32BJ Health Fund
Fall Conference

Hospital Prices: the Policy and the Practical

SEPTEMBER 22, 2022

9:00 AM – 2:30 PM ET

Welcome

Kyle Bragg, President, 32BJ SEIU

Introduction

Cora Opsahl, Director, 32BJ Health Fund

The Problem with Hospital Prices

CORA OPSAHL, 32BJ HEALTH FUND DIRECTOR

Logistics

Restrooms are located to the left of the entrance

Please keep the lobby clear for the 32BJ Union Member Welcome Center

Mask up when in the halls and lobby

Re-check in with Security if you leave the building

“32BJ Overview”

Who is the 32BJ Health Fund?

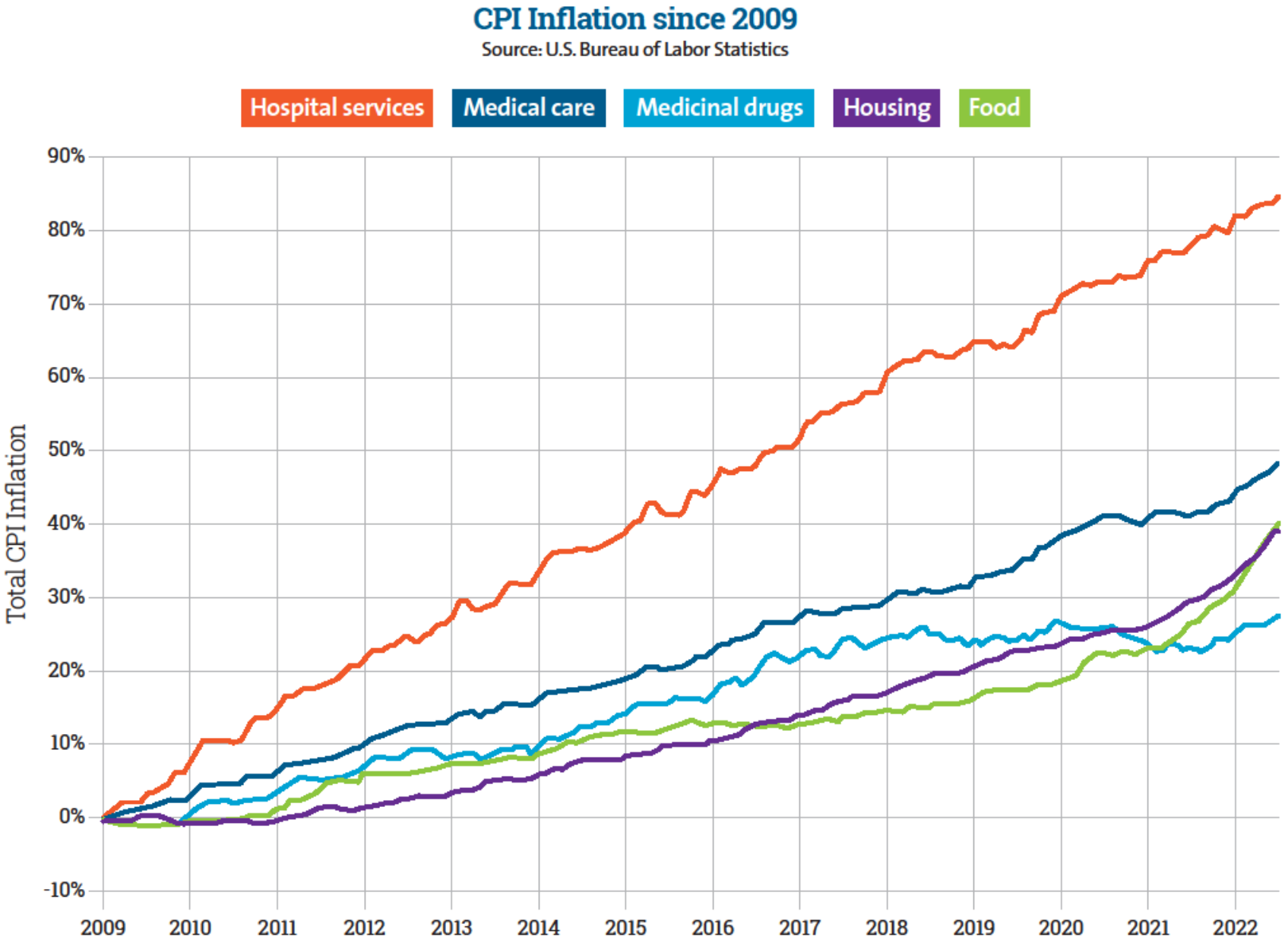
- 32BJ Health Fund is a self-insured, multi-employer plan that provides health benefits to nearly 200,000 union members of 32BJ SEIU and eligible dependents in 11 states and Washington, D.C.

- Union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food services workers, and airport workers

- The Fund is jointly governed by the Union and the Employers, using contributions from 5,000 employers of all sizes to fund health benefits

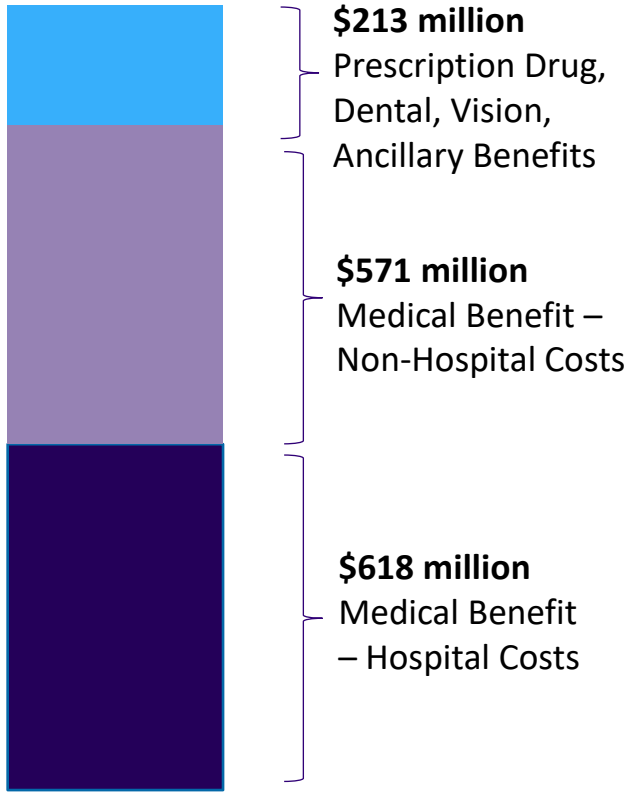
- The Fund provides high-quality health benefits with $0 monthly premiums, $0 in-network deductibles, and low in-network copays

- It is the responsibility of the Fund to solve the problem of healthcare affordability – not our members


CPI Inflation since 2009
Source: U.S. Bureau of Labor Statistics
Hospital services
Medical care
Medicinal drugs
Housing
Food
Total CPI Inflation
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
-10%
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

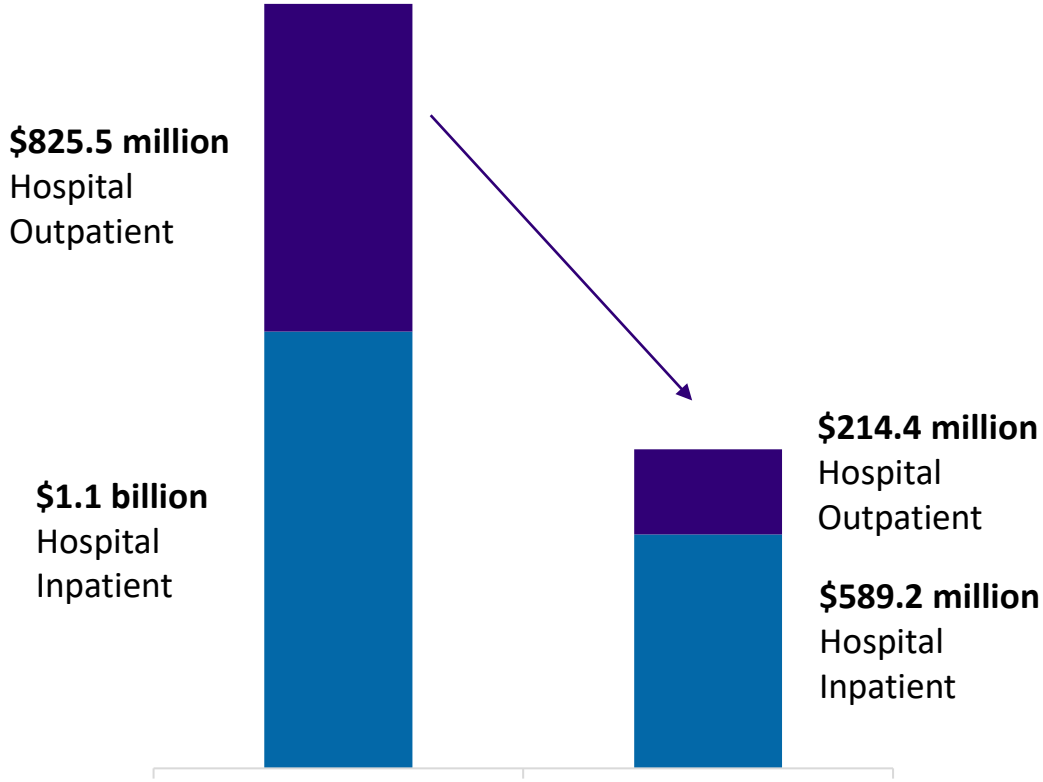
Hospital prices are the largest expense to the Fund

