Franciscan ALLIANCE

April 1, 2022

Dear Senate President Pro Tempore Bray and House Speaker Huston,

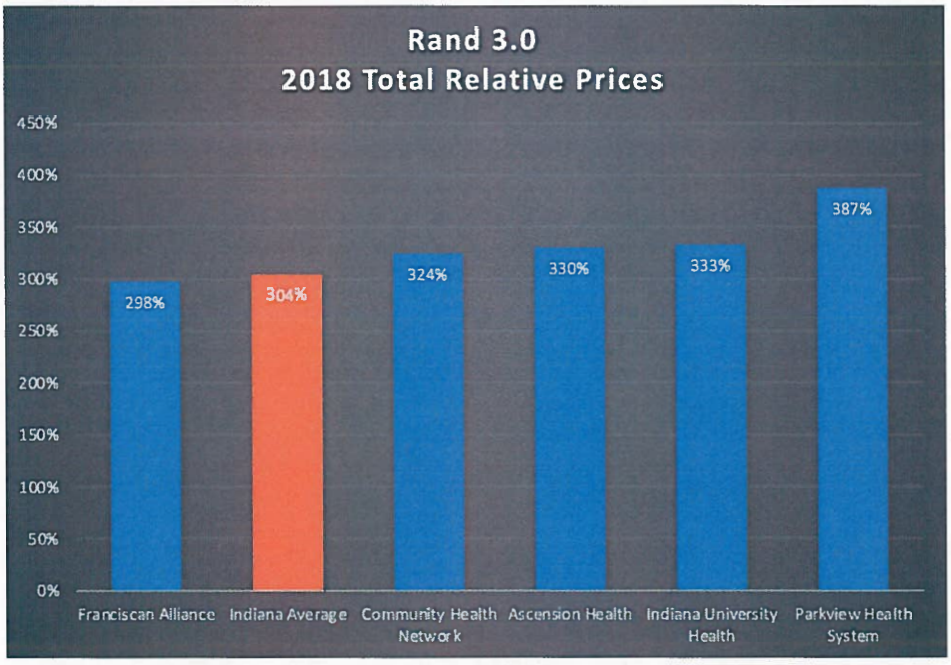
In 1875, the Sisters of St. Francis of Perpetual Adoration opened their first hospital in Indiana. Over the past 147 years, Franciscan Alliance, the Sisters Catholic health care ministry, has been faithful to its mission which calls us to serve the physical, spiritual, and emotional needs of all who Franciscan is privileged to serve, especially those who are most vulnerable in our communities. In 2021, Franciscan provided over $804 million in community benefits and generated $5.25 billion dollars in economic activity by operating its services within the communities served. Over the past 5 years, Franciscan has invested more than $1 billion in new facilities and equipment and will invest another $2 billion over the next 5 years in new facilities and equipment to serve our communities. Less than 1 out of 3 patients cared for by Franciscan paid the full cost of the care they received. If we are to continue to serve Indiana residents in our 12 hospitals and 170 clinics and ambulatory centers located in the State, we need the assistance and support of the Senate, House of Representatives, and the Governor to expand access to care, reduce costs, and improve quality.

CORPORATE OFFICE
PH: 574 256 3935

SHIPPING
1515 Dragoon Trail
Mishawaka, IN 46544

MAILING
P.O. Box 1290
Mishawaka, IN 46546-1290

As you can see from the recently released chart below, Franciscan Alliance is a leader among the larger full-service Indiana healthcare delivery networks in terms of its efforts to lower the cost of services.



Franciscan Alliance is continuing to develop new ways to attack the cost of care amid one of the highest periods of inflation this nation has seen in decades. Franciscan began

preparing for the transition from fee-for-service to a value-based approach to health care delivery and Population Health when we became the first health system in Indiana to form an Accountable Care Organization (ACO) which now covers over 153,533 Hoosier lives. In 2020, Franciscan saved Medicare $26.6 million as a Medicare Shared Savings Plan participant while achieving a 100% quality score across 51,641 Medicare beneficiaries and project greater savings when the 2021 Medicare performance reports become available. Franciscan was the first health care system in Indiana to bring Program of All-Inclusive Care for the Elderly (PACE) programs to the State to meet the needs of dual-eligible Medicare and Medicaid recipients. By offering ways to meet the healthcare and social needs of this vulnerable population, PACE members receive better care and avoid nursing home admissions while saving the State money.

