing each of the reform models on the same basis, **to the extent that individuals in any of the reform models may choose where they would obtain coverage [emphasis added].** (p. 9)

Mathematica was requested to compare various health care reform alternatives, including market-based ones. What is critical to note is their point that a microsimulation model focuses on **individual behavior.** If my employer offers me insurance, what is the likelihood that I will sign up for it? How many people in my category (gender, income, race/ethnicity, even region) would sign up for such a plan? As an uninsured person who now has insurance, will I add cost to that program because of pent-up demand?

A microsimulation model attempts to predict behavior based on a database that includes information on individuals, such as the American Community Survey. Or, the model could rely on a public database that provides information about Medicaid or state employees. Actuaries are skilled at using such data to predict health care usage for insurance companies.

KNG describes how they use their microsimulation model as follows:

> To simulate the impact of the HSP on insurance coverage, health care utilization, and spending, we started with the KNG-Health Reform Model (KNG-HRM), a microsimulation model capable of estimating the impact of health reform efforts. We then modified the model to incorporate New Mexico-specific data on the state's population and **health care utilization**, and to reflect HSP policies. **The model uses an iterative process to estimate coverage choices, health care service use, spending, and premiums, as**

> **coverage affects health care use and spending, which in turn impact premiums and coverage choice.** (p. 15)

Thus, KNG's model focus on individuals and their **behaviors** based on the **choices** they make. KNG's flow chart on p. 16 visually describes this "iterative process."

There is methodological problem that occurs when solely relying on a microsimulation model in situations where choice may not be a factor. Such is the case with the Health Security Plan. There are, indeed, some choices that have to be made, but there are also many fixed assumptions that must be assumed in a cost analysis. For example, those New Mexicans eligible for coverage are **automatically** enrolled (and there are mechanisms that would provide for such a system, as KNG acknowledges). The services (benefits) offered can be no less than what the state employees are entitled to, a comprehensive package that includes preventive care. The enrollee in the plan does not have to select Plan A, which costs X, or Plan B, which costs Y – all with different coverage options and out-of-pocket obligations. In fact, the evidence suggests that when provided with such a choice, consumers may not make the best decision. This then is just one example of choice.

On the other hand, if a plan such as HSP requires bulk purchasing of drugs and other medical equipment and supplies, that is not a choice the enrollee makes but a policy whose success is based on other forces. By how much could drug prices be reduced if New Mexicans were including in one bulk purchasing pool? The analyst would have to look at factors such as how many in the pool, are there other relevant experiences (such as Veterans Affairs) to take into consideration. In other words, economic, political, even historic factors would be relevant to any estimate about drug costs and prices.

There are therefore limits to the type of microsimulation model described by KNG. Thus, it is important for the report to be very clear how it justifies assumptions that do not involve individual choice.

What data regarding New Mexico is included in the KNG microsimulation model? We really do not know. They provide very limited information about sources. On p. 18, they note that their final population sample includes 41,783 "observations representing individuals residing in New Mexico," taken from 2016, 2017, and 2018 American Community Survey (ACS) data. The American Community Survey is an annual national (written) survey that is mailed to a randomly selected sample of Americans **based on mailing addresses**.

KNG does point out that they have made adjustments "to incorporate New Mexico-specific data" (p. 15). Aside from the ACS, Table 3.1 (p. 18) lists other sources that they included in their model – some federal, some state. They also note that they exclude from the analytic file those on Medicare, those who reside in group quarters, and those covered under a military health insurance program. (We must assume they are not mixing apples and oranges. Integrating data from different time periods with different definitions, assumptions, and methodologies poses serious challenges when added to an existing source.)

4. The KNG Health Care Reform Modeling Approach

While all of this sounds impressive, KNG does not provide us with information to assure us that these 41,783 New Mexicans are representative of our state. Who are they? What were the demographics of the original sample, and what adjustments were made? (While various adjustments to the data are discussed, breakout numbers and details are rarely provided.) Since this information comes from current surveys, they need to explain the assumptions they made to update this sample to 2024.

Nor do they provide us with current general population data that breaks out our population by different key categories. Given the fact that the estimated costs for the HSP must begin in 2024, it is important to see current population data and population increase estimates by category. (Certainly, population trends regarding the elderly and the under-30 population would be critical to see, as well as ethnic, gender, and income information.)

Table 4.1 estimates that our population (excluding the over-65, and who else?) will be 1.7 million in 2024. This is an important estimate, but we are clueless as to how this was arrived at. (Sources for all tables and figures are credited to KNG.)

Current population data and projections are missing, but so is other critical current data. On page 28, the draft report points out that according to federal estimates, New Mexico's personal health expenditures (what is spent on services, doctor visits, etc.) in 2018 amounted to $13.5 billion. While the total figure is provided, that's all we get.

