

Health Benefits Fringe Meeting May 12, 2016

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- Town Hall meeting open to all (5/9/16)

Additional workshops occurring Thursday's in May @9am in the Benefits Office & You are invited!

Date	Topic	Speaker	Location
5/12	Cash-Based purchasing of medical services. How much could we all save by purchasing medical services on a cash basis. <ul style="list-style-type: none">• What's involved• How does it work• What doctors are currently participating	Sally Covington, Community Campaigns for Quality Care	District Board Room
5/19	Planning a Peralta Retirement	The District	TBD @ the

- Introduction of Sally Covington How to Reduce Medical Costs, Not Wages, Benefits or Access to Care
9:05-9:40
 - Co-founder of Community Campaigns for Quality Care, a 501c3 public charity founded in 2010 to advance affordable high-quality health care for all regardless of race, gender, socioeconomic or immigration status or zip code, she advises unions, their employers and group buyers of employee health benefit on the key health care cost drivers and recommends practical solutions to reduce employer health benefit costs without raising them for employees.
- Questions and answers: 9:40 – 9:45

How To Reduce Medical Costs, Not Wages, Benefits or Access to Care

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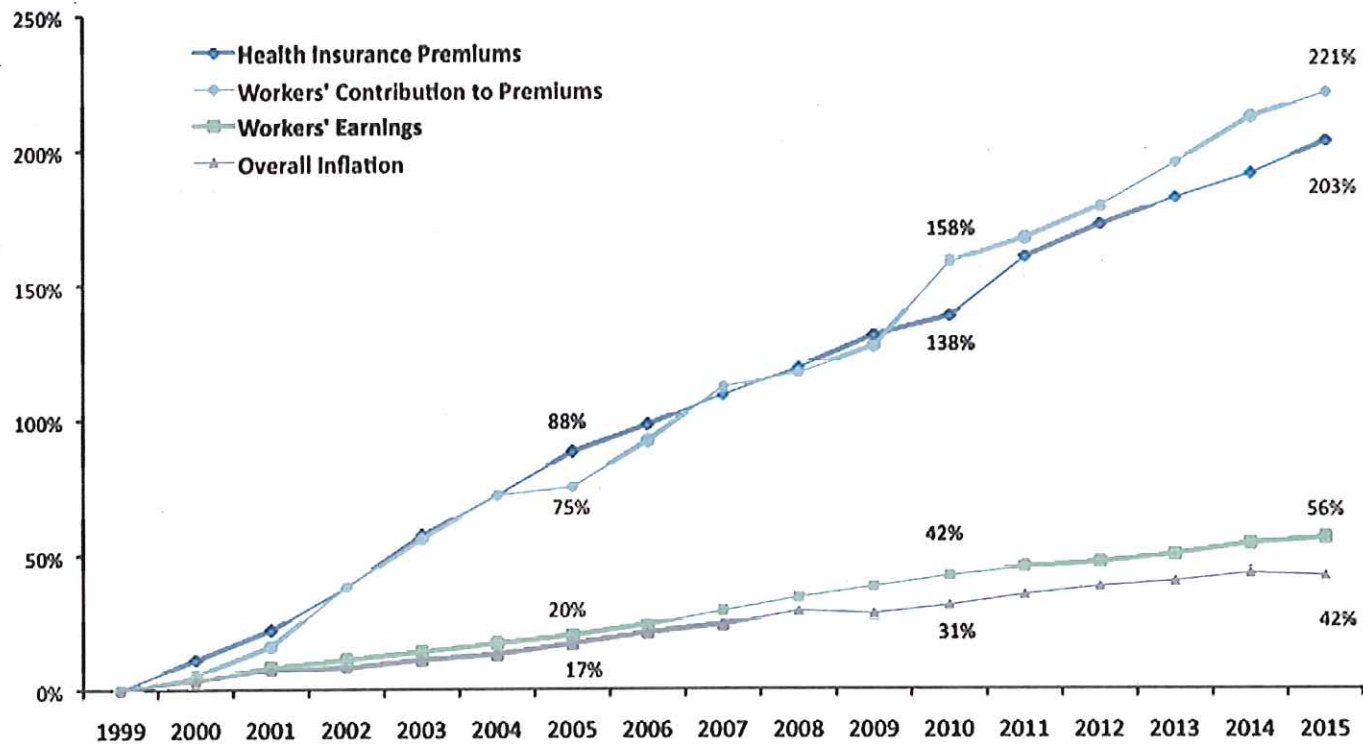
Sally Covington, PhM
Community Campaigns for Quality Care
Phone 510-435-2687 // Email: Sally@communitycampaigns.org

May 12, 2016

The Problem

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Unaffordable inflationary health benefit cost trend



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).