Franciscan is investing in expanding its virtual health capabilities which will expand access to care, save time and money for patients seeking an immediate appointment and diagnosis. In addition to the expansion of virtual care, Franciscan is redesigning its primary care operating model to focus on value-based reimbursement agreements. Bundled programs with direct to employer savings options are starting to be marketed to interested employers. Partnerships with commercial insurers have been initiated and offer an opportunity for employers to explore narrow networks with higher discounts. The administrative cost of health care is overwhelming, and Franciscan is discussing ways with insurers to reduce duplication and unnecessary processes. Expansion of home health care, including "hospital at home" programs are being explored by Franciscan via a pilot we have in place at Franciscan Health Crown Point. Many patients may benefit from quicker discharge from inpatient facilities or avoid a hospital admission altogether by participating in an expanded role of home-based care. The transition of many hospital-based services over to ambulatory service locations offers the greatest opportunity for the reduction in cost and convenience for patients. Franciscan has invested and will continue to invest in ambulatory surgical and diagnostic centers that offer lower cost alternatives to inpatient services.

As partners with the State legislative and executive branches of government, all parties must address the fact that government's Medicaid program forced health care systems and providers to become unofficial taxing bodies. The elephant in the room is the "Cost Shift" from unfunded promises by government to the elderly, poor, and disabled for almost unlimited access to healthcare services through Medicare and Medicaid. The State of Indiana pays Franciscan approximately 61 cents for every dollar that is spent serving the needs of the poor and Medicare pays Franciscan 81 cents for every dollar spent providing care to the elderly and disabled. The only way for hospitals to continue to exist is to "cost shift" these losses to those with commercial insurance. The business community does not want government to raise taxes to cover the actual promises made to the Medicaid and Medicare beneficiaries and it does not want hospitals and other providers to pass the costs of these under-funded mandates to them. Hospitals and other health care providers do not want to be an unofficial taxing body and need the State's help to reduce costs.

What are some of the reasons that costs are so high? Indiana ranks 47th out of 50 states in public health funding. It is much less costly to prevent disease than it is to treat illness.

Indiana ranks in the bottom decile or quartile in almost every major wellness indicator. Indiana's rankings are as follows:

Obesity – 46th
Smoking – 45th
Air Pollution – 45th
Water Pollution – 50th
Social Support Services - 43rd
Family and Community Safety – 41st
Childhood Immunizations - 41st
Frequent Mental Distress – 40th
Occupational Fatalities – 40th
Adverse Childhood Experiences – 36th
Food Insecurity – 35th

The State and the business community must realize that unless there is adequate funding for the above list of social determinants of health and adequate funding to cover the promises made to the poor, elderly and disabled, the utilization of services will be much greater than would occur if funds were spent on prevention.

Indiana suffers from a shortage of physicians and nurses. Franciscan spends hundreds of millions of dollars annually to subsidize physician practices just to bring wages up to national averages. Without hospitals providing physicians with subsidized average wages, Indiana would see an exit by physicians to other states. Insurance companies are making record profits but are not reimbursing physicians who are employed by hospitals as much as they pay some independent physicians. The legislature should study the discrepancies between what hospital-employed physicians are paid compared to independent practices and physicians who are employed by subsidiaries of insurance companies. There may be significant decreases in hospital costs if all physicians were placed on a level playing field. The shortage of nurses within the State during the Covid pandemic created a special opportunity for travel nurse agencies to profiteer during a national emergency. Most hospitals in Indiana have an average RN pay range around the mid-to-high $30-some dollars an hour. Travel nurse agencies have lured away nurses from hospitals with huge salary increases and are charging hospitals $125-$175 per hour for RNs. Not many businesses in Indiana could stay in business with an increase of 400% in labor costs. Labor costs make up over 50% of our operating expenses. We are currently in a high inflation period compounded with a labor shortage. Franciscan has had to spend hundreds of millions in unbudgeted labor costs just to keep our doors open. Yet, all of us want to find ways to reduce the costs of services and we cannot pass along the increased operating costs. Inflation this high has not been seen since the 1980s and unlike other industries hospitals have fixed reimbursement programs.