Other experts who have performed fiscal analyses on plans that provide universal coverage explain important baseline data fairly early on in their reports, and provide detailed data and adjustment information in appendices. (See attached Rand analysis on the NY State Health Act, p. 22.) Instead of walking us through this $13.5 billion number from 2018 and letting us into their thinking about how and why this $13.5 billion is expected to change over the years, and how this impacts their analysis of the current system and the HSP in 2024, KNG simply informs us in Table 5.2 that this amount will be $12.113 billion in 2024. How did they get from $13.5 billion in 2018 to $12.113 billion in 2024?

This is a consistent pattern throughout the KNG report. We never know what exactly is going into the microsimulation model, and there is no explanation about how they arrive at any of the key numbers in Table 5.2 and Table 5.3.

In sum, there are limits to relying on a microsimulation model. And the data used in the model must be trustworthy and how that data is used to justify assumptions must be explained and must make sense. Our comments, unfortunately, give example after example of serious omissions, assumptions, confusing data, conflicting use of terminology, and some serious mathematical errors, all of which raise serious questions about the KNG's estimated cost of the HSP over a 4-year period and the alleged funding shortfall.

"An Assessment of the New York State Health Act,", p. 22, Rand Corporation, 2017

Box 3. Definitions of Health Care Spending and Service Categories

In this report, we refer to total health care spending as the sum of expenditures for personal health care, medical structures and equipment, health plan administration, state government administration related to health care programs and insurance (other than health plan administration), and employer health benefit administration.

The term **personal health care expenditures** refers to spending on treatments for individuals with specific medical conditions. The service categories of personal health care spending in the CMS SHEA are the following:

- hospital care
- physician and clinical services
- other professional services
- dental services
- home health services
- prescription drugs and other nondurable medical products
- durable medical products
- nursing home care
- other health, residential, and personal care.

Expenditures on **medical structures and equipment** reflect purchases of or investments in structures and equipment in the medical sector. **Health plan administration** includes the costs of running government health care programs and the difference between premiums collected and claims paid by private insurers. **State government administrative expenditures** related to health care programs and insurance (other than health plan administration) are costs of regulating health insurance and revenue collection for health care programs. In this analysis, **employer health benefit administrative expenditures** are the portion of wages for compensation and benefits managers dedicated to managing employee health benefits.

5. HSP Cost Increase Considerations
5.a. Utilization of Services

When determining the cost of a plan like the HSP, in which almost all residents of a state will be covered, policy analysts need to take into consideration whether providing insurance to the uninsured, or providing improved insurance to the underinsured, will result in those populations accessing more services and thereby increasing costs.

The report's discussion of utilization is very complicated and confusing and, once again, we do not know how KNG factored into their cost projections in Table 5.2 any assumptions they make. In addition to analyzing the potential increase in services, it is critical to estimate the number of uninsured and underinsured (which includes those who receive employer-based insurance that is not as comprehensive as that offered to NM state employees and their families).

First, let's review KNG's assumptions about utilization and to whom it applies.

Early on, we expressed concerns about KNG's reliance on an Oregon study of previously uninsured residents who received Medicaid coverage. Oregon is not New Mexico (with very different demographics), and the study is old (2008). Under the ACA, many of the New Mexican uninsured have been able to gain coverage through Medicaid, Medicaid expansion, and the insurance exchange. There should be public data available to ascertain utilization patterns among these formerly uninsured New Mexicans. To their credit, KNG did report that they had to "make adjustments" (p. 27) to the Oregon assumptions to reflect New Mexico circumstances (although they do not explain what adjustments they exactly made). They also conclude that those who are eligible for Medicaid or marketplace subsidies but choose to remain uninsured may not "utilize services the way an insured individual would utilize services" when they become enrolled in the HSP.

So the Oregon assumption that there will be increased utilization when the uninsured become insured becomes more complex in our state.

They make other statements that seem to confirm this assumption:

• p. 11: "we did not assume that the uninsured who now gain coverage under the HSP (in part, from retroactive eligibility) would seek care to the same extent that someone who was previously insured. Instead, some may continue to seek care to the same extent they sought care while uninsured. This assumption reflects the reality that having access to care may not change behavior for those who choose to be uninsured, because of financial, cultural, or other reasons." *(What percentage of the uninsured fall into this category? The report does not give us this information.)*

• footnote 15, p. 16: "we operationalized the assumption that not all newly-insured individuals will fully access services under the HSP by assuming smaller increases in the use of services among the uninsured who gained HSP coverage than suggested by the literature." (*What do "smaller increases" amount to, and how do they impact the estimated cost of the HSP in Table 5.2? Again, no data is provided*.)

Yet, later in the report they ignore the nuances expressed above and specify *large* utilization increases for the newly insured, and increased utilization overall:

5. HSP Cost Increase Considerations
5.a. Utilization of Services

"We forecast that the HSP **would result in increased service use** (Figure 5.3). These effects would be larger for those who are uninsured in baseline (Figure 5.3). For the uninsured who would gain coverage under the HSP, we assumed **large utilization increases** in all service categories, including hospital admissions (+24%), outpatient visits (+40%), ED visits (+59%), physician office visits (+43%), and prescription drug (RX) fills (+13%). We also estimated utilization increases among those who would have otherwise had non-group coverage, as we assumed the HSP would have lower levels of cost-sharing than plans typically obtained in the individual market." (p. 41)

In contrast, those who have ESI (employer sponsored insurance) are assumed to not change their utilization patterns.