Hospital prices are the #1 driver of cost to the Fund – comprising 44% of the Fund's healthcare costs



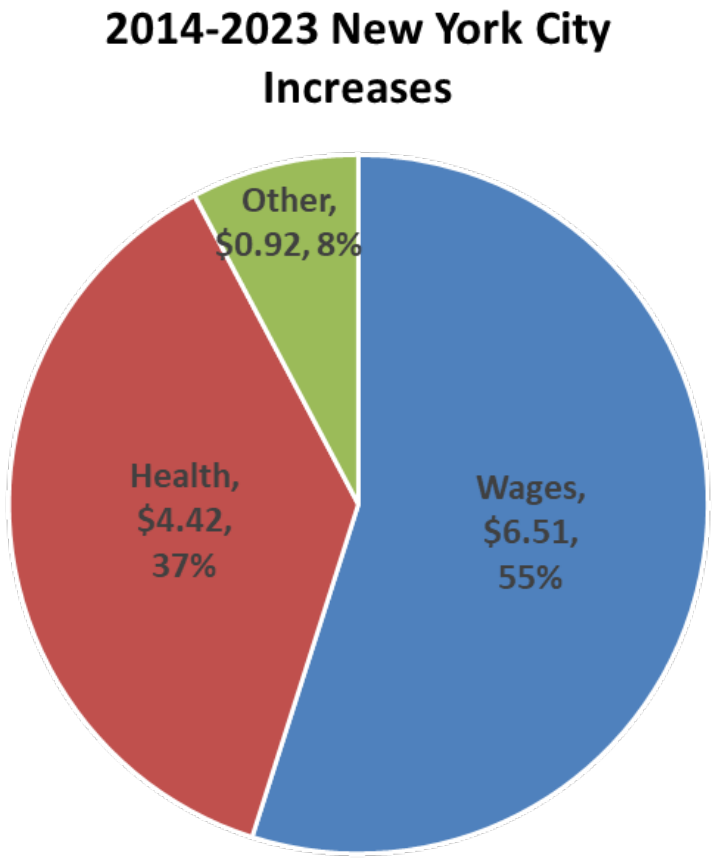
Health Benefit Spending, 2019
Total: $1.4 billion

32BJ Health Fund would have saved $1.1 billion (58%) if it paid Medicare rates for hospital procedures from 2016 to 2019



32BJ Health Fund Medicare Repricing, 2016-2019

Healthcare Is an Ever-increasing Cost for 32BJ



- In 2004, healthcare represented only 17% of total compensation. It is now 37%
- Since 2004, wages have gone up 54% while healthcare costs have increased 230%
- Over the last 10 years, had healthcare spend risen at the same rate as inflation, our members could have had $5,000 more in annual wages

It Begins and Ends with Data

- Receives claims data from all vendors

- Leverages data for all benefit and plan design decisions
  - Medicare compare
  - Hospital compare
  - Procedure bundling and pricing

- Proactively evaluates plan design changes and ways to maximize value

- Utilizes the tools in the marketplace such as Sage, RAND, NASHP, and Turquoise

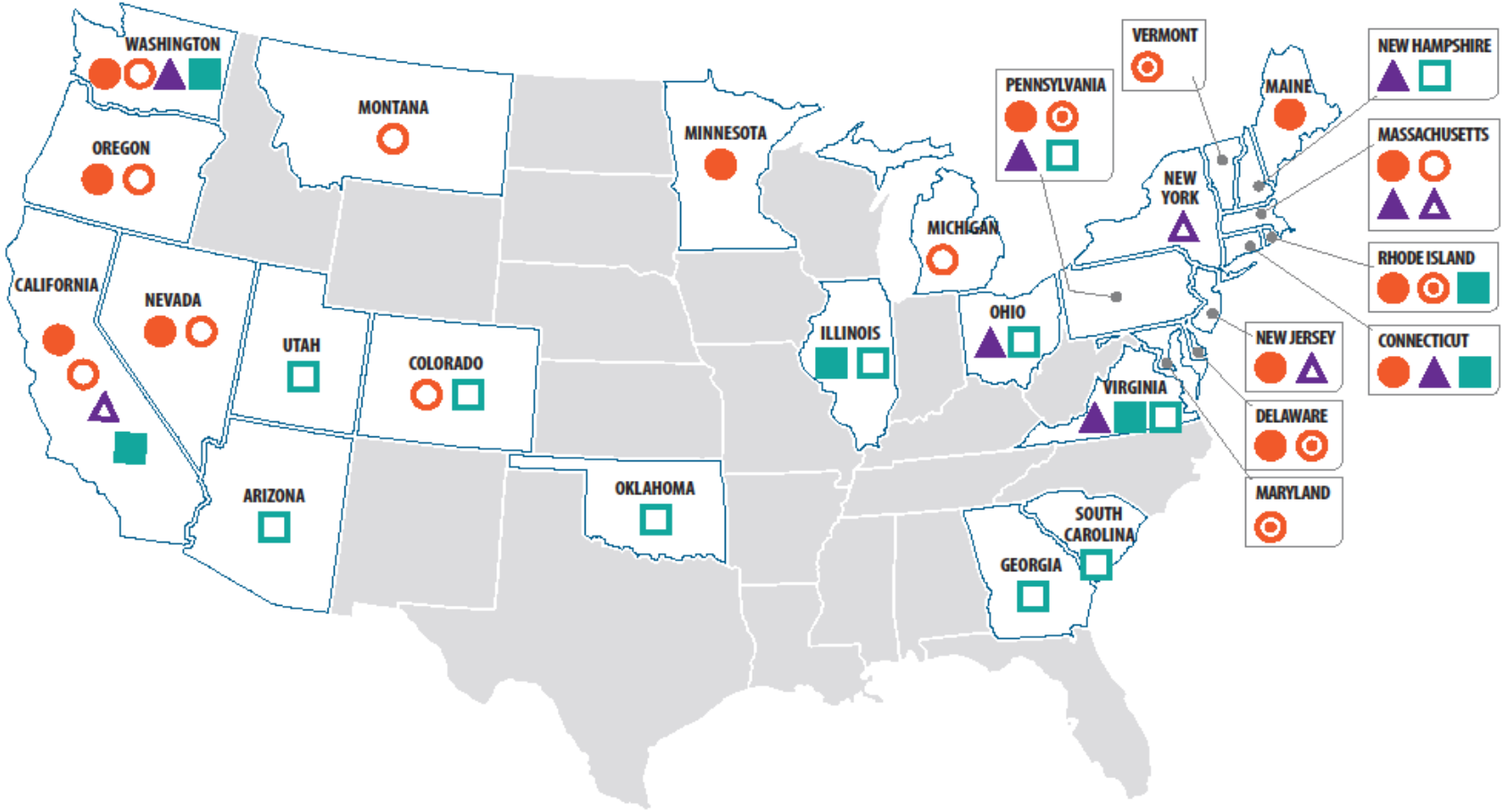
What are you paying?