The worldwide Covid pandemic has had a devastating financial impact on Franciscan Alliance. Without the federal government's emergency assistance funds, Franciscan would have experienced a loss from operations the past two years. Over the past two years, most hospital systems including Franciscan have not generated a minimum operating margin of

4% which is necessary to reinvest in facilities, equipment, and keep up with inflationary wages. The federal government is not providing CARES Act funds to hospitals in 2022 even though Covid patients continue to negatively impact our ability to fund operations this year. Year-to-date, our healthcare system has a negative operating margin for the first quarter, and it will take some time regain a margin necessary to support all of the services we render to the communities we serve.

Franciscan Alliance shares the goal of health care access and affordability – it is instilled in the core values of our organization. As we continue to progress on initiatives to reduce costs for individuals and employers, it is clear that market-driven solutions produce the best sustainable outcomes for Hoosiers. We are committed to working together to achieve our shared goals but ask that you consider the overall cost to Hoosiers for health care, including insurance premiums and pharmaceutical costs (see attached Nathan S. Kaufman report). We look forward to working with you to achieve the immense task of balancing quality, access, convenience, and cost of care. We share your dedication to Hoosiers in this regard and will continue our work fulfilling our mission within every community we have the privilege to serve.

Sincerely,

Kevin D. Leahy
President/CEO
Franciscan Alliance, Inc.

Performance Improvement, Strategy, Transaction Support/Negotiations, Valuations, Retreats, Research

Nathan S. Kaufman, Managing Director
N8@KaufmanSA.com

Analysis of Indiana Insurance Data:
Indiana's Medical Costs Similar to the Other States in the Region; Insurers' Pharmacy Rebates Growing Rapidly

Kaufman Strategic Advisors analyzed recently published data regarding insurance premiums and claims costs in Indiana and neighboring states to understand the critical drivers of premium increases for employers and consumers. The data reveals interesting insights and challenges previous conclusions about Indiana's health care costs.

The actual medical claims costs (spending on hospitals, physicians, and other medical providers) reported to the federal government by Indiana's insurers are similar to those reported for Illinois and Ohio. Michigan's costs appear to be slightly lower than the other states. The unique nature of Michigan's insurance market may contribute to lower claims costs in that state.

Overview of Analysis

The Affordable Care Act requires health insurers to report detail on the revenue and expenses for their fully insured plans to evaluate if they spent sufficient funds on medical claims vs. administration and profits. According to the Center for Medicare & Medicare Services (CMS): *"If an insurance company spends less than 80% (85% in the large group market) of premium on medical care and efforts to improve the quality of care, they must refund the portion of premium that exceeded this limit. This rule is commonly known as the 80/20 rule or the Medical Loss Ratio (MLR) rule."*[1]

The CMS MLR data published in December 2021 for CY 2020 shows that fully insured health plans in Indiana generated almost $560 Million in administrative fees and profits, a substantial increase from roughly $460 Million in 2015 (see Exhibit 1).

To normalize cost data for changes in membership, employers measure their health care insurance spending by dividing the claims costs by the number of enrolled lives per month. The general industry term is the PMPM, or the "Per Member Per Month" spend.

CMS MLR PMPM data for 2020 for Indiana shows health insurers' administrative costs and profits for fully insured health plans increased 73%, from $44 PMPM in 2015 to $76

[1] https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

PMPM in 2020. **During this time, plan profits alone increased from $5 PMPM to $16 PMPM or 220%** (see Exhibit 1). This growth in profitability is associated with several factors, including:

1. Insurance companies in Indiana raised premiums faster than their total claims experience. Over these five years, while total claims increased by $95 PMPM, insurance companies raised their premiums by $128 PMPM.

2. Gross prescription drug costs for the fully insured plans in Indiana have doubled, from $64 PMPM in 2015 to $121 PMPM in 2020. During this time, prescription drug rebates retained by Indiana health plans have almost tripled from $9 PMPM to $27 PMPM. In 2015, health plans in Indiana received 14% of gross drug costs back as rebates from the drug manufacturers. By 2020, the health plans were paid 22% of the gross drug costs as rebates. Patients' deductibles and copayments are based on the gross charge for a medication; thus, patients pay more out-of-pocket when a health plan has high gross prescription drug charges accompanied by high pharmacy rebates.

