TOOLS & SUPPORT
Fall 2020

Making the case for cost-effective networks: 32BJ Health Fund

When a large health system objected to the 32BJ Health Fund's efforts to implement a benefit design that had higher co-pays for higher-cost hospitals and lower co-pays for lower-cost hospitals, the Health Fund refused to back down. Instead, it went to the public and to the media to achieve its goal of implementing a cost-effective network.

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PETERSON CENTER ON HEALTHCARE

Case Study

Making the case for cost-effective networks

The 32BJ Health Fund is a joint labor management partnership providing health care benefits to union members of the Service Employees International Union (SEIU) 32BJ- the largest property service workers union in the country- and their eligible dependents. 32BJ Health Fund self-funds health care coverage for 200,000 plan participants, managing the premium contributions that union members negotiated from over 5,000 employers. Based on its vision "to improve our members' quality of life by administering essential and economical benefits," the Health Fund designs its plan offerings to contain costs and make high-quality health care accessible for its plan participants.

The SEIU 32BJ union members and their families reside in 11 states, with the greatest concentration residing in and around New York City. There, the 32BJ Health Fund contracts with Empire Blue Cross Blue Shield (Empire) as its third-party administrator (TPA) to maintain a provider network and adjudicate claims. Recognizing that its plan participants are low-wage workers, 32BJ Health Fund designs its benefits with the principle that cost containment is the Health Fund's job - not the job of its plan participants. Unlike most large purchasers, the Health Fund does not offer plan participants a choice of plan products - all union members get the same health plan with rich benefits, which includes a large network of providers and zero monthly premium contributions

What is a joint labor management partnership?

Joint labor management partnerships are multi-employer plans governed jointly by a board of union and employer trustees. Often known as "Taft-Hartley Funds" in reference to the 1947 federal law that regulates labor unions, these types of plans cover approximately 10 million Americans.[1]

This case study describes 32BJ Health Fund's (or the Health Fund) public communications campaign to educate its plan participants, elected officials and other members of the public about a large health system's high prices. In a world where health care prices are not transparent, the Health Fund took the unprecedented and bold move to publicize the prices it paid the health system for common procedures. The Health Fund's actions enabled it to implement a high-value benefit design that will preserve low out-of-pocket costs for its plan participants. To understand the initiative, CPR interviewed Sara Rothstein, Director of the 32BJ Health Fund, in February 2020.

[1] https://www.pbgc.gov/prac/multiemployer/introduction-to-multiemployer-plans

The Problem & Background

High health care costs in the Big Apple

In 2017, New Yorkers with employer-sponsored insurance had the 8th highest per person health spending in the country.[2] According to data from the New York State Health Foundation and the Health Care Cost Institute, inpatient prices in New York saw a cumulative increase of 32% between 2013 and 2017, double the increase for inpatient services nationally.[3] Also in 2017, the state received an "F" for its lack of meaningful and accessible price information available to consumers.[4]

In New York City (NYC), rapid health care cost inflation stems from the convergence of several factors – some of which are national trends, and others that are specific to the Big Apple's market dynamics. First, the presence of large, academic health systems with national name recognition, paired with a fragmented insurance carrier market, significantly diminishes any carrier's leverage as a buffer against price inflation. Moreover, recent consolidation among health care providers in the New York metro area has expanded some providers' footprints to the point where a health insurance carrier cannot cut them out of network without falling short of network adequacy requirements. Meanwhile, many New York City employers compete vigorously for top talent and may be wary of disrupting their benefit offerings to address exorbitant prices. Together these factors create a market where the balance of power tilts strongly toward providers, and where *most* purchasers are unwilling to rock the boat.

The Health Fund took exception to the complacency around the high prices in NYC. As a member of Catalyst for Payment Reform, the Health Fund is part of a community of purchasers committed to improving the functioning of the health care marketplace. In early 2018, the Health Fund began to explore how prices varied among the hospitals where its plan participants sought routine care. It knew that continued increases in health care prices were unsustainable for the Health Fund and its plan participants and required bold action.