"Under our model we assumed an increase in the use of services (and thus spending) for those who gain coverage under the HSP. However, spending is lower for individuals who switch from ESI [employer-sponsored insurance] coverage to the HSP, **because we assumed no change in utilization of services** but that health care prices are lower under the HSP than those paid by ESI." (pp 33-34)

Note that they assume that 82% of their "population simulation" is covered by Medicaid or receives employer coverage, where they foresee little change in utilization patterns. (p. 41)

Then, on pages 35 and 36 we are now provided with tables that break out utilization patterns by race (Table 4.4), with no Hispanic breakout information, and by ethnicity (Table 4.5), which breaks out utilization by Hispanic and non-Hispanic. These charts show spending estimates by type of insurance (employer, Medicaid) and type of service (doctor visits, pharmacy, etc.) **for 2024**. KNG comes up with average costs for each group and then – based on this data – forecasts utilization patterns, which their modeling program then adjusts by race, ethnicity, and type of coverage.

These 2024 projections by race/ethnicity, coverage, and type of service then ostensibly serve as the basis for their assumptions about utilization cost increases for the uninsured under the HSP p. 41. However, it is unclear how KNG is using these projections in their cost calculations.

But all this confusing information poses serious problems. To accept KNG's utilization HSP cost numbers, we have to have confidence in the reliability of their population simulation model and understand how they come up with the increases in utilization. We also need to understand how they made these utilization projections for 2024 based on (presumably) 2019 data. Finally, we need to know whether these increases are one time only, and so are assumed only for 2024. We are not provided with any explanations or justifications to judge the accuracy of these three calculations. In addition, we have no idea, for example, how the 40% increase in outpatient visits among the previously uninsured is factored into the comparative cost chart on page 47 (Table 5.2).

5. HSP Cost Increase Considerations
5.a. Utilization of Services

Second, who are the uninsured in 2024?

If KNG is increasing HSP costs due to increased utilization of services by the uninsured, it is important to know how many uninsured remain by 2024 and what increase in cost estimates can be projected.

We know from a 2019 Urban Institute survey conducted for the NM Human Services Department that 187,000 New Mexicans remain uninsured, a dramatic decrease due to the Affordable Care Act. We also know that approximately half of them are eligible for Medicaid or Medicaid Expansion programs. In November 2019 the Human Services Department informed the Legislative Health and Human Services Committee that they have plans to enroll these Medicaid-eligible populations and to come up with proposals in 2021 to address the remaining 94,000. Thus, there will be an aggressive attempt to plug this tragic hole.

Yet, KNG estimates on page 30 that 12% of New Mexicans remain uninsured in 2024. (11% is cited in Table 4.1 on page 31.) Table 4.1 states that the number of New Mexicans who are uninsured in 2024 is **188,000**. Why is this number virtually the same number of uninsured – 187,000 – reported by the Human Services Department in November 2019? There is no explanation for why the number of uninsured has remained constant from 2019 to 2024. If this figure is not an accurate assumption, then all the adjustments made in the KNG modeling program that assume added costs due to the increase in services by the uninsured must be recalculated.

The question of the number of uninsured New Mexicans illustrates why the RFP required the contractor who would conduct this cost analysis to come up with various HSP cost scenarios (not just one). Clearly the pandemic has had a major impact on the number of uninsured, especially those who have lost their employer coverage. Should not this be taken into consideration along with state government and legislative efforts to address this situation prior to 2024?

Plan Administrative Assumptions. KNG assumes that by the fifth year of the HSP (2028), the administrative cost is 5%, as required by the Health Security Act. Therefore, they "assumed that administrative costs would start at 9 percent [in 2024] and fall by 1 percentage point each year" (p. 64). The administrative costs presented in Table 5.2 do not quite follow this assumption, however: 8.2% for 2024; 7.4% for 2025; 6.7% for 2026; 6.0% for 2027; and 5.1% for 2028.

The report then questions the feasibility of the 5% requirement, comparing this percentage to the state's Medicaid program and the Medicare program. New Mexico's Medicaid program relies on the private insurance system and therefore includes its high administrative costs; similarly, the Medicare administrative cost figure cited (7%) includes Medicare Advantage plans, which cost the federal government considerably more than traditional Medicare. (Per the Kaiser Family Foundation [https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/], administrative costs for traditional Medicare are 1.3%, while administration and profits for Medicare Advantage Plans are 14%.) Compared to traditional Medicare, the 5% for the HSP is not an unreasonable estimate after four years of experience.