	NYP Weill Cornell			Mount Sinai Hospital			NYU Langone Tisch			NYC Health and Hospitals Metropolitan		
	Avg Comm. Price	Lowest Comm. Price	Medicare Price	Avg Comm. Price	Lowest Comm. Price	Medicare Price	Avg Comm. Price	Lowest Comm. Price	Medicare Price	Avg Comm Price	Lowest Comm Price	Medicare Price
Inpatient												
C-Section	$30,012	$14,224	$10,153	$17,252	$15,509	$11,093	$34,241	$10,932	$10,979	$13,998	$11,722	$45,451
TJR	$60,361	$30,460	$21,244	$43,546	$33,205	$23,144	$65,308	$22,567	$22,667	$15,360	$15,052	$58,442
Bariatric Surgery	$44,900	$25,600	$17,924	$47,835	$15,783	$19,537	$59,788	$24,896	$19,168	$10,604	$10,597	$54,553
Outpatient												
Breast Biopsy	$ 5,595	$ 2,107	$ 1,732	$ 3,020	$ 2,025	$ 1,732	$ 9,353	$ 2,151	$ 1,732	$ 2,073	$ 1,145	$ 1,732
Colonoscopy	$ 5,588	$ 2,107	$ 1,277	$ 1,995	$ 1,055	$ 1,277	$ 7,330	$ 4,815	$ 1,277	$ 2,267	$ 1,416	$ 1,277

Source: 2021 Commercial Prices, Turquoise Health

Understanding your data and benefit design alone won't bend the cost curve.

State Actions Impacting Commercial Hospital Pricing And Hospital Behavior



Large Scale Payment Reforms
- Cost Growth Benchmark
- Reference Based Pricing
- Other

Health Care Market Reform
- Site Neutral Payment & Facility Fees
- Anticompetitive Contracts

Increasing Hospital Accountability
- Community Benefit
- Price Transparency

“The only way to pay less for healthcare is to pay less for healthcare.”

- DAVID CONTORNO

Let’s kick it off with an easy one:
How should you treat most small cavities?

A Get them filled before they get bigger.

B Brush them really well with a fluoride toothpaste and many will go away.

C Ask the dentist to paint a miracle solution on them that will painlessly stop them in 2 minutes.

What is true about most small cavities

A. Get them filled before they get bigger.

B. Brush them really well with a fluoride toothpaste and many will go away.

C. Ask the dentist to paint a miracle solution on them that will painlessly stop them in 2 minutes.

Most cavities no longer need to be drilled-and-filled…and yet they are

Silver Diamine Fluoride fixes most cavities better than fillings

KHN SHARE THIS STORY:

New Dental Treatment Helps Fill Cavities and Insurance Gaps for Seniors

Silver diamine fluoride, a cavity-stopping liquid that can prevent fillings

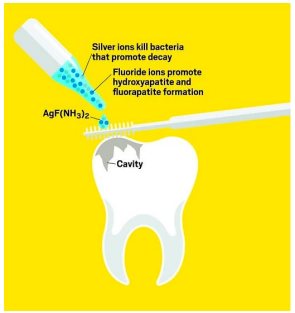
A Cavity-Fighting Liquid Lets Kids Avoid Dentists' Drills

TODAY Silver diamine fluoride can stop tooth decay with one dro SHARE THIS

HEALTH & WELLNESS

Silver diamine fluoride can stop tooth decay with one drop, no drilling required

The treatment is non-invasive and costs a fraction of a traditional filling.



Keynote

Dave Chase, Creator and Co-leader, Health Rosetta

“It Starts with a Dream”

The Future We Choose

March 9, 2016
“Hellth”

March 9, 2031
“Wellth”

Health Sovereignty in Post-Covid Healthcare

INVESTING IN KIDS AND EDUCATION RESTORES THE AMERICAN DREAM.

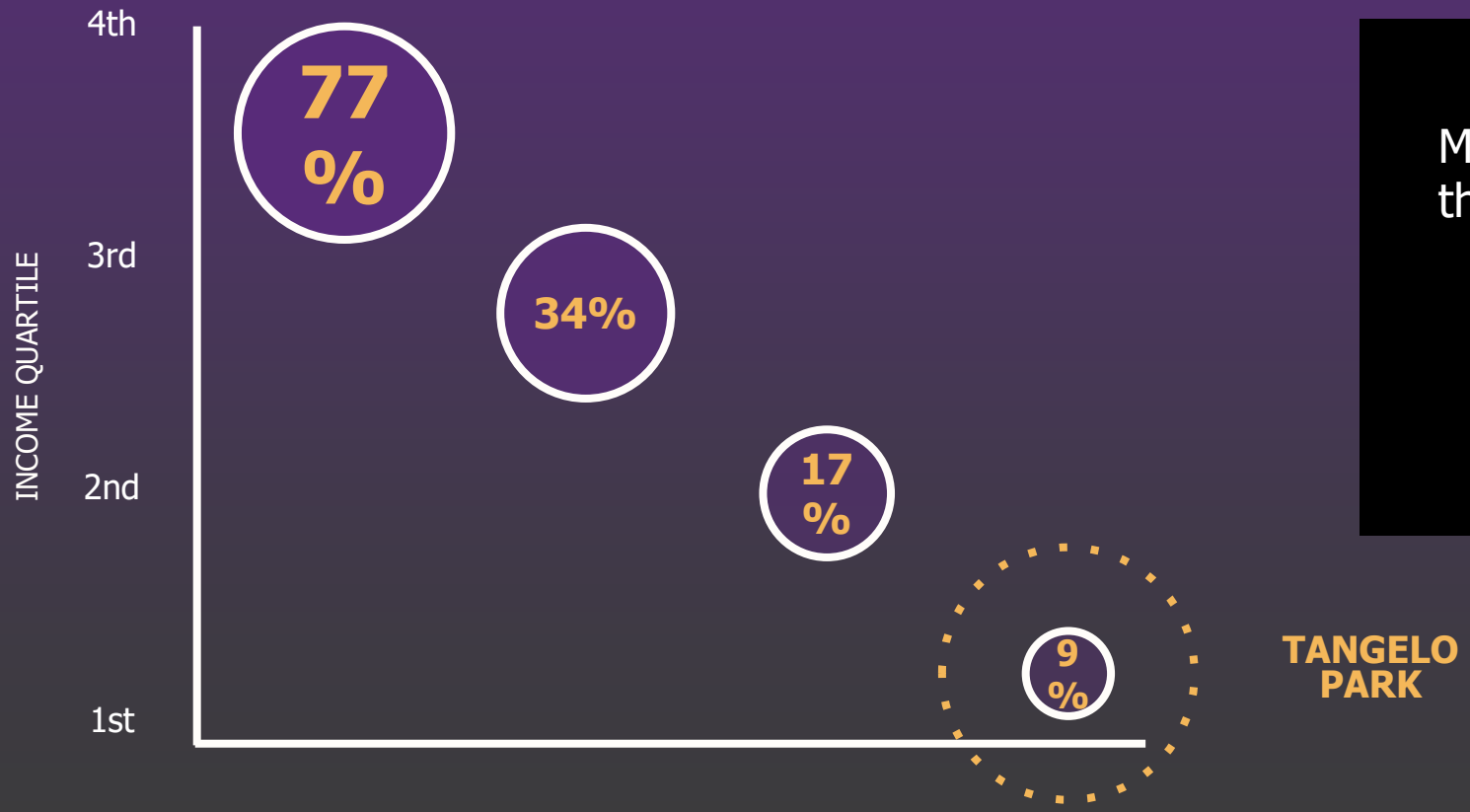
"One thing I quickly learned is that there is as much intellectual talent in the underserved neighborhoods as there is in gated communities. And this investment pays off."

HARRIS ROSEN (Hotelier & Philanthropist funding Tangelo Park Program)

IN THE EARLY 1990s, TANGELO PARK WAS WHERE TOURISTS VISITING ORLANDO AMUSEMENT PARKS WOULD GO IF THEY WERE SEEKING DRUGS.

Similar to Most Low-income Neighborhoods Nationwide, Tangelo Park Was Socioeconomically Underserved and Isolated

Chances of Graduating from College By Income Level



Most of its 3,000 residents fell in the **first income quartile.**

Statistically, children born into these families had a **9% chance of graduating college.**

IN THE EARLY 1990s, TANGELO PARK COMMUNITY MEMBERS WANTED TO TAKE THEIR COMMUNITY BACK TO ENSURE KIDS HAD AN OPPORTUNITY FOR SUCCESS.

The Tangelo Park Program (TPP) Aligns Private, Public, and Community Organizations to Promote Civic Commitment to Children's Educational Success

Quality educational programs that nurture children's developmental, social, and emotional skills.

College scholarships to qualifying graduates of Dr. Phillips and Jones High Schools.