Key Contributing Factors

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No Price Transparency

- Prices are hidden
- Pricing structure is irrational. A single insurer may negotiate 50 different rates for the exact same service



No Price Competition

- Providers set charge master (price list) as starting point for negotiating rates
- Rates are privately negotiated and reflect market clout of negotiators



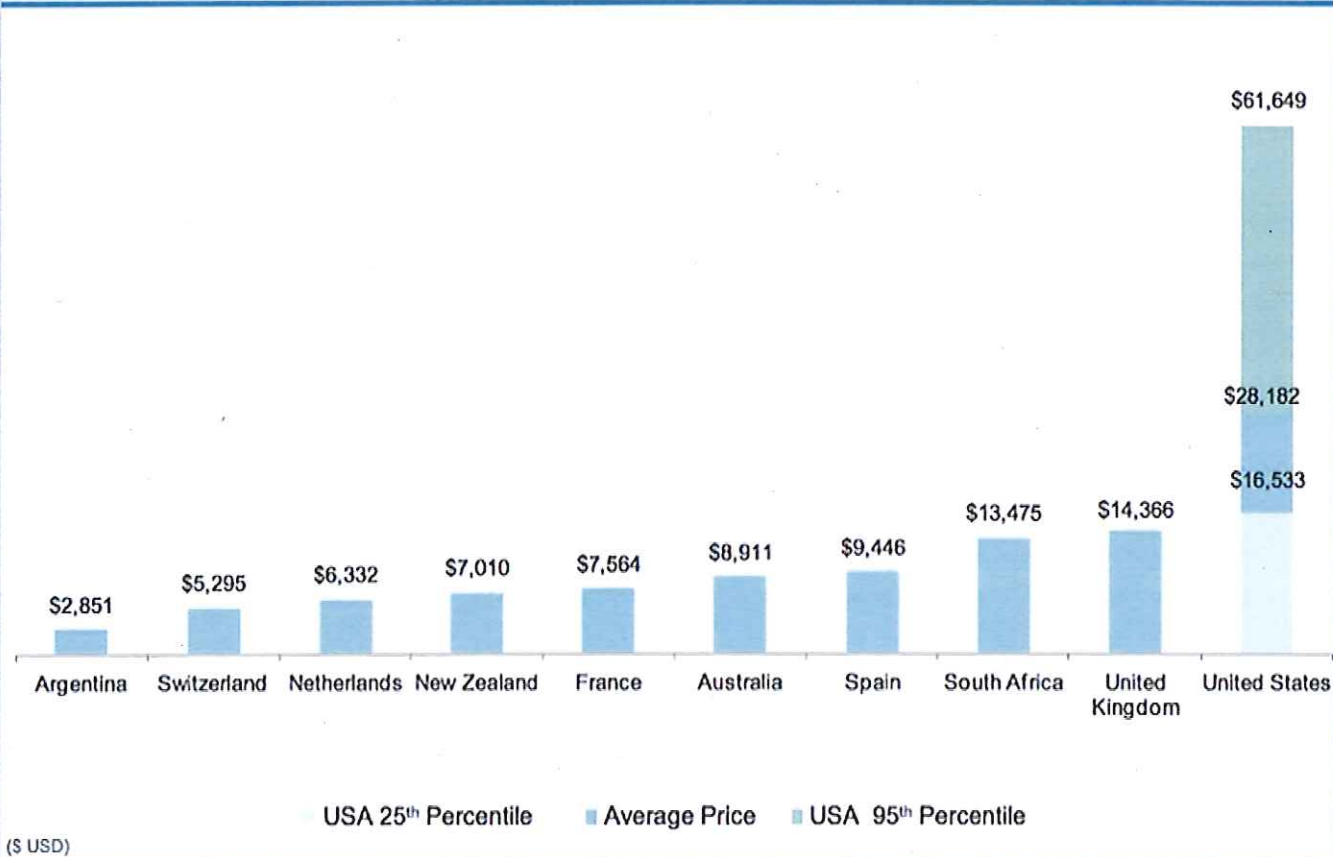
Big Inefficiencies

- Thousands of provider contracts and service prices impose substantial billing, claims adjudication and collection costs on providers

