



LOCAL UNION No. 569
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BROTHERHOOD OF
ELECTRICAL
WORKERS

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SAN DIEGO COUNTY CHAPTER
NATIONAL
ELECTRICAL
CONTRACTORS
ASSOCIATION INC.

February 28, 2014

TO: All Members of the Senate Committee on Health

FROM: Ken Stuart, Administrative Manager

RE: Cost-Containment and Price Transparency

I am honored to be given the opportunity to address this Committee's interest in examining measures that may be implemented to identify existing shortcomings in the health care delivery system as well as some that will control, and even reduce, the continued escalation of medical costs. Having administered/consulted employer sponsored group health insurance plans for 40 years, mostly in the Taft-Hartley arena, I have developed a strong focus on making every effort to contain and/or control claim costs without lowering benefits or shifting increased costs through to the participants as a means of keeping the cost to the group plan as low as possible.

In the Taft-Hartley construction trades paradigm this last point is extremely significant as the direct source of the hourly contribution rates is routinely the working employees who allocate portions of wage increases to their Health & Welfare plan instead of committing the funds to their pay envelope.

In fact, it can be argued that every \$.01/hr that members allocate to their Health & Welfare contribution rate, instead of the in their pocket, may well cost them jobs as signatory employers must overcome a greater cost disparity when bidding against employers who do not provide their employees with medical or pension benefits.

For illustrative purposes the following table reflects the current hourly contribution rates for many International Brotherhood of Electrical Workers (“IBEW”) Health & Welfare plans in California:

<u>IBEW Local #:</u>	<u>Hourly Rate</u>	<u>Annual Cost For 2000 hours</u>
595 (Santa Rosa)	\$14.91	\$29,820
332 (San Jose)	\$12.98	\$25,960
180 (Vallejo)	\$12.95	\$25,900
302 (Pleasant Hill)	\$12.80	\$25,600
6 (San Francisco)	\$12.75	\$25,500
617 (San Mateo)	\$12.61	\$25,220
340 (Sacramento)	\$11.13	\$22,260
11 (Los Angeles)	\$10.59	\$21,180
234 (Castroville)	\$10.30	\$20,600
639 (San Luis Obispo)	\$10.20	\$20,400

Fiscal Issues:

I believe it is reasonable to suggest that the State of California, along with every city, county, municipality, school district and/or employer plan sponsor that provides health care benefits to their employees, is dealing with the pressure of how to pay for the continued escalation of same.

Whether using an insured, self-insured or managed care approach we are all subject to the following statistics pertaining to the current delivery system:

- \$700 billion in annual waste
- 100,000 avoidable hospital deaths each year
- 30% - 50% of total health care spend is for ineffective, improper or inappropriate care
- 3% - 6% of medical claim payments are due to fraud, waste and abuse
- 20+% of diagnoses which are incorrect
- 60+ % of recommended treatment plans are less than optimal for the patient
- 38% of recommended surgeries are totally unnecessary
- Another 18% of recommended surgical procedures are not the correct surgical procedure

After looking over these statistics in relation to the aforementioned hourly contribution rates, the obvious question is whether these working employees and their families would be better off with 30% - 50% of their Health & Welfare contribution rate going back into their pocket while continuing to be covered by the same group medical, dental and vision benefits? At the same time, would containing or reducing these costs not drastically improve the overall fiscal condition of all of the aforementioned providers of group health insurance to their employees?

Major Concerns to Purchaser/Plan Sponsors and Consumers:

Recognizing that whether insured, self-insured or on an HMO/managed care basis, most all employer sponsored group health plans, and now including Covered California, utilize an insurance carrier (hereinafter referred to as “health plan”) in some fashion. The question that must be considered is: Does utilizing a large health plan’s panel of doctors and hospitals who have agreed to provide services at a substantial discount or for a fixed premium rate ensure purchaser plan sponsors that the cost of services will be as low as possible or that only high quality and appropriate care will be delivered leading to optimal medical outcomes? The answer is “absolutely not”.

Health plans routinely negotiate bilateral contracts with providers, many of whom are essential to their being competitive with other health plans in a particular market, that basically determine what their customer clients are going to pay for services. Rarely are provider panels formed based upon identifying which providers render the most appropriate or highest quality level of care. Further, there is a growing use of contracts that are proprietary, meaning purchaser/plan sponsor or consumer clients are bound by terms and conditions they may not see, nor may they verify or validate a service provider’s pricing or billing methodology. Thus, there is little or no protection against predatory pricing or claims processing procedures. Further, the same premise exists for individual consumers who procure coverage privately as their health plan will expectedly pay the same negotiated fees for their claims that directly impacts their premium rates.