Finally, while we have serious questions about the cost estimates made for the HSP, the administration assumptions do comply roughly with the 9% to 5% structure. On the other hand, the administrative costs assumptions of the "total Health Care Spending Baseline from 2024-2028 are puzzling. Based on Table 5.2, we calculated 8.784% as the presumed administrative overhead in 2024, which is lower than the HSP estimate of 9%. That percentage seems to be consistent for the following years as well. Perhaps KNG can explain this puzzle.

6. Potential Plan Savings
6.a. Provider Costs

Provider: Administration Costs and Payments.

One of the problems with the way KNG employs the word "provider" is that sometimes it refers to physicians and other times it includes hospitals and physicians. (In addition to physicians, "providers" should include pharmacists, nurse practitioners, and others that may be relevant to a particular subject like provider payments).

Provider administrative costs.

There is a great deal of literature, some of which is cited in the preliminary report, that concludes that in a system of reduced payers (insurers, self-insured private employers, public entities that pay the claims) with standardized rules and processes, the cost of provider administrative time could be reduced (p. 26). Based on their modeling system, KNG concludes that in New Mexico "administrative costs account for 27.6 percent of physician practice costs" (p. 26). There is no explanation as to how they arrived at this number. What we do know is that the data focuses on administrative issues in physician offices. (The sole NM source cited is the American Community Survey, with a final sample of 41,783 New Mexicans. The others come from experts describing national estimates.) Of course, there are a variety of different types of physician practice settings: private practice, group practice, and employment in hospitals, etc., as well as urban/rural differences that need to be taken into consideration. The report, however, does not address this issue.

What does this 27.6% represent in actual dollars in what year? How would this information be incorporated into the calculations presented in Table 5.2, which estimates baseline total health costs and HSP health costs from 2024-2028 by category of medical services? Does, for example, the $1.023 billion estimated to be spent on office visits in 2024 under the HSP include any administrative overhead reductions?

Is KNG, in fact, including provider administrative overhead reductions in its HSP cost estimates? They seem to contradict themselves.

On page 25, they make an inaccurate claim that based on public feedback they decided not to "assume a reduction in price for health services as a result of lower administrative costs." This is incorrect. Public feedback never made this assertion. In fact, several physicians who testified were critical of the KNG March workplan assumption that *provider payment rates* would be lowered over the 5-year period as administrative savings occur (Policy Assumption #7, p. 9 and also p. 10). "We will assume that the HSAP payment rates are established to equal payment rates prior to implementation of HSAP. Over the subsequent five years, payment rates will be decreased to the end administrative savings are expected to be realized." Provider administrative savings were assumed to occur precisely for the reasons KNG cited above.

6. Potential Plan Savings

6.a. Provider Costs

Despite the public comment, on page 26 they state the following: "However, in sensitivity analysis, we did assess the potential impact of lower provider reimbursement so that the state may capture some of the administrative costs savings on the provider side."

They never tell us the results of the sensitivity analysis. Not until page 43, when they address the effects of the Health Security Plan on health care pricing, do we find out that they did not assume any provider savings.

"By simplifying the payer landscape, the HSP could reduce provider-side administrative costs. This could offer a rationalization for reducing provider reimbursement, *which could help fund the plan.* However, in our base scenario, we kept average payment levels the same as in baseline." (p. 43)

And they make this assumption again in their discussion of alternative funding strategies (to help address the alleged $7 billion shortfall). In this alternative, however, they have reduced provider administrative costs from 27.6% to 19% without any justification.

"Strategy 3: Reduce rates paid to health care providers. The HSP may significantly reduce provider-side administrative costs by simplifying the payer landscape. For example, we estimate that baseline hospital administrative costs were about 24 percent of hospital spending in New Mexico. Similarly, baseline physician administrative costs are about 19 percent of physician spending. Much of these administrative costs are insurance and billing related. If the HSP offered an easily-navigated reimbursement system, perhaps provider-side administrative costs would be lower. The HSP could recover these savings by reducing payments, which would help fund the program.

We experimented with the effects of reducing payment rate increases to eventually remove half of the baseline administrative portion of spending. Figure 5.8 shows how these adjustments would affect health facility and physician price growth rates relative to the Consumer Price Index for Medical Care Prices- (CPI-M) growth." (p. 52)

KNG seems to assume that unless provider payments are reduced, there can be no administrative savings. Their position, which was clear during the March public hearing, is that the HSP must be able to capture these savings, not physicians (many of whom would, presumably, be making greater salaries based on a simplified payer system).

Clearly they have not included in their report their number crunching that looked at reducing provider rates to "remove half of the baseline administrative portion of spending" (p. 52). We are only presented with a graph that shows the conclusions they seem to seek. (Note: The title of the graph is "Figure 5.8 – Price Growth Effect from Recovering 50% of **Provider-side** Administrative Costs over Five Years." The graph also includes "facility" growth rate reductions. In the Health Security Act there is a difference, which is clearly defined, between the term "provider" and the term "health facility.")