Family support to create parent involvement in their children's education.

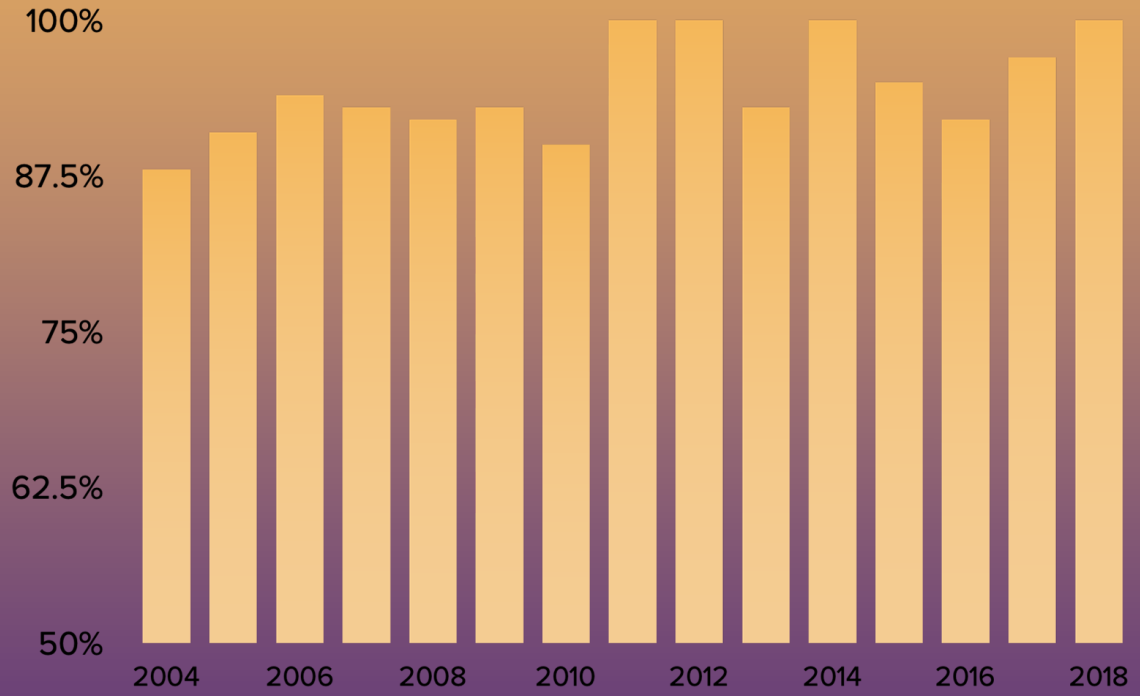
Majority of the programs' preschool students enter elementary school on or above track and demonstrate superior readiness skills.

"This program is drastically different from others because it wraps both arms around the community and says we are here to serve you and help you become the best person you can be….
A lot of these programs, they have only one piece here and one piece there."

– DR. BERNICE KING, DAUGHTER OF MARTIN LUTHER KING, JR.

Since the Start of TPP, the Tangelo Student High School Graduation Rate Has Approached 100%

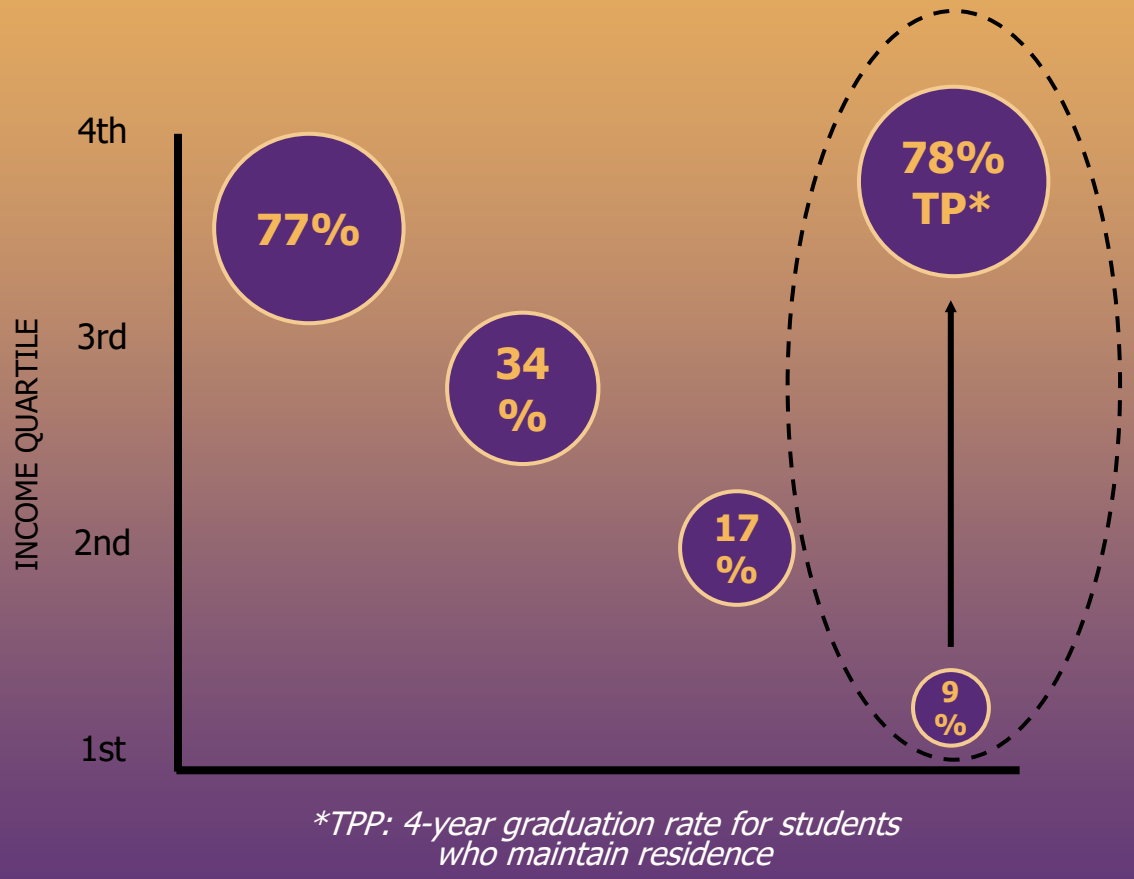
Percentage of Tangelo Students Receiving High School Diplomas



An average increase of approximately 30% over the 1991-93 school years

And Their Likelihood of Graduating College Has Increased by 8x

Chances of Graduating from College By Income Level



**TPP: 4-year graduation rate for students who maintain residence*

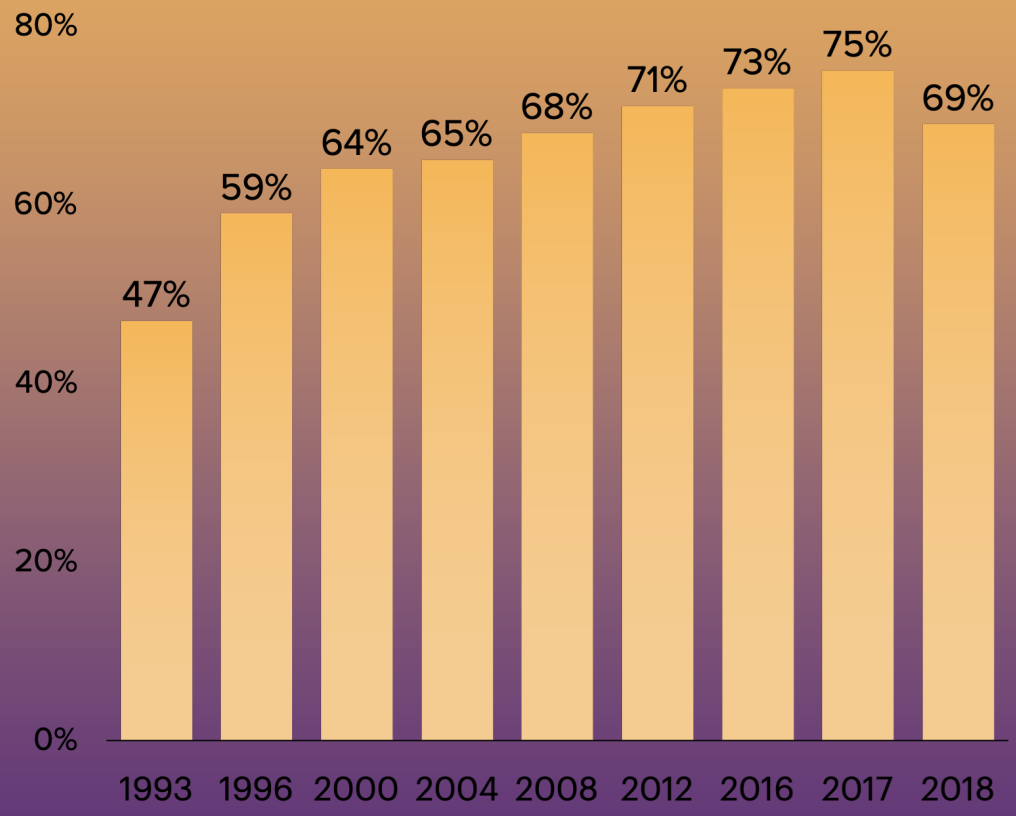
Crime Rates Plummet

Tangelo Park Crime Rates

Estimated savings from a reduction in crime:
$270,000 to $300,000 for the community

