How to Reduce Health Care Costs and Improve Access: What Unions Can Teach Us

Please note: The March issue of *Transforming Care* contains more detail on the initiatives described in the webinar, as well as other examples of efforts to curb the rising costs of health benefits.

Answers to questions posed by participants during the July 1 webinar

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From Mark Blum, executive director of America's Agenda

Have you found some unions are reluctant to adopt these new models?

Readiness to lead innovation is not evenly distributed among union leaders, that's for sure. But I would not characterize unions as "reluctant" to adopt innovative new models of care delivery. It is a process. We have to bear in mind, always, that union and employer health and welfare fund trustees carry the weighty fiduciary responsibility of administering funds to optimize delivery of health benefits in the interest of workers and their families. So it's hardly surprising that these trustees tend to be somewhat conservative about abandoning models of care delivery that worked reasonably well for their funds in the past. In a sense, it is their version of the physician's maxim, "Do no harm."

At the same time, however, rapidly rising costs put inexorable pressure on union trustees to find solutions to delivering better care at more affordable costs. In my experience, a relatively small number of visionary thought leaders — that is, union and employer leaders who see clearly that rising health costs will cripple their ability to fulfill their obligation to maintain good health benefits for the working families they represent — move first to adopt or engineer new models of care delivery that promise to deliver substantially higher value for the health care dollars they spend. As evidence mounts that a particular kind of innovation is successful, adoption broadens to peers and funds that adopt innovation a bit more slowly until a tipping point is reached where the innovation becomes broadly adopted. For example, we are right now in a period where the notion of adopting primary care that is accountable to the union/employer, self-funded health plan, rather than to an external health system, is trending strongly. There is virtual universal interest, at present, and adoption of Taft-Hartley trust-owned or directly contracted primary care centers to serve the trust's beneficiaries is accelerating.

Another example: There is an emerging understanding, right now, that the old model of contracting care delivery solutions for a union's own members, only, misses significant economy of scale opportunities that could be possible if Taft-Hartley health and welfare trusts where to jointly participate in, and even jointly own, their own innovative, high-value care delivery solutions — particularly in the area of high-performance direct primary care. The notion that multiple union-owned, or even Labor-movement-owned provider solutions offer higher-value long-term alignment of interests between health care purchasers and providers is gaining traction. I expect that over the next few years, we will see accelerating adoption of innovative,

high-value, multi-union-owned care delivery solutions that can have community-wide benefit, rather benefitting only an individual union or trust.

What does it mean for DPC [direct primary care] to look beyond ASO/PPO networks? Is it instead setting up payment through Medicare plus in the summary plan description? Firing the BUCA network (Blue Cross, United Healthcare, Cigna, and Aetna)?

The example in your question seems to describe adoption of Medicare reference-based hospital pricing. Reference-based pricing is an increasingly popular alternative to relying on commercial health plan-negotiated prices.

Reference-based hospital pricing is an example of how some self-funded health plans are moving beyond the traditional fee-for-service ASO/PPO network paradigm, but I was not referring specifically to reference-based pricing. In the panel presentation, I provided some other examples, e.g. NY Hotel & Motel Trades Council trust's employment of its own specialist network and a self-funded plan servicing UAW aerospace workers' adoption of direct bundled payments for surgical procedures at a fraction of the fee-for-service cost within their rented ASO/PPO network. My panel colleagues Kathy and Ken provided other examples of how their own trusts have negotiated alternative payment models or incented their members to access care from a select group of high value providers within their ASO/PPO networks. These are all examples of looking beyond conventional ASO/PPO networks.

In fact, I didn't propose "Firing the BUCA network…" I suggested, rather, that the undifferentiated fee-for-service ASO/PPO network is an increasingly unaffordable model of care delivery. Successful self-funded Labor/employer health plans like those you heard from are actively innovating to neutralize the major health care cost drivers for members — a goal that cannot be accomplished by simply providing member access to a conventional ASO/PPO network. The Labor/employer health plans that are most active in care delivery innovation see the traditional ASO/PPO network in the rear view mirror, already — an unaffordable artifact of the past.

What is the name of the PBM bill reviewer the state of New Jersey used?

Truveris, Inc. Truveris developed the technology platform that was used to project the expected costs for each PBMs pricing proposals in each round of the NJ reverse auction. These cost projections were shown transparently to the PBM bidders to create the dynamic "price" competition between them that ultimately lowered state costs by 18.5% or $1.6 billion over 3 years.