Prices Under Managed Care Model

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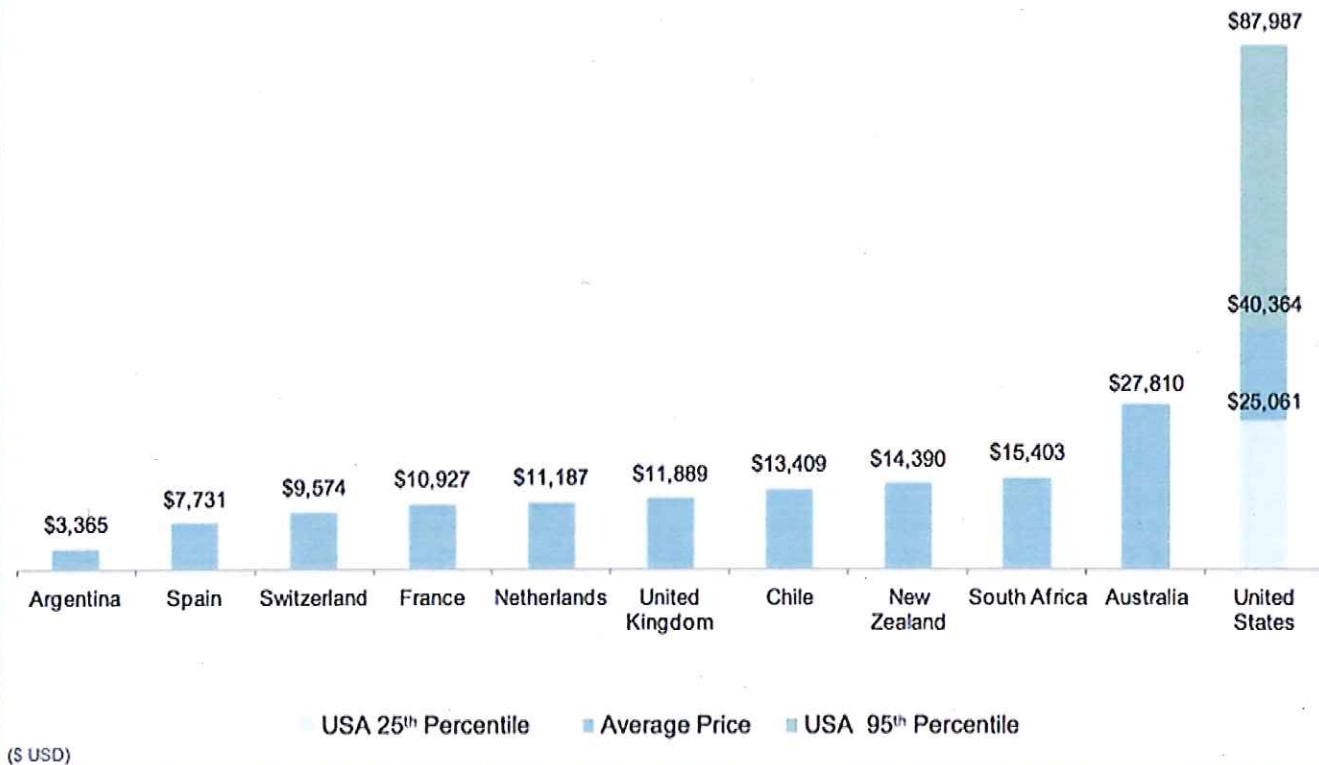
2012 Total Hospital and Physician Cost: Angioplasty