Exhibit 1 – Financial Profile of Fully Insured Plans 2015-2020

Financial Item	2015	2020	Change	Percent Chg.
Number of Covered Lives	843,441	589,790	(253,651)	-30%
Health Care Quality Improvement and Non-Claim Expenses	$409,825,390	$442,677,479	$32,852,089	8%
Estimated Gross Gain/Loss (Before MLR Rebates)	$48,216,106	$116,746,822	$68,530,716	142%
Health Care Quality, Non Claims and Gain (Before MLR Rebate)	$458,041,496	$559,424,301	$101,382,805	22%
Earned Premiums - PMPM	$409	$537	$128	31%
Incurred Claims Net of Risk Adjustment - PMPM	$342	$437	$95	28%
Health Care Quality Expenses and Non Claims Expesnse- PMPM	$39	$60	$21	53%
Estimated Gross Gain/Loss (Before MLR Rebates) - PMPM	$5	$16	$11	244%
Health Care Quality, Non Claims and Gain (Before MLR Rebate) PMPM	$44	$76	$32	73%
Estimated Risk Adjusted Medical Claims PMPM	$287	$344	57	20%
Estimated Risk Adjusted Net Prescription Drugs PMPM	$55	$94	39	71%
Risk Adjusted Gross Prescription Drugs Reported PMPM	$64	$121	57	90%
Risk Adjusted Prescription Drug Rebates Reported PMPM	$9	$27	18	207%
Prescription Drug Rebates Reported PMPM as Percent of Gross Drugs	14%	22%	9%	

Source: CMS MLR Data

Employers and Policymakers Should Shift Their Focus from Unit Prices to Costs

While transparency measures have brought much attention to unit prices for hospital and physician services, the data demonstrates that these unit prices do not correlate with the total cost of care. Indiana has been singled out as having high unit prices for hospitals, but little has been said about the comparatively low commercial unit prices for physician services in the state. Conclusions about health care costs based primarily on analyses of hospital unit prices can be inaccurate; among the issues not considered in studies focusing on unit price are relative utilization (the number of services used by enrollees), the cost burdens of recruiting and retaining physicians when insurance

companies underpay these professionals, and the amount of funds needed to subsidize care for uninsured and underfunded government patients. A more accurate measure of employer health care costs can be found in the CMS MLR data reported by insurers.

The main driver of healthcare cost inflation to employers in Indiana are healthcare administrative costs and pharmacy costs. From 2015 through 2020, medical claims costs on a PMPM basis in Indiana increased by about 20%. However, as previously mentioned, during this same period, health plan administrative costs and profits PMPM increased by 73% and gross prescription drug costs PMPM increased by 90%. Even more notable is that prescription drug rebates retained by the health plans increased by over 200% in this period (see Exhibit 1).

Insurance Companies Vertically Integrate to Keep Profits High

As noted earlier, MLR limits established by the Affordable Care Act have constrained the profitability of commercial insurance plans. In response, several of the nation's largest insurers, including Anthem and United Healthcare, have acquired or developed pharmacy benefit managers (PBMs) and specialty pharmacies. Profits from these enterprises generally accrue to the parent company outside the MLR regulations.

Owning PBMs and affiliating with specialty pharmacies enables insurance companies to move dollars between entities to maximize profits outside of most public reporting. Theoretically, a PBM owned by a health insurance company could charge its fully insured health plan lower costs for drugs to offer a more competitive premium. The PBM could then compensate for those lower drug prices in their own fully insured plans by raising prices for the same medications to other PBM customers, including self-funded ERISA plans.[2] Or a health plan-affiliated PBM could inflate gross drug prices to their own health plans to inflate health plan costs and avoid paying MLR Rebates.