The same technology platform was used to review the bi-weekly PBM invoices (or bills) and identify deviations from the contract — generally overcharges — within a matter of hours. Millions of additional dollars were recouped by the state through this procedure.

Please explain the reverse auction again.

In New Jersey, as elsewhere, prescription drug prices had become the most rapidly growing component of overall health care costs. In 2017, New Jersey public sector unions persuaded the state to adopt a "PBM reverse auction" for pharmacy benefits as an alternative to the traditional "RFP" (Request for Proposals) process in which a consultant attempted to evaluate and compare diverse, highly complex, and frequently opaque pricing schemes of pharmacy benefit managers (PBMs) seeking to secure the state's business. In the alternative PBM reverse auction process, the state began with drafting its own detailed, best-in-class contract terms. As a condition for participating in a reverse auction to win the state's contract, New Jersey required PBMs to accept the state's preferred prescription drug formulary and pricing terms, drug classifications, and definitions, rather than proposing their own.

New Jersey acquired a technology platform from Truveris, Inc. with capability of evaluating complex PBM pricing proposals and projecting their costs over the life of a 3-year contract. These cost projections functioned like prices in the reverse auction. After each round of bidding, the state selection committee—and the competing PBMs—were able to make "apples-to-apples" comparisons between PBM bids after each bidding round. The dynamic competition created between PBMs over multiple rounds of bidding drove down the price of prescription drug costs by 18.5% — a savings to the state of $1.5 billion over three years.

Millions of dollars in additional savings were achieved by deploying the same technology platform used to conduct the 2017 reverse auction to conduct real-time, claim-by-claim review of bi-weekly PBM invoices, flagging overcharges and other billing deviations from the state's contract terms.

Is the reverse PBM auction only for the ERISA population or does the commercially insured population use this as well?
The PBM reverse auction process can be used for commercially insured populations, as well self-funded ones. There is no conceptual reason why its use would be limited to public or private sector or ERISA or non-ERISA populations, so long as prescription drug benefits are purchased through a PBM.

From Kathy Silver, president of the Culinary Health Fund

Which bundling provider does the Culinary Health Fund use?

Bundling is done in house by the Fund's network team.

Does the Culinary Health Fund contract with federally qualified health centers?

FQHCs are part of the Fund's larger provider network; however, they do not have a big presence in Las Vegas.

Does the Culinary Health Fund pay for acupuncture?

Yes. That benefit was rolled out Jan. 1, 2019 in response to the opioid epidemic. We were looking for other pain management strategies to reduce opioid utilization.

What happened to global costs after you implemented the health center?

With the exception of ED utilization, which has gone down tremendously, other costs have gone up. This was not unexpected as we feel there was a lot of pent up demand for services and access that was finally being met with the health center. We don't feel that we will really see a reduction in total costs until we have three or four health centers operating around the valley. Then we can actually more fully engage in our enhanced primary care and overall population health strategy. At that point, members and dependents will be required to use health centers for their primary care. Right now: we feel that many members are still shopping around and continuing to see their original primary care provider and use the health center

From Ken Stuart, former administrative manager of the health trust for the San Diego chapter of the International Brotherhood of Electrical Workers

Do you use a vendor to make PBM work more transparent – if so, who?

Tim Thomas of Crystal ClearRx/Consultant and Navitus is the PBM.

For bundling payments?
We use Global One Ventures' outpatient surgery facilities and physicians. Global One puts together a series of quality surgicenters and surgeons and establishes the bundled pricing to include all service provider, facility, and joint (if applicable) charges. As an example, a knee or hip replacement would cost under $30,000 for everything. They even make available stop-loss insurance. They will also work in an incentive bonus to be paid to participants using the program, which advantages both participant and purchaser.

From *Transforming Care*'s editors

Are there any innovative initiatives for smoking cessation or organizations working on this specifically? Smoking prevalence is very high in the union world. This might be a way to save health care costs up front.

At its newest facility, Brooklyn Health Center, the New York City's Hotel Trades Council and Hotel Association of New York City has had success in encouraging people to quit smoking — achieving high quit rates (39.7% of smokers had stopped at 6 months; 30.2% were no longer smoking at 18 months). From the March issue of *Transforming Care*: "We put patients' smoking status on the banner of their electronic health records," says Robert Greenspan, M.D., CEO of the New York Hotel and Motel Trades Council and the Hotel Association of New York City Employee Benefit Funds. "Then doctors, dentists, therapists, and pharmacists encourage smokers to try tobacco cessation programs in a variety of ways. If we're going to try to change behavior, 20 minutes with your doctor is not going to do it."