Students Who Receive College Scholarships through TPP Graduate Debt Free

Percentage of Bachelor's Recipients with Loan Debt (Nationally)

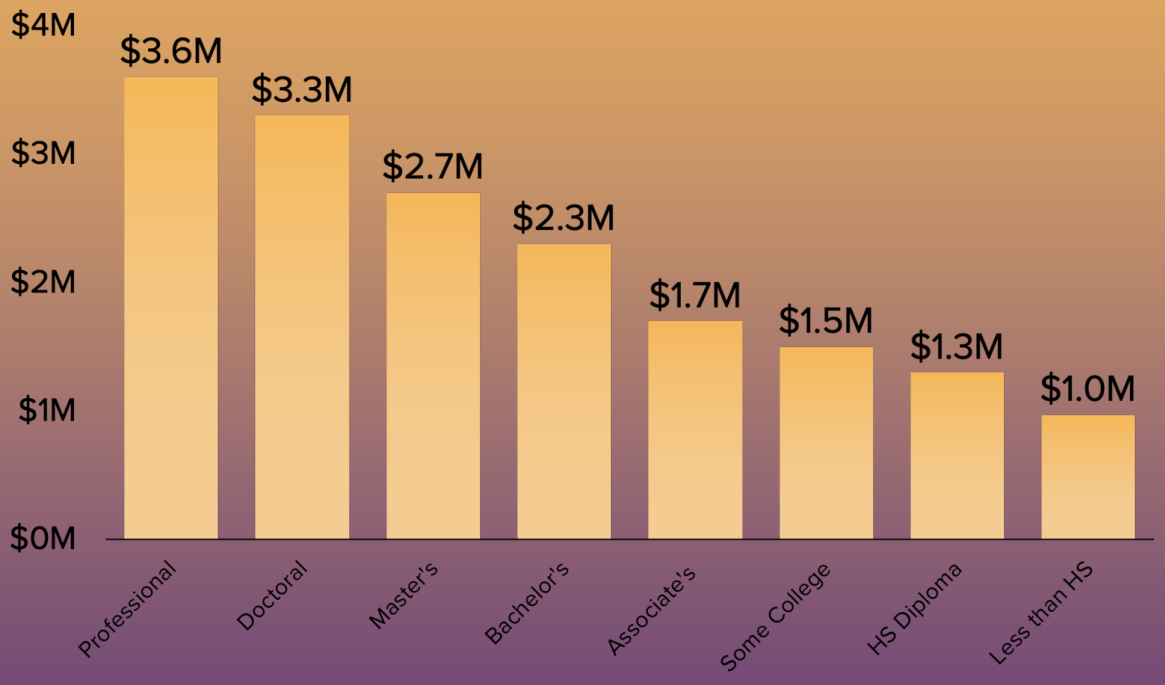


TP Bachelor's Recipients with Loan Debt:

0

Students Who Receive College Scholarships through TPP Graduate Debt Free

Lifetime Earnings Based on Education



Estimations for the increase in the total annual benefit and lifetime earning per student to a cohort of said students are $50,000 and $1.05 million, respectively

Return on investment to society

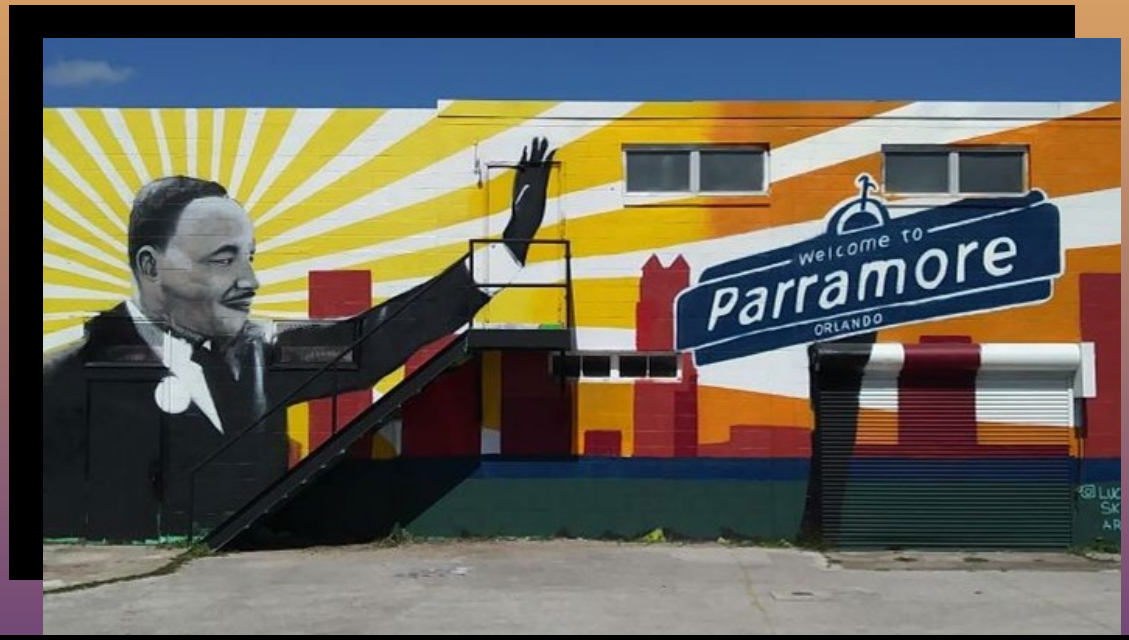
Total 26 Year Investment: $12,807,800

1/2 early childhood programs | 1/2 scholarships

INVESTMENT $1

ROI $7

INSPIRING OTHER COMMUNITIES TO RESTORE THE AMERICAN DREAM.