More important, when hospital charges are to be paid on a percentage of billed charges basis the purchaser plan sponsor is responsible to pay the negotiated percentage, after any applicable discount, but has no idea as to how much the price(s) had been marked up. Add to that, the billing service provider expects the contracting health plan to guarantee payment in accordance with the terms of their “secret” contract which causes the health plan to pay the claim as billed or, if claims are paid by a third-party, demand that the payer honor the terms of their contract.

About my Plan:

Our plan is self-administered with approximately 6000 covered lives. Presently 97% of our participants are in a self-funded freedom of choice PPO plan and 3% are in an HMO. The current cost of our PPO Plan (full family medical, dental and vision coverage) is \$907.20 versus \$1,423.17 for HMO coverage. We have trended at approximately 4% over the last 11 years, which is about

50% of the industry average. This is the direct result of aggressive cost-containment programs, some of which afford direct financial incentives for using specified providers known to provide the most appropriate and high quality care.

Being self-administered we pay our own PPO Plan claims which are filed by service providers directly with our health plan and then submitted electronically to our office along with initial pricing. We then scrutinize the claims in accordance with our Plan and ultimately inform the health plan as to how much, if anything, to pay per claim. However, it should be noted that the health plan does perform a degree of pre-screening for fraud, waste and abuse. That said, we first send incoming claims to TC 3 Health for additional screening fraud, waste and abuse along with out-of-network claims pricing. It should be noted that we are realizing between 2% and 3% in additional savings as a result of this additional screening.

Our having demonstrated that there exists more extensive savings than are being provided by our health plan's screening exposes a problem with a whole sector of service provider charges that may not be screened in accordance with nationally standardized code editing and raises a question as to why not? The answer is that some proprietary contracts forbid application of these standardized code edits, especially to hospital charges. The sole beneficiary of such restrictions is obvious.

What happened to my Plan over the last two years?

We have had 5 specialty drug pricing issues with the same hospital system. One in particular paints a clear picture as in 2012 a hospital submitted a charge of \$39,915 for 125 mg of chemotherapy (issued in 20 mg vials) that cost \$3,036 (per CMS published pricing). Our health plan advised that the allowable charge to be paid was approximately \$22,000. As noted, we use an independent service provider to pre-screen all incoming claims to determine both proper billing and pricing. In this case the AWP was identified as being \$3,036 and the allowable charge was \$3,643 (a reasonable 20% markup). Had the same medication been procured through a non-hospital source its price would have been in line with these last two amounts, however on a % of billed charges basis a hospital theoretically has unlimited billing capacity and understandably expects to be paid the contracted % of all billed charges.

Upon advice from TC 3 we denied the approximately \$18,000 balance on the premise it grossly exceeded usual, reasonable and customary pricing as is defined in our plan document under the definition of eligible expenses. The hospital appealed the denial on the premise their contract with the health plan provides for all billed charges to be paid at the specified %, no questions asked. The health plan informed us that they inquired of the hospital as to whether the claim was properly calculated and was told "yes", which was accepted as gospel and conveyed to us with an edict to honor the terms of the contract or face the consequences. Thus, by refusing to assist in pursuing validation as to the method in which these billed charges were calculated it seemed clear the health plan is far more concerned about keeping their hospital clients happy than protecting their purchaser client and consumers.

The reality is that the hospital used their then current chargemaster price of \$6,386.40 to calculate a 1 mg unit charge for a 20 mg vial of \$319.32 (versus \$24.29 @ AWP) to be applied to the 125 mg dose which comes to \$39,915, a 1300% mark-up of the \$3,036 price for the same medication using AWP. By the way, payment of the allowable charge of approximately \$22,000 would represent a net mark-up of 740% for simply receiving and preparing the medication. It is also reasonable to assume that a large health system would place significant pressure on the Oncologists in their related medical groups to use only their hospital pharmacies to procure their medications knowing full well that the substantial mark-up in those prices will generate significant profitability.

When looking at this particular hospital's chargemaster history for this medication it is interesting to note that the 2011 price for a 20 mg vial was \$ 333.15, yet increased to \$6,386.40 in 2012 (+1917%). Compounding the problem is that the whole \$39,915 charge was put through as eligible expense to be paid under the health plan's contract with the hospital. As an aside, the hospital's posted year-over-year increase for this same medication for 2009 to 2010 and 2010 to 2011 was 7% and were right in line with the AWP pricing methodology noted in the hospital employee's e-mail. This also raises the question of how would a purchaser or consumer ever know for sure they are being protected in terms of their health plan even being aware of and/or enforcing the hospital's posted % change to its charge codes? **In this instance if we weren't paying our own claims or using a secondary source of screening we never would have known about the magnitude of the charge or the changes in charge code pricing.**

We were repeatedly pressed for payment by both the hospital and the health plan, in response to hospital pressure, and the only response from our health plan I received to our substantiated position that this charge grossly exceeded usual and customary pricing was “a contract is a contract, you have to pay the appropriate % of billed charges”. This went on for quite some time until there was ultimately an acknowledgment by the hospital that there had been an error in their chargemaster, which would be corrected. Ultimately, this and the other 4 pricing matters were settled directly with the hospital CEO.