Prices Under Managed Care Model

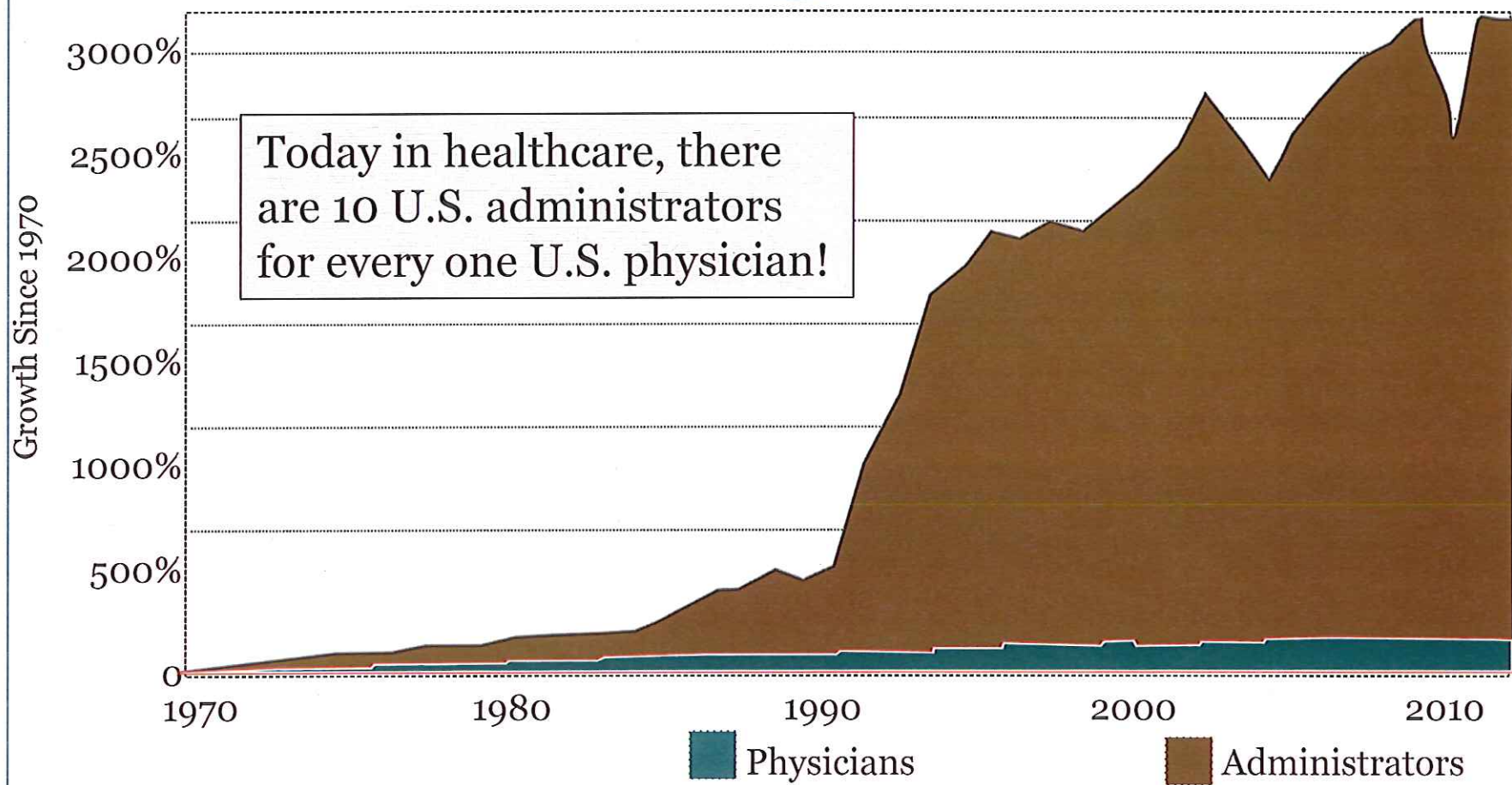
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2012 Total Hospital and Physician Cost: Hip Replacement



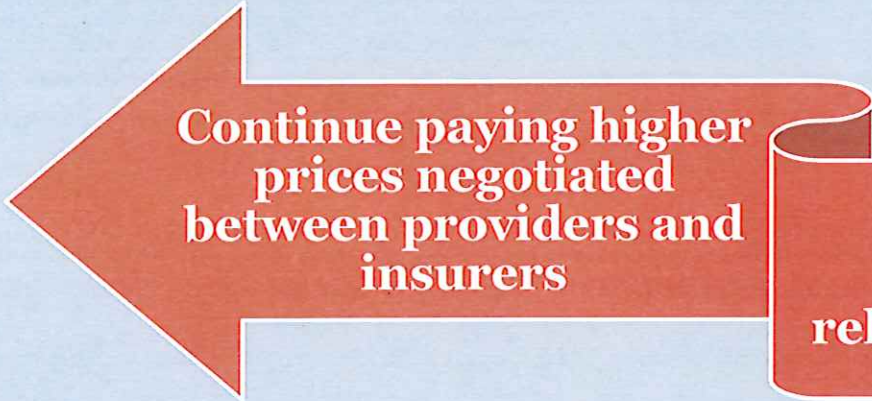
Huge Administrative Cost Burden

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Two Paths

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**Continue paying higher
prices negotiated
between providers and
insurers**



**Pay lower prices that
providers offer when
relieved of insurance billing**

One definition of insanity:
keep on doing what you've always
done and expect a different result.