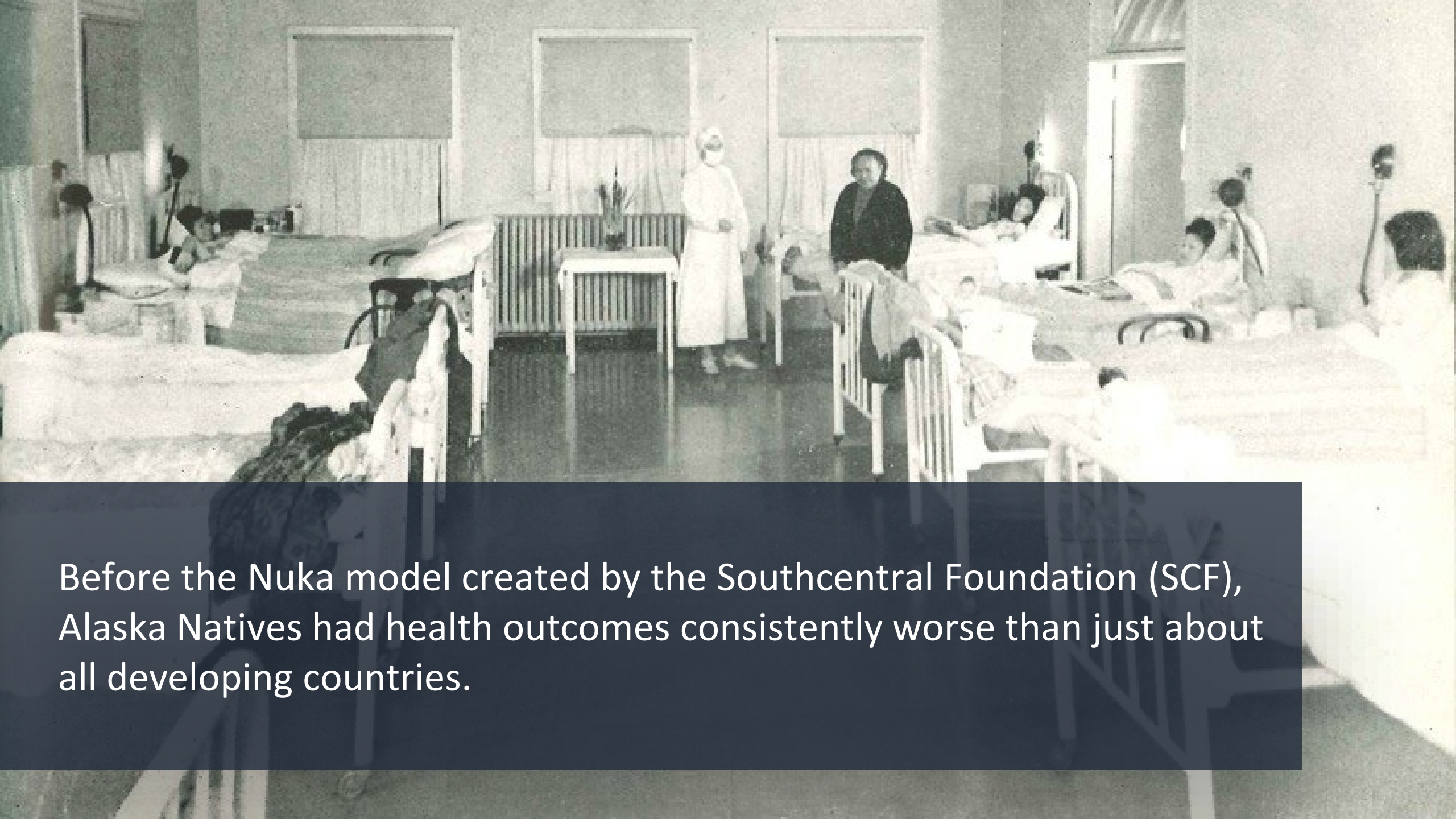


TANGELO PARK'S SUCCESS IS BEING REPLICATED IN SIMILAR LARGER NEIGHBORHOODS IN ORLANDO. WHY NOT IN YOUR COMMUNITY?

NUKA MODEL:
Community-driven Change

"Healthcare isn't who pays for it, it is about who cares."

– Terry Simpson, MD, Southcentral Foundation board member



Before the Nuka model created by the Southcentral Foundation (SCF), Alaska Natives had health outcomes consistently worse than just about all developing countries.

Before the Nuka model created by the Southcentral Foundation (SCF), Alaska Natives had health outcomes consistently worse than just about all developing countries.

In 1998, SCF assumed responsibility for healthcare by taking the following approach:

- They oversaw a total redesign of the healthcare system **literally changing everything**
- They kept the **best of modern medicine** and **melded it with Alaska Native values** and **wisdom of the elders**
- They put the **customer-owner** (formerly known as "patients") in charge at all levels
- They adopted a **no-excuses model to provide care in remote Alaskan villages** with no medical professionals

Stunning Results

ER & Urgent Care	⬇ 50%
Hospital Admissions	⬇ 53%
Specialist Utilization	⬇ 65%
Primary Utilization	⬇ 20%
Percentile in HEDIS* Outcomes	75-90%
Childhood Immunization	93%
Diabetes with 50% of HbA1C Below 7%	
Employee and Customer Satisfaction	90%

*Industry standard measuring healthcare quality

Stunning Results

Increase in high school graduation and college education.

Career opportunities developed in healthcare: **over 50% of the 2300 SCF employees being Alaska Native.** [Previously only one Alaska native on staff.]

Results sustained for more than a decade.

“This is now your healthcare system. You have control over it.”

Alaska Native people have shown, it isn't who pays for the healthcare that impacts results, **health is impacted when we build relationships between caregivers and customers.**

What the customer-owner did not want, what SCF worked hard to make certain of, was that they were simply not going to “manage” what had been done before.

What does local control mean?

It’s not a local governing board answering to a higher authority.

The key is ownership to all who would seek treatment.

Owners don’t make excuses

Serving **65,000 people** over the size of Sweden with **remote villages with no medical professionals and limited access.**

Yet, all their members had access to Covid vaccine via sleds, boats and planes (in the Alaskan winter) by the end of January 2021.


"YOU NEVER CHANGE THINGS BY FIGHTING THE EXISTING REALITY. TO CHANGE SOMETHING, BUILD A NEW MODEL THAT MAKES THE EXISTING MODEL OBSOLETE."
- BUCKMINSTER FULLER

Nuka System: 65,000 Voices

RELOCALIZING HEALTH

5 steps to make health plans local, organic, and sustainable; transforming health plans from the #1 driver of inflation, debt, poverty, and bankruptcy to the top driver of well-being.

L

Learn how to be liberated from the status quo

Mindset shift: Stop accepting 5% to 20% annual cost increases and paying more to get less.

O

Optimize health plan infrastructure

Work with aligned, transparent service providers.

C

Carve out pharmacy benefit manager (PBM)

Save by accessing, understanding and utilizing pharmacy claims data.

A

Advanced primary care

Prevent avoidable hospitalizations. Reduce downstream costs and offer a better and more proactive care experience.

L

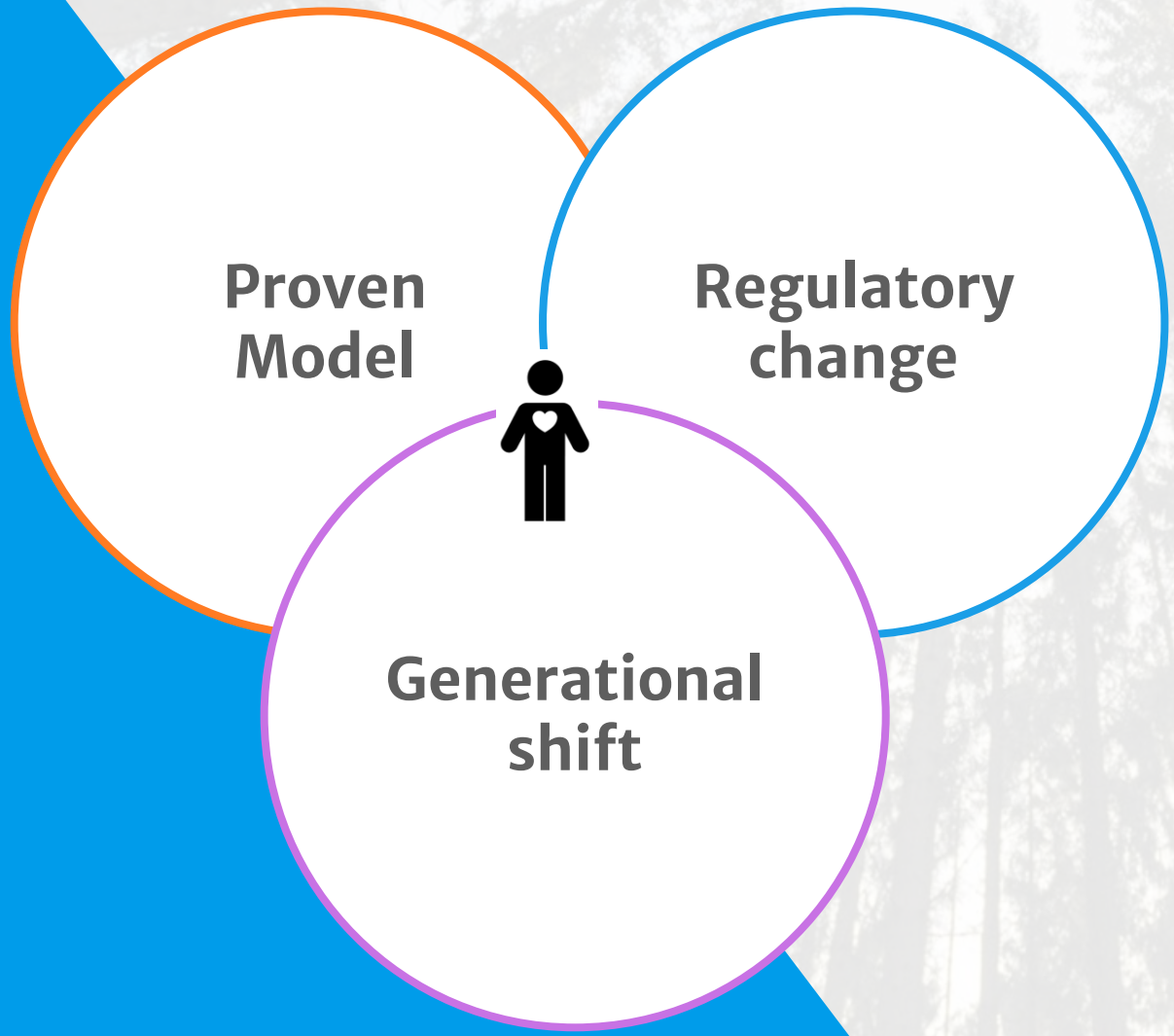
Leave behind value-extracting PPO networks