From 2012 to 2016, it is estimated that over half of the increase in list prices for drugs were paid to PBMs as higher rebates, and the value of rebates paid to PBMs doubled over this period.[3] In 2015, pharmaceutical manufacturers received only thirty-nine percent of the gross national spending on drugs. In contrast, PBMs, health plans, supply-chain entities, and wholesalers captured forty-two percent of gross expenditure.[4]

Finally, given their high dependence on pharmacy rebates for profitability, health plans are instituting policies to capture specialty pharmacy rebates that were traditionally paid

[2] https://www.fiercehealthcare.com/payer/blues-plans-sue-cvs-claiming-pharmacies-inflated-prices-for-generics, and 3 AXIS ADVISORS, *Responsiveness of Maximum Allowable Cost (MAC) To Generic Drug Inflation*, Apr 3, 2020

[3] YALE LAW AND POLICY REVIEW- *Pharmacy Benefit Mangers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs*, (Home>YLPR>Vol. 38 (2020)> Iss. 2) p.378

[4] Ibid, p.372

to hospitals and physicians for supplying infusion drugs to patients. This new policy is contrary to physician preferences, raises quality concerns, inconveniences patients, and has resulted in regulations prohibiting the policy in at least eight states.

Indiana Medical Costs in Line with Its Neighboring States; Michigan's Low Costs Explained by Unique Insurance Market

Pivoting back to the medical cost for fully insured plans, we found that Indiana was far from the high-cost outlier that it has been portrayed. In four of the six years of CMS MLR data analyzed from 2015 to 2020, medical claims costs in Indiana were lower than in Illinois and proximal to Ohio. In 2015, medical claim costs in Indiana were equal to those of Illinois, and only in 2019 were slightly higher than Ohio and Illinois before declining in 2020. Also, the growth rate in medical claims costs over this period was noticeably slower in Indiana than in Illinois and Ohio (see Exhibit 2).

Exhibit 2 – Profile of Medical Claims for Indiana, Michigan, Illinois, and Ohio 2015-2020

	Estimated Medical Claims PMPM						
	2015	2016	2017	2018	2019	2020	% Chng
Indiana	$299	$303	$305	$324	$353	$344	15.2%
Michigan	$268	$278	$285	$293	$305	$294	9.7%
Illinois	$299	$306	$315	$330	$344	$360	20.4%
Ohio	$278	$294	$303	$321	$343	$335	20.8%
		Highest Medical Claims PMPM					

Source: CMS MLR Data

The cost outlier in this region is Michigan. The CMS MLR data for Michigan is intriguing, and it bears more exploration. In 2020, Michigan had significantly lower medical claims costs and gross and net prescription drug costs than its three contiguous states (see Exhibit 3).

Exhibit 3 – Premium and Claims for Indiana, Michigan, Illinois, and Ohio 2020

	Fully Insured Health Plans 2020			
	Indiana	Michigan	Illinois	Ohio
Premium	$ 537	$ 438	$ 502	$ 504
Incurred Claims	$ 438	$ 359	$ 438	$ 416
Estimated Medical Claims PMPM	$ 344	$ 294	$ 360	$ 335
Estimated Net Prescription Drugs PMPM	$ 94	$ 65	$ 78	$ 81
Gross Prescription Drugs Reported PMPM	$ 121	$ 89	$ 103	$ 106
Prescription Drug Rebates Reported PMPM	$ 27	$ 24	$ 25	$ 25
Health Plan Gain Before MLR Rebate	$ 16	$ 10	$ 6	$ 18

Source: CMS MLR Data

Unlike Michigan, between 2015 and 2020, average premiums for the fully insured health plans in Indiana, Illinois, and Ohio rose at significantly faster rates than their incurred claims, contributing to the profitability of fully insured plans in those states. Gross prescription drug claims, which determine the cost of patient copayments, grew faster in Indiana than in the other three states. Note: Indiana's fully insured health plans had the highest prescription drug rebates in the group (see Exhibit 4 &5).