Problem 1. The HSP should produce provider administrative savings. Removing this from the total baseline cost of the HSP is in essence raising questions about the accuracy of the HSP baseline cost estimate (and there are already questions given the conflicting information

presented in Table 5.2 and Table 5.3. See comment #1.) It is much too simple to present this problem as an either/or situation. (Either the HSP gets all the savings or there is an assumption that the providers will.)

NM is a rural state. There are serious differences in payments to rural providers vs. urban ones. There are large gaps between what primary care providers are paid and what specialty providers (who tend to live in our urban centers) are paid. Reducing payment rates to allegedly help solve the "shortfall" makes no sense in a state like ours and is an unimaginative approach to a complex problem. In KNG's analysis of the Medicare for All Act (not to be confused with Medicare for All), they assumed additional increases from a baseline Medicare rate for hospitals, primary care, and behavioral health services. (The Impact of Medicare for America – Final Report, October 2019, KNG, pp. i-ii).

There are other elements to consider when estimating provider rates in New Mexico.

Under the Health Security Act, since not everyone is covered by the HSP (KNG estimates 81% of the under-65 population will be covered by the HSP [p. 38]), there will be other sources of provider revenue beyond the Health Security Plan. Thus, to determine provider administrative savings due primarily to billing and insurance (as KNG states above) is more complex under this system.

For example, a provider whose current payer (patient) mix changes to one where the overwhelming number of patients are covered through the Health Security Plan would experience different administrative costs than one whose patient mix primarily consists of Medicare patients or military retirees.

Aside from payer mix, there are other issues to consider as well. A simpler integrated IT system (that includes an all-payers claims database) could have a positive cost impact on all providers, regardless of their patient mix, as long as every provider could switch to such a system. This greater administrative simplicity proposed by the Health Security Act could result in less time needed to deal with insurance hassles – a clear objective of the Act. It could also result in the possibility of seeing more patients or hiring an additional nurse. In fact, in a medically underserved state, administrative savings are indeed an opportunity to expand needed services. (Even in Albuquerque, the limited supply of neurosurgeons, dermatologists, primary care doctors, and others has an impact on how many patients can be served, waiting times, and the time providers can actually spend with patients.)

The Health Security Plan proposes a paradigm shift and presents a very complex approach to provider payments and administrative costs. Are there ways to ensure that providers will be able to work with the HSP to figure out how best to invest those savings, to enable them to see more patients and spend more time with them?

Section 29 of the Health Security Act describes an important process that addresses rate determination for providers. As Gallup physician Dr. Kathy Mezoff (Comment #7 on the KNG

proposed March workplan) noted, "What I like about the Health Security proposal is that physicians will have a say. It is not a 'take it or leave it' approach. If there are disagreements, there is a dispute resolution system to handle any conflicts."

Providers are not only able to negotiate with the Plan, there are also built-in opportunities for payment increases based on the Medical Care Price Index of the CPI (as is noted in the preliminary report). In addition, and this point is not mentioned in the preliminary report, the Health Security Commission has the ability to lower or raise these rates depending on "special and unusual" New Mexico circumstances (p. 52, lines 14-16). Finally, "supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state."

Why can one not assume that the annual negotiation process will be designed in such a way as to ensure that any administrative savings are invested in specific practices? Doesn't this process provide an opportunity for accountability? Would not this process be more amenable to resolving the serious situation of providers – especially those in primary care who are, in Dr. Mezoff's words, "overworked and underpaid"?

Instead, the preliminary report only assumes administrative savings if there are reductions in provider rates.

Conversely, after determining first-year payment rates relying on possible scenarios (not just the one proposed in the preliminary report), rates would be assumed to increase based on the Medical Care Price Index of the CPI and factors such as payer mix, type of practice (primary or specialty), type of setting (rural or urban), and administrative savings that might have occurred due to the impact of the Health Security Plan in the prior year.

So, while in theory administrative savings should benefit the HSP, in reality what is important is to ensure that there are accountable systems in place to encourage providers to invest in their practices and come up with solutions to help them practice medicine in this very tense, complicated, and unfriendly environment.

The experience Maryland has had with global budgets is relevant here. CMS allows hospitals that achieve savings to invest in services that will enhance the health care of the populations they serve. The same philosophy should be applied to providers.

Provider Rates.

The draft report, which we assume does not include provider administrative savings when calculating the cost of the HSP (a serious flaw), also comes up with a one-size-fits-all approach for provider payments: Physician prices are set at 6% above Medicare. The term "physician" is used, so we have no idea how pharmacists' rates are determined, or nurse practitioners'.

6. Potential Plan Savings

6.a. Provider Costs

And, once again, we have no basis to judge why the figure is 6%, what that looks like for different types of practices (primary vs. specialty care, urban vs. rural practices) and how that 6% is factored into the cost assumptions of the Health Security Plan as described in Table 5.2.

This is a clear case where several scenarios should be considered, with tables that include how each scenario impacts providers in different settings and ultimately impacts cost. Regardless, it is critical that when determining the cost of the HSP, provider administrative costs are assumed.