Average PPO network pricing is 260% of Medicare rates — you're not saving money.

hr Health Rosetta

Long Overdue Shift is Upon Us

WHY NOW

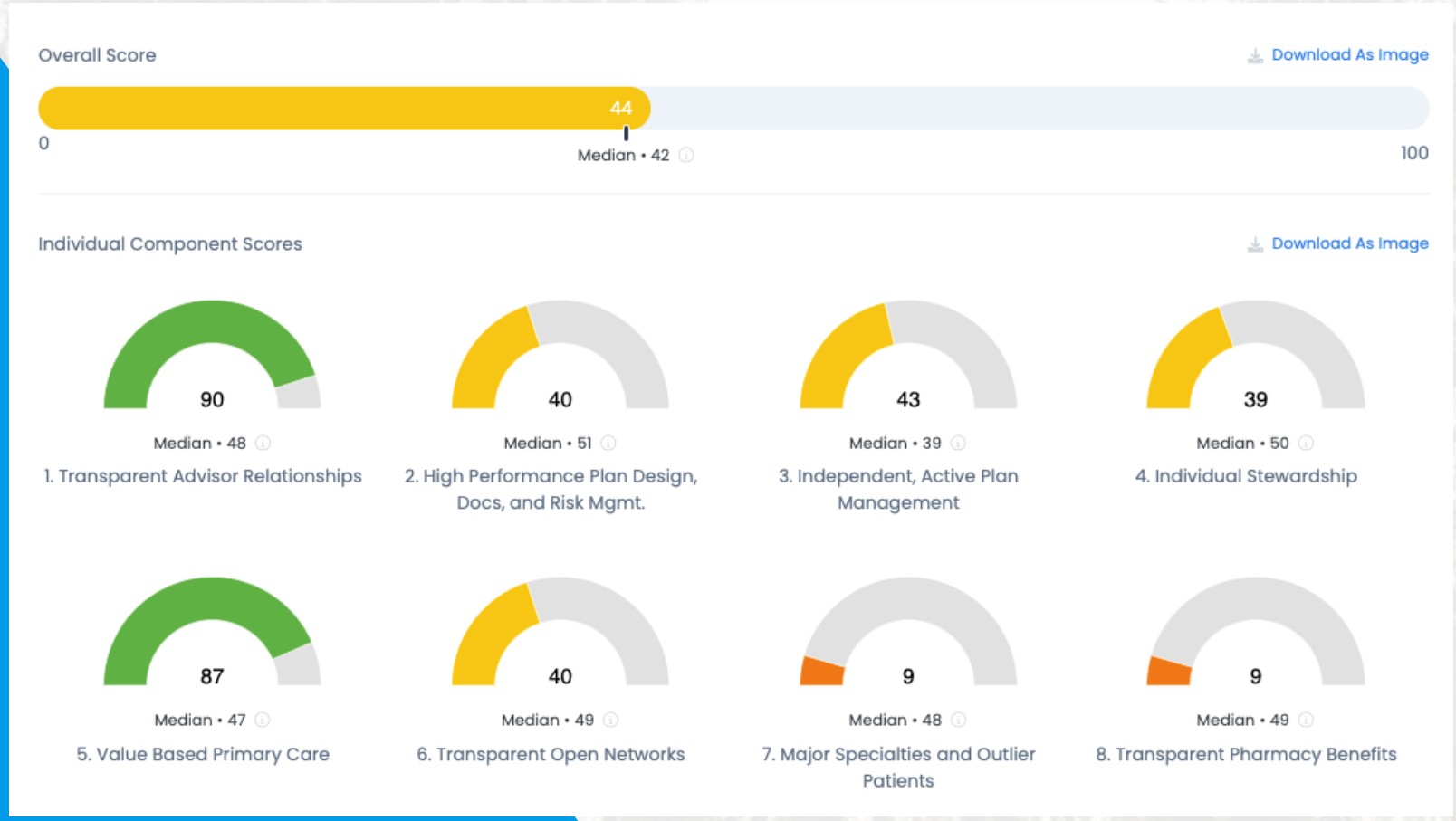


Why now?

- Regulatory: Largest change in employee health plans since 1943 & corporate governance since 2002
- Generational: Vast majority of workforce millennials, Xers & Z with different demands
- Model: Health Rosetta Advisor program already reaches 5M+ lives. Grassroots model drives word of mouth. No need for billboards, stadium sponsorship, or TV ads

THE PRODUCT

Plan Grader: Diagnoses Health Plans + Prescribes Proven Fixes



Informed by the foremost experts in high-performance health plans stewarding > 5 million lives, Health Rosetta scores the 40 most important attributes of a vibrant health plan. Health Rosetta model transforms the "prescription" into saved lives & dollars.

The First Objective Measure for $2 Trillion of Spending

WHAT'S POSSIBLE WITH COHPs

WORLD CLASS ORGS GAIN COMPETITIVE ADVANTAGE

SAVINGS
Savings go to enhanced pay and profit-sharing

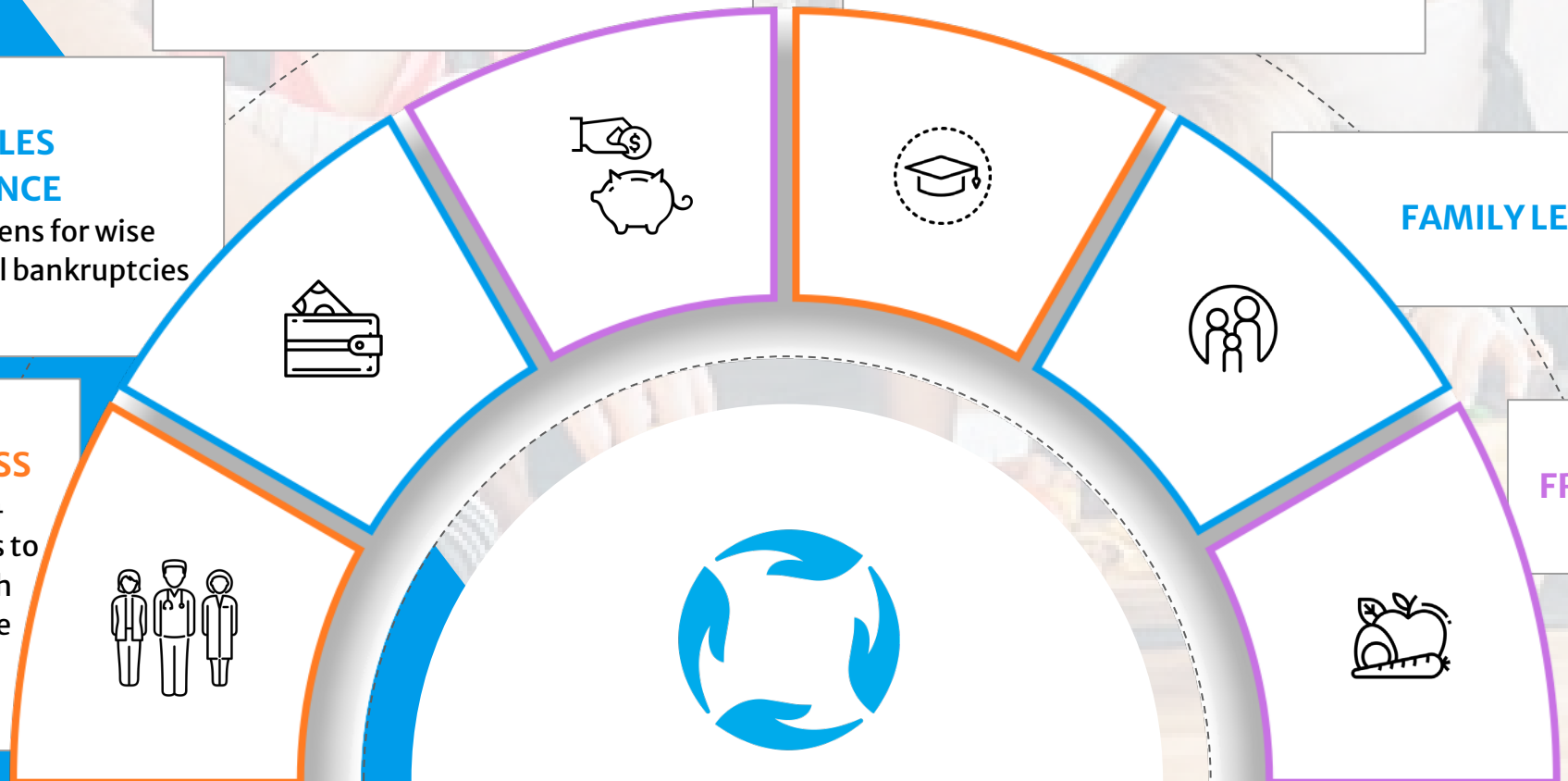
EDUCATION
Funded college & continuing education for employee AND children