Competitive Bidding

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1. When a doctor and patient determine need for a test or procedure, the patient can call a service representative to request provider “bids” for the service (e.g. MRI scan).
2. Service representative obtains and delivers service bids to patient, along with information on bidding providers’ credentials, experience, and track record.
3. If patient chooses a bidding provider, the employer plan arranges cash payment (via wire transfer) to provider at time of service and waives patient out of pocket costs.

How Does This Help?

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1. Bay Area providers currently offer patients much lower prices than they negotiate with insurance companies in return for cash payment.
2. Why? Providers spend a lot of time and money on insurance billing and bureaucracy, which they dislike.
3. Cash prices are 65% below insurance contracted prices!

MRI Scans: PPO vs. Cash Rates

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SF Bay Area Facility	Insurance Rate for Non-Contrast MRI	Cash Price Rate for Non-Contrast MRI
Alta Bates Summit Medical Center, Summit Campus	\$1,346	\$466
San Mateo Medical Center	\$2,690	\$585
UCSF Medical Center	\$1,690	\$1,628
Seton Medical Center	\$5,061	\$1,752
Washington Hospital, Fremont	\$5,113	\$1,770
Mills Health Center	\$5,662	\$1,960
CA Pacific Medical Center, Pacific C.	\$7,791	\$2,697
Marin General Hospital	\$7,826	\$2,709

Source: insurance rate estimated from paid claims data (Jan 2013-Oct 31 2014) provided by Northern CA employer self-funded medical plan. See "Digging Deeper on 'As Hospital Prices Soar, a Single Stitch Tops \$500' from the NY Times," for cash price rates, available at: blog.pricinghealthcare.com.