Designing the Strategy

The need for apples-to-apples price comparisons

The traditional quarterly reports purchasers receive from their TPAs are not designed to illuminate price differentiation among health care providers. But the Health Fund, armed with eight in-house data analysts, knew that its claims data could provide meaningful cost-per-

[2] https://nyshealthfoundation.org/resource/health-care-spending-prices-and-utilization-for-employer-sponsored-insurance-in-new-york/
[3] Ibid.
[4] https://www.catalyze.org/product/2017-price-transparency-physician-quality-report-card/

episode information if analyzed in a consistent manner. It developed apples-to-apples price comparisons for a set of common procedures and episodes of care, using industry standards such as PROMETHEUS Analytics® and resources from the Center for Medicare and Medicaid Services as references. For inpatient care, the Health Fund focused on the most common, planned inpatient admissions - vaginal deliveries and cesarean sections, bariatric surgeries, and hip and knee replacements. For outpatient procedures, it chose amongst the most frequent episodes that generally have relatively low variation in quality - such as mammograms and colonoscopies.

The resulting analysis showed that the Health Fund paid thousands of dollars more for hospital care in one system – New York-Presbyterian - than the average price it paid for identical procedures at other hospitals in the same geography. For example, the Health Fund paid on average $83,000 for hip replacements at New York-Presbyterian (NYP), which was $25,000 more than the average price at the rest of the NYC area hospitals. The average price of a vaginal delivery at NYP, at $24,000, was nearly $7,000 more than the average price at other providers. 32BJ Health Fund confirmed its hunch – that it paid different hospitals different amounts for the same care. But the question remained: how could the Health Fund translate this knowledge into action that would lead to meaningful change? In an ideal world, the prices for health care services would be rational and transparent, allowing patients to choose among various providers. However, health care markets don't operate that way. Until high-priced health systems agree to lower their prices, purchasers must be innovative and find ways to circumnavigate the high prices.

The right benefit design

Armed with price data, the Health Fund set out to create a benefit design that discouraged patients from using high-priced hospitals. To do so, it bifurcated its network into higher-cost and lower-cost hospitals and set up varying co-pay amounts to create incentives for plan participants to seek care from the lower-cost hospitals. This type of benefit and network design, often referred to as a "tiered network," is relatively common – over 31% of firms with more than 5,000 employees reported having a tiered network in 2019.[5] A tiered network approach suited the Health Fund because it created a pathway for plan participants to seek care from lower-cost hospitals without restricting choice or exposing plan participants to out-of-network charges. The Health Fund began sharing the analysis of hospital prices with its Board of Trustees and plan participants to raise awareness about the wide variation in prices paid by the Health Fund to hospitals in the network and begin exploring a new benefit design that differentiated between higher-cost and lower-cost hospitals as a potential

The Health Fund's greatest asset: plan participant trust

Once the data revealed the varying prices that the Health Fund paid in NYC, it shared the results with plan participants. It needed them to see the price differentials for themselves and understand why changes in benefit design were necessary.

[5] https://www.healthsystemtracker.org/brief/employer-strategies-to-reduce-health-costs-and-improve-quality-through-network-configuration/

solution. Lower-cost hospitals were placed on the preferred list and higher-cost hospitals on the non-preferred list.

However, the Health Fund found a major obstacle to this solution: one large health system, NYP, objected to participating in a network that differentiated between preferred and non-preferred providers unless it was on the preferred list. The Health Fund and its TPA could only implement the Health Fund's network and benefit design strategy if they overcame NYP's objection.

Putting a face to the cause

While the Health Fund was educating its plan participants and Board of Trustees about the high cost of care at NYP, the Health Fund's TPA was renegotiating its contract with NYP. Contract disputes between insurance carriers and health systems are common, but carriers do not evoke the same public sympathy or support conferred to local hospitals. The general public sees not-for-profit health systems in a positive light for serving their local communities and providing many jobs, whereas insurance carriers – especially for-profit ones – are often blamed for escalating health care costs. The Health Fund knew that its TPA could not win the contract dispute and implement a custom cost-effective network on its own; the Health Fund needed to support its TPA by demonstrating how high-priced health care jeopardized high-value benefits for low-wage workers. Consequently, the Health Fund's first priority was to secure support from its plan participants. After doing so, it could bring its cause to the public so that elected officials and the media could become allies to the Health Fund (and by extension, to the TPA) in its effort to create the new network design.