A significant component of this example is that we made repeated attempts to get verification and documentation as to the basis by which these charges were being calculated and billed, only to be repeatedly denied on the premise the contract is proprietary. In fact, I asked our health plan representative to check on this aspect and was shocked to learn they too were denied by the hospital even though they are a party to the contract.

One last important aspect of this whole ordeal is that we were instructed by our health plan we could not apply code edits to this particular hospital system’s bills, although it was permissible for others and all professional fees. **Who, besides the health system benefits directly from such a restriction? By health plans knowingly disregarding violations of nationally standardized billing and editing practices that benefit their panel providers the only result can be that their insured or self-insured clients will be adversely impacted due to higher claims experience that will expectedly lead to higher claim/premium costs.**

What was learned from this experience?

It would appear to be against public policy for a purchaser or consumer to be advised they are not entitled to see existing contract language that may be directly related to the means by which they are being billed prior to making a determination as to whether the amount(s) billed were both accurate and conform to acceptable billing practices. In no other industry is a customer provided an invoice for goods or services they are usually unaware of, or have no control over, and then be told they have no right to determine the accuracy or validity of the underlying charges appearing on a detail of all billed charges.

Purchasers plan sponsors and consumers can not assume that their interests are being protected by whichever health plan they choose to provide their coverage and/or access their panel providers as it is clear the health plans are not only disadvantaged by the clout exercised by large health systems, but it appears there is a greater value placed on the health plan-health system client relationship than the health plan-purchaser client relationship from whom most of their revenue is derived.

What areas should this Committee consider acting upon?

1. Proprietary contracts between health plans and health systems (hospitals and medical groups):

Recognizing the leverage larger health systems have over health plans, due to the latter's dire need to have larger hospitals participate in their networks for competitive purposes, purchasers and consumers would benefit from legislation addressing any absolute lack of transparency which stacks the deck in favor of hospitals who negotiate bilateral "proprietary" contracts with health plans that establish how much purchasers and consumers will have to pay for unknown services which may be charged at costs that routinely have little or no direct correlation to the underlying cost of the service or goods they receive.

The direct impact of these "secret" agreements to purchasers and consumers is that some provisions totally deprive purchasers of much needed measures of protection from their health plans that directly lead to higher claim costs, especially when service providers are being rewarded for improperly or excessively billed charges. In fact, where a health plan receives, prices and adjudicates provider billings their client purchasers or consumers are usually prevented from conducting any degree of due diligence in terms of verifying or validating billed charges to ensure that payments meet their plan's requirements as to usual, reasonable and customary limitations. In fact, provisions in some health plan - hospital proprietary agreement requirements that do not permit a purchaser to follow the terms of their plan document may expose a federally regulated ERISA Plan to the commission of a prohibited transaction.

Recommendation: That language preventing purchasers and consumers from seeking and/or being provided with verification and/or validation of any and all billed charges by their health plan should be prohibited as should a hospital contracting fees that exceed the usual, reasonable

or customary level for such goods or services in the geographic area in which they are rendered. Hospitals should be required to provide a claims payer, purchaser or consumer with copies of their actual invoice for medical equipment, specialty drugs and durable equipment.

2. **Claims pricing/billing/adjudication:**

Application of NCCI Code Edits

Attached material clearly shows that NCCI's sole purpose was to ensure proper national methodologies for all billings, **not just Medicare claims**. This is further substantiated in the last paragraph which states that NCCI edits are nationally recognized as a widely used standard to ensure accurate coding and reporting of services. Nationally 3% - 6% of total claim payments fall into the category of fraud, waste and abuse.

If a health plan selectively applies code edits to only physician and professional charges, but not hospital charges presumably due to direct contractual restrictions or in outright deference to hospitals their purchaser plan sponsor and consumer clients are severely disadvantaged by virtue of claims being paid that shouldn't be due to violations of nationally standardized billing methodologies.

Recommendation 1: Language appearing in any contract between a health plan and a health care service provider (hospital, physician, professional, etc.) that in any way prevents the health plan or a third-party payer from applying any and all nationally standardized or recognized code edits to service provider billings should be expressly prohibited.

Recommendation 2: That any third-party claims payer may apply nationally standardized code edits in the course of adjudicating claims submitted for payment by a health care service provider in addition to those that may initially be applied by a health plan within their claims adjudication process and that no provision in any agreement between a health plan and health system, physician and/or other health care service provider may prevent or override such determinations.