Exhibit 4 – Percent Change in Premiums and Claims for Indiana, Michigan, Illinois, and Ohio

	Average Percent Increase 2015-2020			
Percent Increase 2015-2020	Indiana	Michigan	Illinois	Ohio
Premiums PMPM	6.2%	2.9%	5.7%	5.2%
Incurred Claims	4.7%	2.1%	4.2%	4.7%
Medical Claims	3.0%	1.9%	4.1%	4.2%
Gross Prescription Drug Claims	16.5%	8.0%	8.5%	10.5%
Net Prescription Drug Claims	12.9%	2.8%	4.8%	7.1%
Prescription Drug Rebates	39.0%	54.3%	33.4%	30.5%

Source: CMS MLR Data

Exhibit 5 – Change in Premium and Claims for Indiana, Michigan, Illinois, and Ohio 2015-2020

Increase From 2015-2020				
	Indiana	Michigan	Illinois	Ohio
Premiums PMPM	$ 128	$ 55	$ 112	$ 105
Incurred Claims PMPM	$ 95	$ 40	$ 85	$ 85
Medical Claims PMPM	$ 45	$ 26	$ 61	$ 58
Net Pharmacy Claims PMPM	$ 37	$ 8	$ 15	$ 21
Gross Prescription Drug Claims PMPM	$ 55	$ 25	$ 31	$ 37
Increase in Pharmacy Rebates PMPM	$ 18	$ 17	$ 16	$ 15
Gain Before MLR Rebate PMPM	$ 11	$ 14	$ 17	$ 12

Source: CMS MLR Data

One likely reason for Michigan being a low-cost outlier compared to its three nearby states is the nature of its insurance market. The dominant health plan in Michigan is Blue Cross Blue Shield of Michigan (BCBS-MI), a not-for-profit health plan known for its collaborative relationship with hospitals/health systems and other providers. The plan's board of directors is balanced with extensive medical-provider representation in addition to business and labor representatives. Many observers have noted that this

collaborative approach successfully balances healthcare affordability with quality and sustainable access for Michiganders.

Unlike Michigan, for-profit health insurance companies comprise a significant share of the fully insured markets in Indiana, Ohio, and Illinois. These companies appear to be far less collaborative than BCBS-MI. The dominant plans in these states are Anthem Blue Cross, United Healthcare (in Indiana and Ohio), and Healthcare Services Corporation (in Illinois). Health systems must negotiate higher unit prices when dealing with less-collaborative insurance companies. The negotiated unit prices must compensate for high claims denial rates, aggressive steerage of patients away from hospitals to "cheaper" providers, and inadequate payments to physicians. Anecdotally, we hear less about this type of "friction" in Michigan than in other states in the region because of their collaborative approach.

Data on employer premiums from the Kaiser Family Foundation also confirm that Indiana is not a high-cost outlier in the region. From 2019-2020, premiums for employers in Indiana for family coverage declined and were below the national average in 2020. The KFF data shows that Indiana premiums were proximal to neighboring states, i.e., lower than Illinois and Kentucky and slightly higher than Michigan and Ohio.[5]

Conclusion

This analysis of the publicly available data for fully insured plans from 2015 through 2020 demonstrates that Indiana is not an outlier in healthcare costs relative to similar states in the region. Rankings by unit price, such as in the RAND reports, do not reflect the actual claims expenses incurred. Employers and policymakers should look to measures that use the total cost of care and PMPM cost information as benchmarks to make comparisons rather than unit prices or a relative percentage of Medicare. In addition, there should be more focus on the fastest-growing health plan expenses that do not contribute to the direct delivery of care, i.e., health plan administrative costs and profits that represent over 18% of the premium and the opaque transactions involving health plans, PBMs, and the pharmaceutical industry.

About Nathan Kaufman

Nathan Kaufman is Managing Director of Kaufman Strategic Advisors. With more than 40 years of experience as a strategist, executive and negotiator, he Nate is considered one of the nation's healthcare industry experts. He is a strategic advisor to healthcare

[5] https://www.kff.org/other/state-indicator/family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

executives, boards, physician groups and other healthcare companies. He is known for his practical advice focusing on succeeding in the new post-COVID, value-based risk environment. In addition, he is a seasoned negotiator and has successfully completed hundreds of transactions involving payer contracts, physician compensation, service line development, acquisition/sale of surgicenters and imaging centers, restructuring employed physician groups, and developing clinically integrated networks. This provides Nate with a unique viewpoint since he not only studies industry trends but operates in the 'trenches' which gives him a deep understanding of healthcare delivery.

Nathan Kaufman, Managing Director

Kaufman Strategic Advisors, LLC

11440 West Bernardo Ct., Suite 155

San Diego, CA 92127

(858) 487-9771

N8@kaufmansa.com
www.Kaufmansa.com