Rolling out the Campaign

The Health Fund worked with the Union, SEIU 32BJ, to develop a public education campaign. Health care costs are a major issue in collective bargaining between the Union and employer sponsors of the Health Fund. Both share an interest in controlling these costs while still ensuring access to high quality benefits, and both saw the value in entering the public arena to achieve price transparency and affordable benefits. The Union used three channels to help make the case to the public: public advertisements, a city council hearing, and engagement with elected officials. The Union kicked off the campaign by running two ads in Crain's New York Business, the local business newspaper popular with the area's hospital executives. The Union sent a clear message: it had data showing price disparities, and it wasn't afraid to name names in the public square. The Union used similar ads in a social media campaign directed at the Health Fund's plan participants. The ads compared NYP's average price for common health care services, like cataract surgery, to the average prices of the other hospitals in the region. The Union's ad sent a clear message: NYP's prices were higher than average prices in the rest of the market.

The Union selected the NYC City Council as its second arena for publicizing the high prices paid by the Health Fund, testifying along with some of its union members at a hearing on health care price transparency for the Council's Committees on Health and on Hospitals. Resulting media

coverage laid bare how the hearing's topic served as a proxy-war between the Health Fund's TPA and the NYP health system.[6]

Price transparency data is powerful

" SEIU 32BJ made the case that high-priced health care is unsustainable for working class people."

Sara Rothstein
Director, 32BJ Health Fund

Finally, the Union knew that contract disputes between health systems and insurance carriers usually end up on the desk of elected officials. The Union spent several months educating elected officials as to why NYP's contract language stood in the way of the Health Fund's ability to deliver cost-effective health insurance to its union members. The Health Fund's data analysis, revealing the wide variation in prices for the exact same services, made it hard for officials to brush the Health Fund's concerns aside. When reflecting on these meetings, Rothstein commented, "SEIU 32BJ made the case that high-priced health care is unsustainable for working class people and that health plans should have the right to implement plan designs that encourage use of lower-cost providers."

Staffing and Resources

The Health Fund described the process as "an intensive effort." To maximize the impact of its messages, it collaborated with the Union, which hired a graphic designer to create newspaper ads and collateral for plan participant-facing email and social media campaigns. Additionally, the Health Fund held many conversations with its Board of Trustees, working iteratively with them to understand the results of the data analysis, the barriers created by NYP's objection to a cost-effective network, and the opportunity to use price information to implement cost-saving strategies.

Even though the goal of the public campaign was to implement a network design that used co-pay differentials to reduce use of higher-cost providers, meeting that goal was only the first step. Simultaneously, the Health Fund had to prepare plan participants for the new benefit design. Moving from an all-access network to a network that differentiated between preferred and non-preferred hospitals represented a major change. The Health Fund held in-person meetings with plan participants to raise their awareness about the issues and the proposed solution. The entire process lasted about six months.

Results

After its intensive effort both internally and externally, the Health Fund achieved its goal. Its TPA announced that the Health Fund could proceed with implementing the new benefit design placing higher-cost providers in the non-preferred category.

[6] https://www.politico.com/states/new-york/newsletters/politico-new-york-health-care/2018/11/20/city-council-takes-up-32bj-line-on-hospital-procedures-138212

With formidable obstacles behind it, the Health Fund set out to focus on implementation.