Prevention of health plans entering into agreements with competing health systems or providers.

If a health plan is prevented from entering into an agreement with any other health system or service providers due to fear of losing available discounts or other advantages from a contracting health system or service provider then purchasers and consumers are deprived of realizing any fiscal advantages that would have become available under the terms of the separate agreement.

Recommendation: That language in any agreement between a health plan and a health system or service provider that provides for the elimination of negotiated discounts or other advantageous terms and conditions built into said agreement in the event the health plan enters into an agreement with a competing health system or service provider operating in the same geographic area should be prohibited.

Manipulation of the chargemaster

I expect the example of the pricing issue noted above clearly establishes what can be done through chargemaster and individual charge code manipulation. California law requires hospitals to make public their prices of all services, goods, and procedures for which a separate charge exists in the form of a chargemaster which is then used to generate a patient's bill. Under the Payers' Bill of Rights each hospital is required to submit a copy of its chargemaster and the estimated year-over-year percentage change each July 1. Since it is the chargemaster that becomes the source or foundation for determining hospital billed charges it would appear that in the best interests of their purchaser and consumer clients that all health plans should be required to certify all changes in chargemaster pricing on a year-over-year basis by identifying and validating the reasonableness of any substantial increase to individual charge codes. The necessity for this requirement is to protect purchasers and consumers from being the unwilling victim of substantially increased pricing that greatly exceeds usual, reasonable and customary levels which also affords a hospital the means to covertly increase its fees even if they negotiate a new agreement with a health plan providing for no change in the applicable % of billed charges to be payable.

Recommendation: For all prescribed medications (or at least specialty medications) hospitals should be required to use CMS published AWP or ASP pricing and apply standardized pricing methods to determine billed charges. Purchasers and consumers should be entitled to receive from the billing hospital a detailed breakdown as to the pricing methodology utilized to determine the amount of billed charges as well as validation as to the billing methodology being permitted under the bilateral agreement between the hospital and health plan. Further, health plans should be required to validate that an increase to any charge code which exceeds the posted annual increase percentage to the chargemaster does not exceed the usual, reasonable and customary charge for that service or product.

3. Claims Data

From discussion with the CEO's of Blue Shield, Blue Cross and United Healthcare in California it clear that the high cost of anticipated litigation being initiated to prevent their making claims data in their possession readily available for quality and appropriateness type studies, and then publishing the results, has created an understandable reluctance to do so. Such studies are intended to accurately compare the performance of all health care providers and identify those physicians and hospitals that provide the highest quality and most appropriate medical care. The prevention of the health plans from doing without a fear of litigation deprives purchasers, consumers and the health plans of the opportunity to utilize this information to identify providers with the highest probability of properly diagnosing and treating their patients, not to mention contributing to lower insurance premiums directly emanating from better and more effective medical care expected to lower overall claim costs. The need for allowable pricing, instead of only billed amounts, being made available is also tantamount to properly identifying who does the best work at the most reasonable cost.

Recommendation: That any health plan, third-party administrator or employer who makes claims data available in accordance with HIPAA privacy standards for the purpose of the conduction of studies to determine the quality and/or appropriateness of services rendered by hospitals, physicians and/or health care service providers should be fully protected from being sued for doing so and/or publishing said findings for the benefit of their client purchasers and consumers and the public in general. It would also be helpful if allowable pricing were to be required as part of all such data to be provided.

The bottom line is that health plans and health systems derive a very large majority of their revenue from purchaser plan sponsors and their participant consumers. That said, purchasers plan sponsors and consumers must rely on the health plans (who negotiate from a position of weakness) to protect our interests in that all of those rights are routinely negotiated away or ignored due to health plans having to keep the health systems and service providers happy so they remain in their networks and permit them to remain competitive. The impact of this imbalance is that purchasers and consumers have little or no redress and/or means to ensure that our dollars are being appropriately committed and/or disbursed.

Affirmative legislation focused on establishing true transparency as to reasonable and validated pricing for medical goods and services, service provider billing and claims adjudication practices, contracting between health plans and health systems, and making available as much actionable quality and appropriateness as possible to permit purchaser plan sponsors and consumers to be empowered to make prudent, informed health care delivery decisions will be a great way to level the playing field. The end result will be a greatly improved health care delivery system from which purchaser plan sponsors and consumers can reasonably expect to receive “true value”, defined as optimal medical outcomes at the most reasonable cost; . This way everyone wins.

Thank you for allowing me this opportunity. I am also attaching two articles appearing in the International Foundation of Employee Benefit Plans monthly “BENEFITS” magazine that address the concepts of true cost-containment and the need to focus on quality and appropriateness of medical care as the way to fix this severely broken system.



Ken Stuart