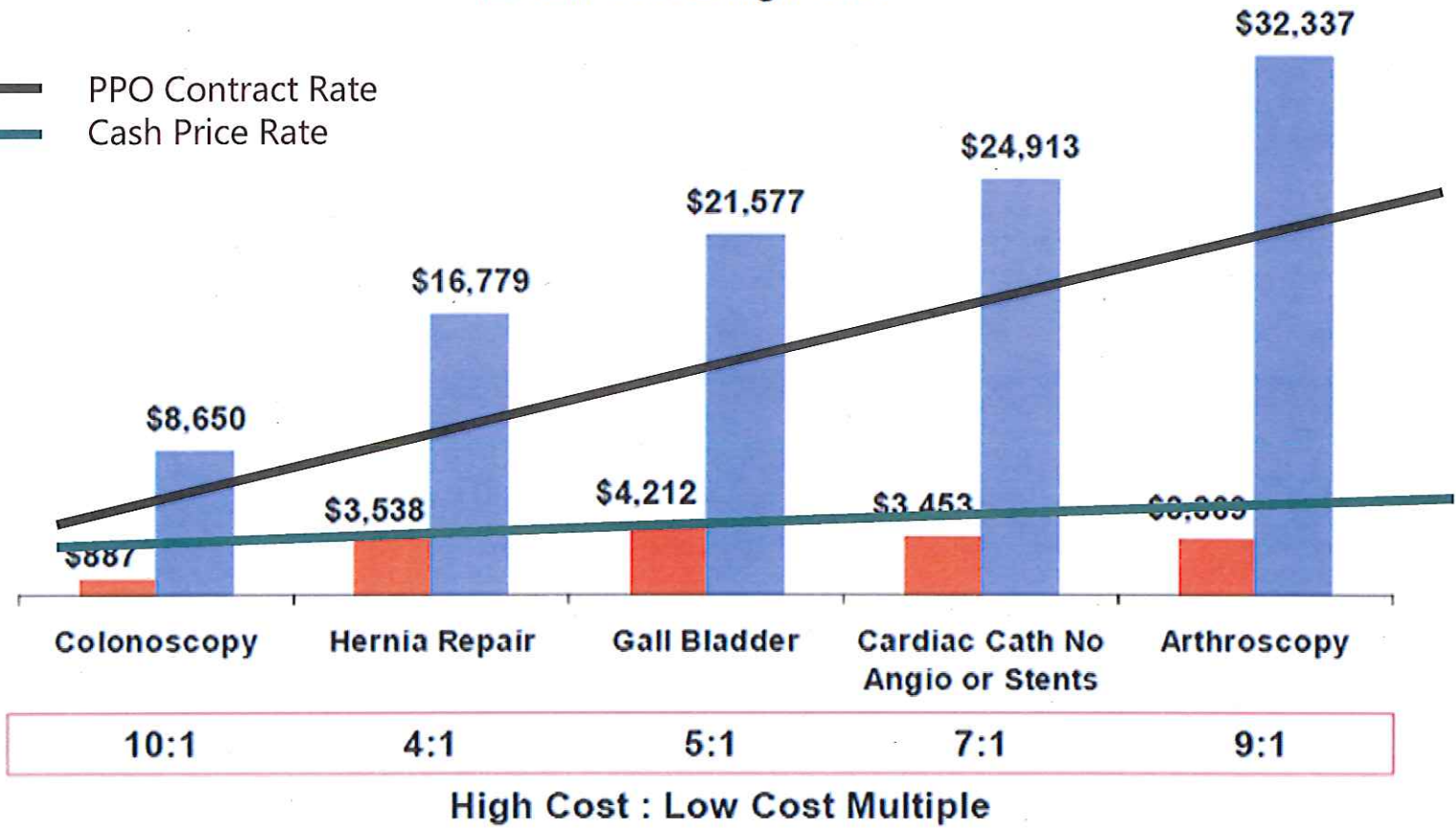
The Overcharge: PPO vs. Market Rates

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Cost Per Procedure (\$) - Greater SF Bay Area MSA

Low Cost High Cost

— PPO Contract Rate
 — Cash Price Rate



Projected Health Plan Savings*

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Northern CA ESHP, 22 months paid claims data	Baseline PPO Spending	Total Spending under Medicare+	Savings from Medicare+ fee schedule \$ and %	Savings from Comp Bidding at cash price rates, \$ and %	Combined Savings \$ and %
All claims	\$471,463,258	\$354,278,748	\$117,184,509 (25%)		
Comp bidding, 50% patient participation				\$85,756,588 (18.2%)	