An error in the draft report also needs to be corrected.

1. On page 3 is a statement regarding Section 26 of the Health Security Act. "health care providers may not deny care due to nonpayment for previous services (HB 295 § 26)."

Section 26 is a nondiscrimination clause, and the sentence about not discriminating based on payment status is taken out of context and is irrelevant for the purposes of the report. Under the HSP, providers will get paid for services rendered regardless of whether an enrollee has paid the required premium. Providers will *not* get paid for prior medical debt that incurred before the implementation of the HSP. On page 11, KNG discusses this approach, called "retroactive enrollment," in which "providers can be paid for services by enrolling eligible patients after care has already been received."

6. Potential Plan Savings
6.b. Hospitals: Administration, Global Budgets and Costs

Administrative Savings: The draft report states that based on their research, KNG has determined that hospital administrative costs amount to 24.5% of hospital budgets (p.26). That percentage is a big proportion of New Mexico hospital budgets. However, this percentage does not separate out estimated billing and insurance (B and I) overhead costs from other needed administrative tasks, so despite what is stated below, it is not clear whether 24.5% is an overall administrative cost figure or their estimated billing and insurance-related administrative costs.

"Studies have also shown that hospital administrative costs are larger in a multi-payer system due to time spent on **billing and insurance-related costs**. We estimated the portion of provider-specific costs which is linked to administrative activities and could potentially be reduced under the HSP. (p. 26)

Once again, the report fails to tell us how they factor in the potential savings in HSP costs due to administrative reductions.

Utilization and hospital costs.

In addition to estimates relating to utilization increases in other areas, the draft report estimates increases in utilization costs for hospitals, and runs into some of the same problems. The same assumptions for providers (and subsequent problems occur with their hospital estimates. Based on the modeling system they employed that we described in the utilization section, they conclude that the uninsured are the major source of increases in hospital utilization, which clearly impact baseline HSP cost assumptions. These increases amount to +24% for hospital admissions, +40% for outpatient visits, and +59% for emergency room visits for the previously uninsured (p. 41; as we have come to expect from this report, there are slightly different numbers for the same data presented in Figure 5.3, p. 42.). Not only are we not given any specific justification for these large increases in utilization, we have no idea how these numbers are translated into dollars and factored into Table 5.2 HSP cost estimates. Are these increases over a 5-year period? This, too, needs to be clarified.

And, once again, we need to raise the issue of the percentage of uninsured that is assumed in 2024. While there are serious questions about the 188,000 estimated to be uninsured in 2024, it would appear that these numbers are reduced over the 5-year fiscal analysis projection period (2024-2028). As they diminish, how does that impact hospital utilization and associated costs?

Global budgets.

The report acknowledges the importance of global budgets: "an innovative concept that moves reimbursement away from fee-for-service to a prospectively set amount of revenue given to hospitals. The idea is to create an incentive for hospitals and other health care facilities to reorganize how they deliver care" (p. 14).

Global budgets, however, involve more than a way to reorganize care and provide hospitals with a stable revenue source. They enable hospitals to shift funding to needed areas.

The US Department of Health and Human Services through CMS offers funding to states that want to experiment with this approach. Maryland was the first state to do so. Now Pennsylvania has developed their model. CMS is interested in supporting global budgets because of their potential to reduce Medicare costs.

KNG-estimated global budget cost reductions. The preliminary report assumes that under a global budget system, hospital spending will be reduced by 2% (p. 27); it is unclear whether the 2% reduction is annual or over the 5-year period. Once again, there is no explanation of how these decreases due to global budgets are factored into the analysis (and how they impact the results in Table 5.2).

While we are not given any information to justify the 2% reduction in hospital spending**,** KNG cites the Maryland experiment, which has lowered hospital admission rates for Medicare recipients by 4%.

There are more advantages to global budgets than admission declines, as pointed out in Maryland's third annual report (March 2018).

> Inpatient admissions for both Medicare beneficiaries and commercial plan members declined more in Maryland than in the comparison group. *The greater decrease in admissions in Maryland could be due in part to the higher level of hospital engagement in developing strategies to adapt to global budgets, such as hospital programs that aim to reduce utilization by improving care management and avoiding unnecessary hospitalizations* [emphasis added]. (p. 45) (https://downloads.cms.gov/files/cmmi/md-all-payer-thirdannrpt.pdf)

KNG does seem to assume that the 2% would have a possible positive effect on overall hospital costs. "The HSP would subject health care facilities to global budgets. This would encourage providers to improve efficiency and reduce volume. **We assumed that this would decrease health facility admissions and outpatient visits, which partially offsets the increase in utilization from coverage improvements" (**p. 41).

How does this decrease in utilization offset the increase in utilization from "coverage improvements"? (Presumably this means coverage for the uninsured, but we do not know.)