Preferred and Non-Preferred Hospitals

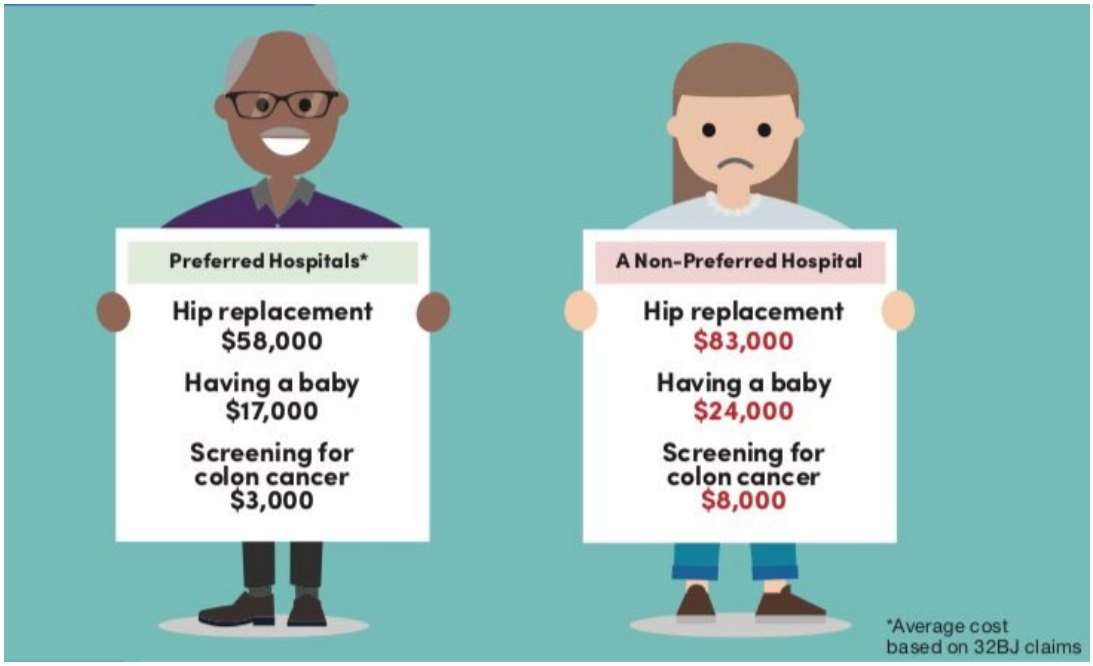

Figure 1. Educational material on the new benefit design.

The Health Fund rolled out its new benefit design in April 2019. The design uses co-pay differentials to incentivize patients to use preferred hospitals. For planned inpatient admissions (such as delivering a baby), the difference in out-of-pocket costs is significant: plan participants pay a $1,000 co-pay at non-preferred hospitals, while paying only $100 at preferred hospitals. For planned outpatient procedures, plan participants pay a $250 co-pay at non-preferred facilities, and a $75 co-pay at preferred ones.

The Health Fund worked with a communications firm to develop, test, and disseminate materials to educate plan participants on the benefit design.[7]

The Health Fund's education efforts were successful. Upon surveying its plan participants, the Health Fund found that most were aware of the benefit design and understood why the Health Fund had made this change. Some plan participants noted that they were unhappy about having to pay more to use certain hospitals. But when they saw the differences in prices paid by the Health Fund to NYP compared to the average at other hospitals, these plan participants did not think the benefit design was unfair. The Health Fund also monitored the number of complaints or questions on the new benefit and network design through its call center and noted that plan participants filed few complaints.

Changing where care is taking place

Preliminary results from the first year of the program show that more than 25% of planned inpatient admissions have shifted from non-preferred hospitals to preferred hospitals. The shift spans across all of the inpatient admission categories included in the benefit design. The Health Fund achieved this shift partly through its call center, which is integrated into its TPA's care management platform. Within the prior authorization process required for certain inpatient

[7] https://www.catalyze.org/product/32bj-new-network-communications/

procedures, the call center staff can help redirect care by calling plan participants with scheduled inpatient admissions at non-preferred hospitals and making sure they are aware of the higher co-pays at those locations. The Health Fund's data team is still examining the 2019 claims data to understand how many outpatient procedures occurred at preferred or non-preferred facilities, as well as the resulting cost-savings from shifting care away from high-priced hospitals.

Lessons Learned

Reflecting on the experience, Rothstein noted that the Health Fund's success hinged on taking time to talk to both plan participants and the public. Helping plan participants understand the underlying reasons why the Health Fund deployed a network with preferred and non-preferred hospitals and the consequential changes in co-pays was an important step in the process. Not only did this proactive communication build trust between plan participants and the Health Fund, but it also allowed the plan participants to engage in the public conversation about the reason for this change and to make the best use of their health coverage.

Bringing alternatives to other purchasers

Other purchasers might wonder: *why don't more insurance carriers offer solutions like* 32*BJ Health Fund's cost-effective network design to other purchasers?* Often, insurance carriers need support from employer-purchasers in their negotiations with providers to implement cost-containment strategies. For the Health Fund, that meant proactively supporting the TPA in its contract negotiations with NYP by educating the public on the impact of high-priced health care on low-wage workers. There are other ways for employers to aid their insurance carriers or TPAs in negotiating cost-containment or other high-value programs, such as meeting with local hospitals or sending out a mail campaign highlighting price inflation as a major source of rising health care costs. A short description of a similar effort made by the Self-Insured Schools of California is on the next page.