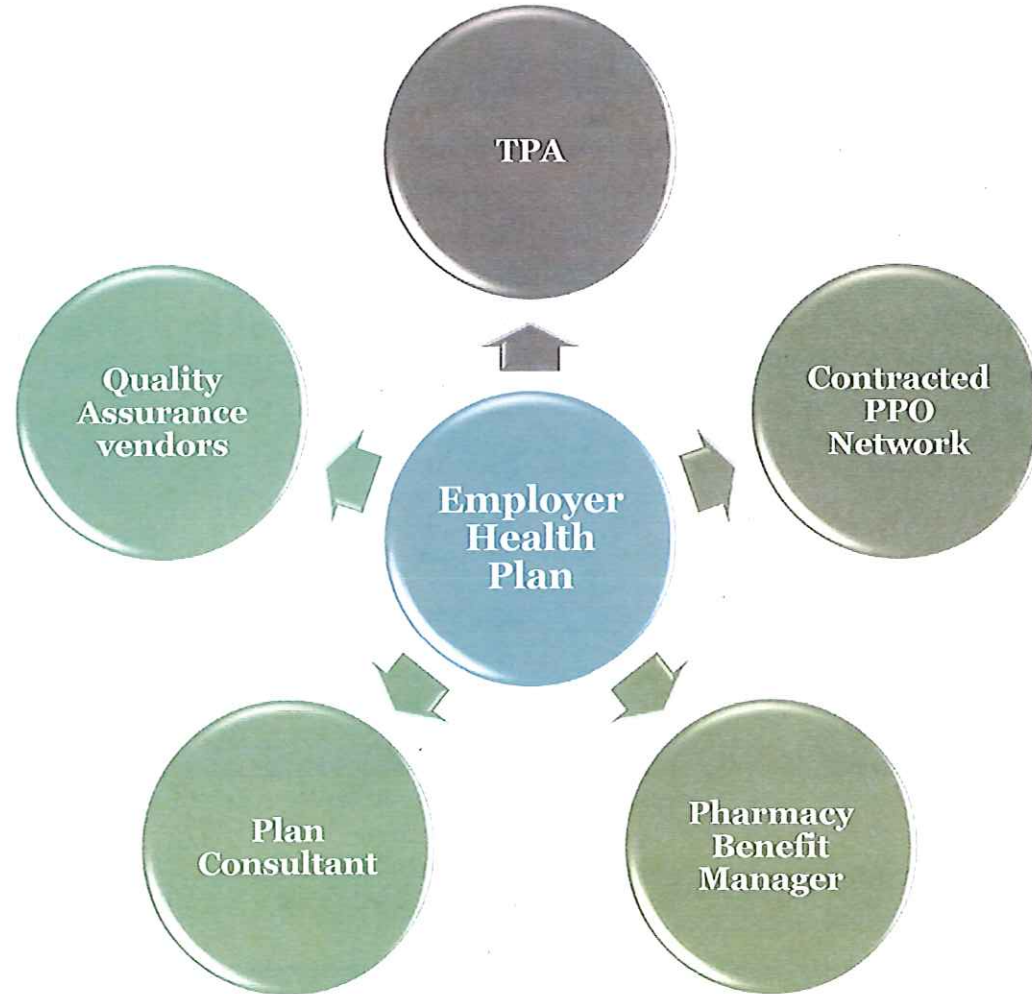
Plan and Member Benefits

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1. Plan saves money whenever plan members request and obtain provider bids and choose a bidding provider.
2. Members get advance information on service prices and provider credentials, experience, and track record and \$0 out of pocket costs if they choose a bidding provider.
3. Savings are shared with health plan members.

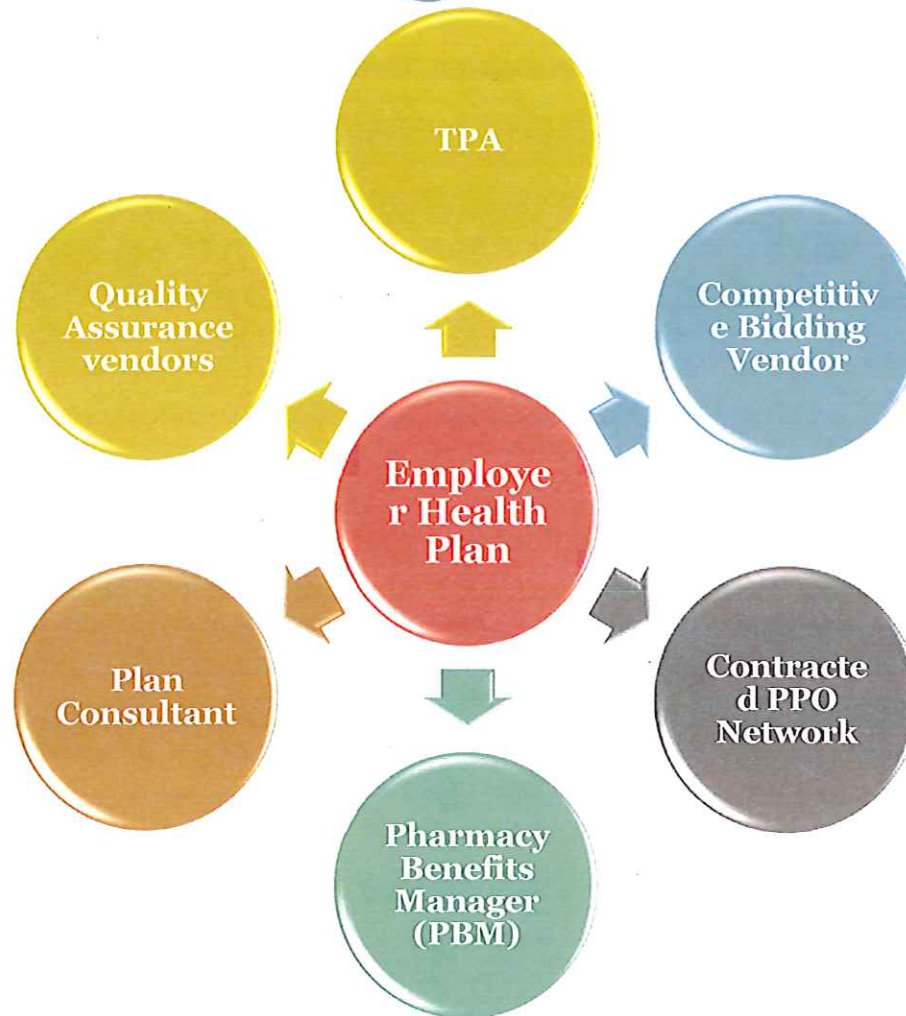
Plan Infrastructure

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Infrastructure W/Competitive Bidding

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Potential Next Steps

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1. Transfer claims file for savings analysis
2. Implement pilot: select single specialty services (e.g., radiology, gastroenterology)
3. Evaluate results, share savings