Global budgets impact billing costs. There is another element that needs to be added to the global budget cost savings equation. As quoted above, KNG notes that "studies have also shown that hospital administrative costs are larger in a multi-payer system due to time spent on billing and insurance-related costs" (p. 26). Why then doesn't KNG assume billing and insurance costs would be reduced under a global budget system?

6. Potential Plan Savings
6.b. Hospitals: Administration, Global Budgets and Costs

Under the HSP, most patients would have coverage through the HSP, which would require a system of global budgets. Other insurers would be included in the global budget system (as are many private plans in Pennsylvania – a more recent experiment). Not including savings from billing would lead to an overestimation of hospital costs under the HSP. Certainly, a scenario that reduces hospital costs by more than 4% should have been an option included in the analysis.

The mystery hospital costs in Table 5.2. Based on KNG's assumptions about hospital costs (stemming from utilization increases and reductions in admissions and outpatient visits), it is important to review the figures presented in Table 5.2 and make comparisons between the baseline health care spending costs and the HSP.

Keep in mind that the numbers in Table 5.2, as stated throughout these comments, have not been explained. A review of the cost numbers shows that hospital admissions under the HSP have not been reduced during the 5-year study period. On the other hand, there are some reductions (in costs) for outpatient visits. Emergency room visits pose another problem, since the table projects that under the HSP those costs will increase.

Since global budgets are a critical mechanism for controlling rising costs, there needs to be a clear explanation of how these numbers were arrived at, given the 2% estimated reduction in hospital costs (for in-patient admissions and outpatient visits) and the assumptions about uninsured usage. The increase in emergency room usage is very puzzling, since the HSP is a plan that reduces the uninsured, according to KNG, to less than 1%, and should, therefore, reduce emergency room usage, as previously uninsured residents access care through other means.

Based on the figures below, under the HSP, outpatient visit costs were reduced by 7.2% in 2004 compared to the current system and by 7.4% in 2008. Hospital admissions remain around the same. The cost of ER visits increased by 11.4% in 2024 and by 8.8% in 2028. How do the estimated utilization increases referred to above factor into these numbers?

Table 5.2, p. 47 (In millions of dollars)

	Outpatient Visits		Hospital Admissions		Emergency Room Visits	
Year	2024	2028	2024	2028	2024	2028
Baseline Health Care Spending	1,140	1,329	2,085	2,435	906	1,070
Health Security Plan	1,058	1,230	2,079	2,432	993	1,173
HSP cost increases/decreases	-82	-99	-6	-3	+87	+103

•**Global budgets impact on Medicare**. A major reason why CMS provides funding to states that want to experiment with global budgets is the expectation that this approach will reduce Medicare costs. Since hospital costs are a major factor in overall rising health care costs, it is

highly likely that a global budgets system will have a positive impact on overall health care spending in New Mexico, as well as on the Health Security Plan. This is an important point that needs to be taken into consideration.

Hospital Payments.

Since global budgets are assumed, this section is puzzling.

On page 43, KNG presents their payment assumptions formula: As we mentioned in the provider payment section, "physician" ["provider"?] prices are set at 6% above Medicare. KNG assumes that hospitals will have a dramatic increase in "prices" above the Medicare rate: inpatient prices 24% above Medicare, outpatient prices 58% above Medicare; and ER prices 82% above Medicare.

What are the justifications for these rate increases? Given the fact that hospital ("health facilities") have global budgets – an approach that already is reducing Medicare costs – how do global budgets relate to a system based on prices (and charges)? Both Maryland and Pennsylvania, with the help of CMS, have come up methodologies to work with hospitals to develop global budgets.

And, how do these presumed rate increases impact the costs in Table 5.2? A scenario that assumes global budgets is definitely in order. How this system would impact the cost of the HSP is important to ascertain.

6. Potential Plan Savings
6.c. Bulk Purchasing of Pharmaceutical Drugs

The Health Security Plan assumes bulk purchasing of drugs, medical equipment, and other supplies. The preliminary report only focuses on the potential reduction in pharmaceutical drug costs.

On p. 33, the report estimates that projected spending on pharmaceutical drugs in 2024 under the current system would be $1.5 billion. (This figure is $1.599 billion in Table 4.3 [p. 33] and $1.593 billion in Table 5.2 [p 47], so it is likely that the $1.5 billion cited in the text on p. 33 should instead be $1.6 billion.)

The report also assumes that pharmaceutical drug utilization will increase by 13% under the HSP for the previously uninsured (p. 41). Aside from a statement that this is "slightly lower" (p. 63) than the dated Oregon Experiment (15%), there are no explanations or studies cited as to how they calculated this 13% increase. Is the total increase over the 5-year period? Certainly, unlike administrative savings, which could be more stable, drug costs could vary.

On page 65, KNG discusses their optimistic and pessimistic scenarios and how each scenario could impact the cost (over time?) of the Health Security Plan. "The optimistic scenario assumes that the state leverages its purchasing power from the consolidated HSP to achieve a 10-percent reduction in prescription drug spending." Is this a one-time reduction? An annual reduction? A cumulative reduction? Moreover, on what basis are they making this assumption? And, since consolidated drug purchasing is a basic assumption of the Health Security Act, why are they not assuming this 10% reduction as a matter of course? Finally, how do increases in drug utilization factor into this equation?