Next Steps

32BJ Health Fund's work analyzing claims data to understand changes in utilization patterns and resulting cost savings will continue throughout 2020. The Health Fund is simultaneously preparing to roll out a new benefit design program for maternity care.[8] The maternity care initiative began with an evaluation of quality and utilization data to identify high-value obstetricians, midwives, and hospitals. The new program, along with the cost-effective network design, reinforces one of the Health Fund's guiding principles: employer-purchasers have a role to play in navigating the complicated health marketplace to make the health care system more responsive to the needs of those who use and pay for health care.

[8] https://www.catalyze.org/product/maternity-payment-benefit-design-solutions

An alternative approach to framing carrier-hospital contract disputes

Self-Insured Schools of California (SISC) provides health care benefits for over 400 school districts and over 300,000 plan participants. When a major health system in central California announced its intention to terminate its contract with Anthem Blue Cross (SISC's TPA), SISC Deputy Director, John Stenerson, knew what lay ahead. Every few years, a major health system would demand an exorbitant fee schedule increase, the insurance carriers would attempt to hold their ground, the health system would threaten to terminate, and a game of "chicken" would ensue. The drama is intense, but the ending is usually the same: in markets where a single health system dominates, the health system holds the cards, and predictably, the carrier gives in. The health system has the upper hand not only because it holds monopoly power in the market, but *also* because it garners sympathy with the community: no one wants to blame the doctors or hospitals.

This time, however, Stenerson decided to take some control over the situation. Instead of exposing the health system publicly, SISC focused its efforts on its own membership. SISC crafted a mailer and sent it to all plan participants. The mailer included the following messages:

- The health system threatening termination is already one of the *most* expensive providers in the state and is seeking an increase in prices beyond current inflation trend;
- *That health system* is leveraging its monopoly as a negotiating tactic: they know that their removal from the network would cause significant disruption and confusion for SISC members and other patients in the region;
- There is a direct connection between health system price increases and the premium contributions SISC members pay: 95% of premium dollars go directly to provision of care – and over half of health care premiums goes toward facility care;
- SISC is hoping for a swift resolution to the contract negotiations; if the negotiations are not successful, know that SISC and Anthem are the entities fighting to keep health care affordable.

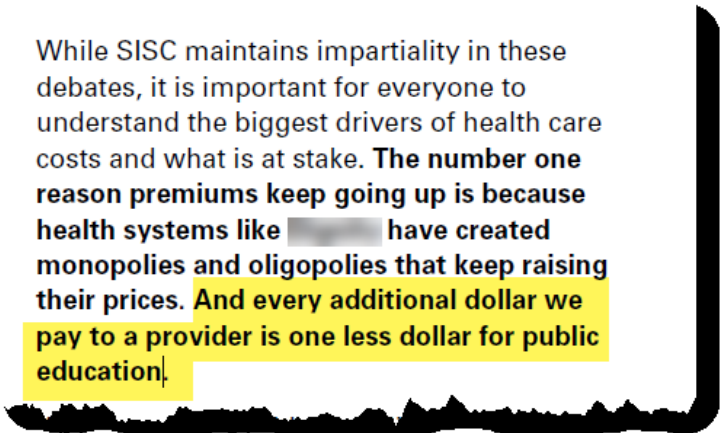
While SISC maintains impartiality in these debates, it is important for everyone to understand the biggest drivers of health care costs and what is at stake. **The number one reason premiums keep going up is because health systems like [redacted] have created monopolies and oligopolies that keep raising their prices. And every additional dollar we pay to a provider is one less dollar for public education.**

Figure 2. A section of SISC's mailer, with the health system name redacted.

The health system heard about the mailer from plan participants and reached out to SISC to discuss. Ultimately, Anthem and the health system agreed to new contract provisions. While the provisions of the agreement are confidential between the two parties, the fact that the health system did not terminate its contract suggests, to Stenerson, that SISC's efforts "took away their termination trump card." SISC has since used this strategy when two other California health systems threatened to terminate contracts – both providers recanted. But perhaps more importantly, Stenerson reports that SISC's plan participants have come to understand that "it's not insurance carriers that are raising rates and becoming more profitable, it's dominant hospitals and health systems raising prices that cause premiums to go up."