Questions and Answers

1. Regarding PPA: who owns the software? The Company? Of whom are they an agent? How long have you been partnering with them and are you aware of any references?
2. Is access to the owner of PPA available directly to PCCD without the involvement of Community Campaigns for Quality Care?
3. Regarding the data request: it appears that there is a monthly on-going requirement –why?
4. The footnotes on page 3 indicate a need for Rx, however, the pp on page 1 indicates that pharmacy should be excluded.
5. As you have stated in prior conversations, if the drivers of health care cost include overhead and availability of medical professionals, how does cash-based pricing affect those primary drivers? If at all?
6. Is there a cash-based network currently available in our immediate area?
7. If Anthem providers have an exclusive arrangement with a non-disclosure element of the fee schedule, then does it stand to reason and the cash-based providers would be non network? If so, given our current plan design, what incentive is there to voluntarily participate.
8. If there is no network and our employees are only paying \$300 for the deductible, then what incentive does the end-user have to shop around for a provider with whom they are not affiliated?
9. At least half of our population is in Kaiser, how can we affect those premiums by the cash-based pricing model?
10. If CALPers is one of the single largest purchasers of health insurance in California, what is it's position on cash-based pricing?
11. What would the employer's liability be in the event of unforeseen complications arising from a non-network provider?
12. Is there a guarantee minimal participation level?
13. If a non-disclosure agreement is signed by PPA, Can PPA prohibit the use and release of the data without our expressed and prior written consent.
14. We are not committing but are exploring due to HIPPA issues, privacy issues and non-disclosure agreements with our current network, based on your experience with PPA, what has been the typical turnaround time for data
15. Where is the profit motives?
16. Does PPA receive compensation?

2016-2017 Monthly Contribution Rate Matrix for:

- Active, Benefit-Eligible Employees
- Complete Table on Benefits Webpage: <http://web.peralta.edu/benefits/>
- Rates are subject to the outcome of union negotiations

Medical Coverage (for all employees except Local 39, 1021 and Confidential)		Medical Coverage (for Local 39, 1021 and Confidential)	
Single Party Coverage	Kaiser HMO	*PPO Lite	**PPO Traditional
Employee Pays	\$0.00	\$15.00	\$179.23
Peralta Pays	\$684.42	\$701.64	\$716.64
Total Cost	\$684.42	\$716.64	\$895.87
Two-Party Coverage	Kaiser HMO	*PPO Lite	**PPO Traditional
Employee Pays	\$0.00	\$30.00	\$400.44
Peralta Pays	\$1,368.85	\$1,571.15	\$1,601.15
Total Cost	\$1,368.85	\$1,601.15	\$2,001.59
Family Coverage	Kaiser HMO	*PPO Lite	**PPO Traditional
Employee Pays	\$0.00	\$45.00	\$601.57
Peralta Pays	\$1,936.92	\$2,316.47	\$2,361.47
Total Cost	\$1,936.92	\$2,361.47	\$2,963.04
** PPO Traditional premium is billed to the retiree. The actual premium is based on Medicare coordination. Visit the Peralta District Benefits website for a complete matrix of rates: http://web.peralta.edu/benefits/			
Dental Coverage			
Your choice of dental coverage and COBRA continuation options are based on District-affiliation and outcome of union negotiations when applicable.			
Delta Dental		United Health Care	
Single Party Coverage	Managers	PFT	Local 39, 1021 & Confidential
Employee Pre-tax*	\$34.30	Pending Negotiations	PFT
Employer Non-Taxable*	\$30.39	\$30.39	\$0.00
Total Cost and/or COBRA Equivalent Rate	\$64.69	\$64.69	\$30.39
Two-Party Coverage	Managers	PFT	Local 39, 1021 & Confidential
Employee Pre-tax*	\$61.36	Pending Negotiations	PFT
Employer Non-Taxable*	\$48.61	\$48.61	\$0.00
Total Cost and/or COBRA Equivalent Rate	\$109.97	\$109.97	\$48.61
Family Coverage	Managers	PFT	Local 39, 1021 & Confidential
Employee Pre-tax*	\$94.12	Pending Negotiations	PFT
Employer Non-Taxable*	\$74.07	\$74.07	\$0.00
Total Cost and/or COBRA Equivalent Rate	\$168.19	\$168.19	\$74.07

*Designation as it appears on the Peralta pay advices.

NOTE: The PPO Traditional and PPO Lite rates are subject to change pending outcome of union negotiations.