Predictably, their pessimistic scenario assumes the state will not be successful in controlling pharmaceutical drug costs and will in fact stop participating in the Medicaid prescription drug rebate program (raising drug prices by 25%). Why would New Mexico or the HSP ever stop participating in that program (unless a better alternative was available)? Again, there is no evidence giving credence to this pessimistic scenario.

One relevant NM study was referenced in the fiscal impact report (FIR) on the Pharmaceutical Purchasing Council legislation that passed in 2019. The FIR estimated that if nine NM agencies engaged in bulk purchasing of drugs, there would be savings ranging from $14 million to $35 million annually. https://nmlegis.gov/Sessions/19%20Regular/firs/SB0131.PDF

The Pharmaceutical Purchasing Council is tasked with coming up with a plan to reduce drug prices. A law passed during the 2020 legislative session will enable the state to apply for a federal permit to import certain drugs from Canada.

There are many states trying to come up with ways to deal with rising drug costs, New Mexico among them. Since the HSP begins operations in 2024, there is reason to assume that the optimistic scenario is the one most likely to occur. The preliminary report once against overestimates the cost of the Health Security Plan by not taking into account cost savings that

are more than reasonable. Certainly a cost analysis should be present that includes reasonable assumptions about provider overhead and pharmaceutical drug cost savings. These calculations could present a very different picture than the one claimed about a shortfall.

IT systems

While IT systems are mentioned, they seem to be ignored as an important component of administrative savings – not only for the providers and health facilities but also for the HSP itself. Simplifying billing and insurance-related costs requires an IT system.

There are no ifs, ands, or buts: the Health Security Act requires an integrated database of health records—and the RFP stated that the fiscal analysis should consider "the cost and savings of an integrated healthcare IT system, data warehouse, and electronic health record system" (RFP, p. 35).

New Mexico already is in the process of expanding an all-payer claims system, which, once the HSP is established, would still include those not covered by the HSP. Such information would clearly be useful for physicians treating HSP beneficiaries and non-beneficiaries. Moreover, should residents who were non-eligible for the HSP later become HSP beneficiaries, their medical history would be easily accessible. There are states that have implemented such systems, so it is surprising that there is no discussion or estimates in the preliminary report addressing how HSP costs might be impacted.

An integrated database system should make it possible to reduce duplicative services, but it can also provide information regarding quality of care and help to spot outliers. Some experts, like Dr. William Hsiao, argue that such a system would be able to reduce fraud and abuse. (William Hsiao, "Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont" [2011], pp. 46-48.)

There have been numerous recent studies published that describe the negative impact on physicians of the complex requirements of our current health care system. There have been reports of increased stress and even suicide. A 2019 article in the *Boston Globe* described physicians as "a profession struggling with the unyielding demands of electronic records and ever-growing regulatory burdens." ("Physician Burnout Now Essentially a Public Health Crisis," Priyanka Dayal McClusky, *Boston Globe,* 1/17/19). There are other studies on this crisis, including several published in *Mayo Clinic Proceedings*. (For example, "The Association Between Perceived Electronic Health Record Usability and Professional Burnout Among US Physicians," Edward Melnick, MD, MHS, Liselotte Dyrbye, MD, MHPE, et al., *Mayo Clinic Proceedings*, XXX 2019 1-12 (in press). See also *Mayo Clinic Proceedings* on this issue in volumes 91–94).

The Health Security Act requires provider input into developing electronic records along with other rules that impact the practice of medicine. (Providers are represented on the commission responsible for overseeing the HSP.) The simplification required under the Health Security Act will not only impact provider administrative costs but may also help to retain and attract physicians.

Including the broad impact that an IT system will have on health care costs and provider satisfaction should be included in this analysis.

Certificate of Need (Resource Certification)

Section 35 of the Health Security Act requires the commission responsible for the HSP to develop a "resource certification program" that will develop rules, with public input, that specify when such a certificate is needed and what the requirements are to receive a certificate. Again, the RFP specifically states that the fiscal analysis should consider "utilization and system redundancy and unnecessary services with consideration of certificate of need or a resource certification program" (RFP p. 35).

Many states still have a Certificate of Need program, which was originally developed to ensure planning of new services and health facility construction.

> "Certificate of Need (CON) laws are state regulatory mechanisms for establishing or expanding health care facilities and services in a given area. In a state with a CON program, a state health planning agency must approve major capital expenditures for certain health care facilities. **CON programs aim to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need."** ("CON – Certificate of Need State Laws," National Conference of State Legislators, 12/1/19)

While this program will be phased in during the early part of the five-year period (2024-2028), the preliminary report does not include any discussion or analysis of the potential savings that might accrue to the HSP.