NO DEDUCTIBLES
NO COINSURANCE
Removing financial burdens for wise decisions means no medical bankruptcies

FAMILY LEAVE

PRIMARY CARE ACCESS
Employer provides 7x24 primary care access, access to world class hospitals with transparent quality/price info

FREE, HEALTHY MEALS



SAFE HARBOR PLEDGE ENSURES TRANSPARENCY & OPENNESS

WE HEREBY PLEDGE TO ADHERE TO THE FOLLOWING PRACTICES TO ENSURE A FAIR ARRANGEMENT FOR ALL PARTIES INVOLVED IN THE CARE WE DELIVER:

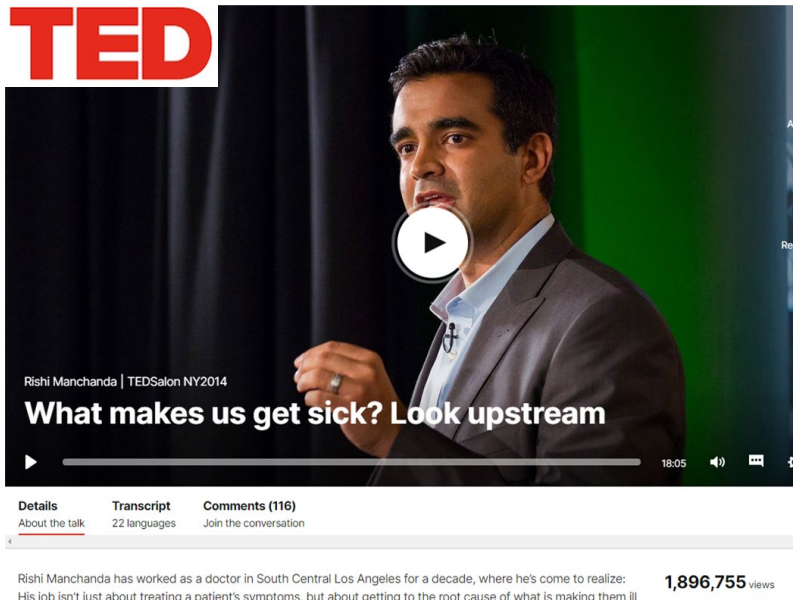
- Transparent, bundled prices
- Transparent infection rates
- Transparent safety culture
- Shared Risk (Warranty)
- Right Care
- Data Liquidity (for purchasers & patients)
- Ease of use and administration
- No clinician retaliation and intimidation
- No predatory billing (surprise bills, patient lawsuits)

WHAT CAN WE LEARN FROM **FIRE DEPARTMENTS?**

- **Locally funded and governed** fire departments are integral members of their community
- Fire department leaders are longstanding, deeply **committed to their community**
- Where necessary, there is **national coordination** on issues such as natural disasters and terrorist threats
- Fire departments have to manage to a **budget determined by locally accountable leaders**
- Fire departments play an **important role in urban/community design** without holding overall responsibility
- Collaboration between fire departments including **training each other in an open-source manner** benefits all

WHAT IF WE VIEWED **EVERY HOSPITALIZATION AS A FAILURE?**

INVITE AVIATION-LEVEL SCRUTINY TO MAINTAIN HIGHEST QUALITY & GAIN MARKETING ADVANTAGE



- **Radical transparency** on sentinel events but don't stop there…
- **Open doors** to academic studies (clinical, financial, operational, cultural)
- Shift from old school **blaming/shaming/cloaking culture to root cause analysis** (Linus's law: "Given enough eyeballs, all bugs are shallow") of infections, complications, etc.
- **Community benefit redefinition**: Community health workers (CHW) track psychosocial facets driving hospitalizations (interview opted-in patients/families); prenatal/elder care education; CHWs are disaster-ready workforce (e.g., Covid-19 contact tracer, future community health challenges)

HEALTH ROSETTA'S LAW: THE GREATER THE TRANSPARENCY, THE GREATER THE QUADRUPLE AIM ACHIEVEMENT

THE CASE FOR **OPEN-SOURCING HOSPITAL OPERATIONS & FINANCES**

INTERNAL PROCESSES ARE STRANDED VALUE IN CONVENTIONAL HOSPITALS

Proprietary & defensible value is irreplaceable relationships (employer & patient)

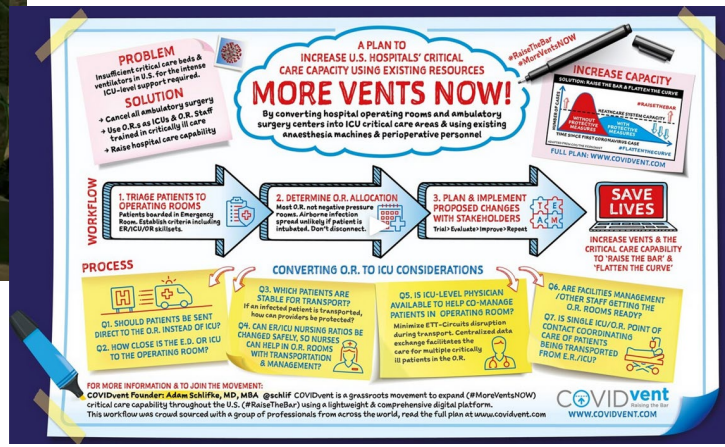
Traditional hospitals' most important relationship is with carriers (not patients or employers)

- Magnet for outside improvements & talent
- Faster & more meaningful innovation feedback loops
- Creates "antibodies" for losing focus & selling out to make a quick buck

Open source ICU developed in 4 weeks for Covid-19 to expand capacity

ER costs reduced 100-fold;
ER access increased 1000-fold

Recent open-source examples



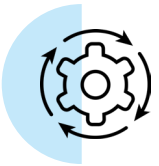
Covid-19 catalyzes OR ⇒ ICU conversion

CURRENT NORMS **PREVENT EFFECTIVELY TACKLING HOSPITAL COSTS & QUALITY**

Revenue cycle billing processes = complexity + oligopolistic pricing

Limits direct employer/patient relationships

Financial Engineering



Bureaucratization continues to advance administrative FTE creep

Conflicts of interest between
+Hospitals/carriers
+Hospital/vendors
+Hospitals/physicians
=artificially inflated cost of care

Federal payor requirements are well-intentioned but miss the mark

CHANGE CAN HAPPEN QUICKER THAN MOST THINK

Easter morning 1913: 5th Ave, New York City.
Spot the horse.

"Out of darkness is born the light."
– St. Catherine of Siena

The Future We Choose

March 9, 2016

March 9, 2031

Appendix

STATUS QUO PLANS VS. COHPS

	STATUS QUO Plans	COMMUNITY-OWNED
PLAN DESIGN ETHOS	One-size-fits-all built for communicable disease era & acute care	Purpose-built for chronic disease era where lifestyle drives health outcomes
SUCCESS DEFINED BY	Pleasing Wall Street	Improved health outcomes & reduced waste
USE OF PROFITS	Taken OUT of communities	Reinvested into communities*
IMPACT	Highest costs & worst outcomes in developed world	Lower costs Superior outcomes

*Community determines use of Health Rosetta Dividend -- we recommend investing in community assets including better jobs/pay, education, public health, & physical environment (e.g., clean water)

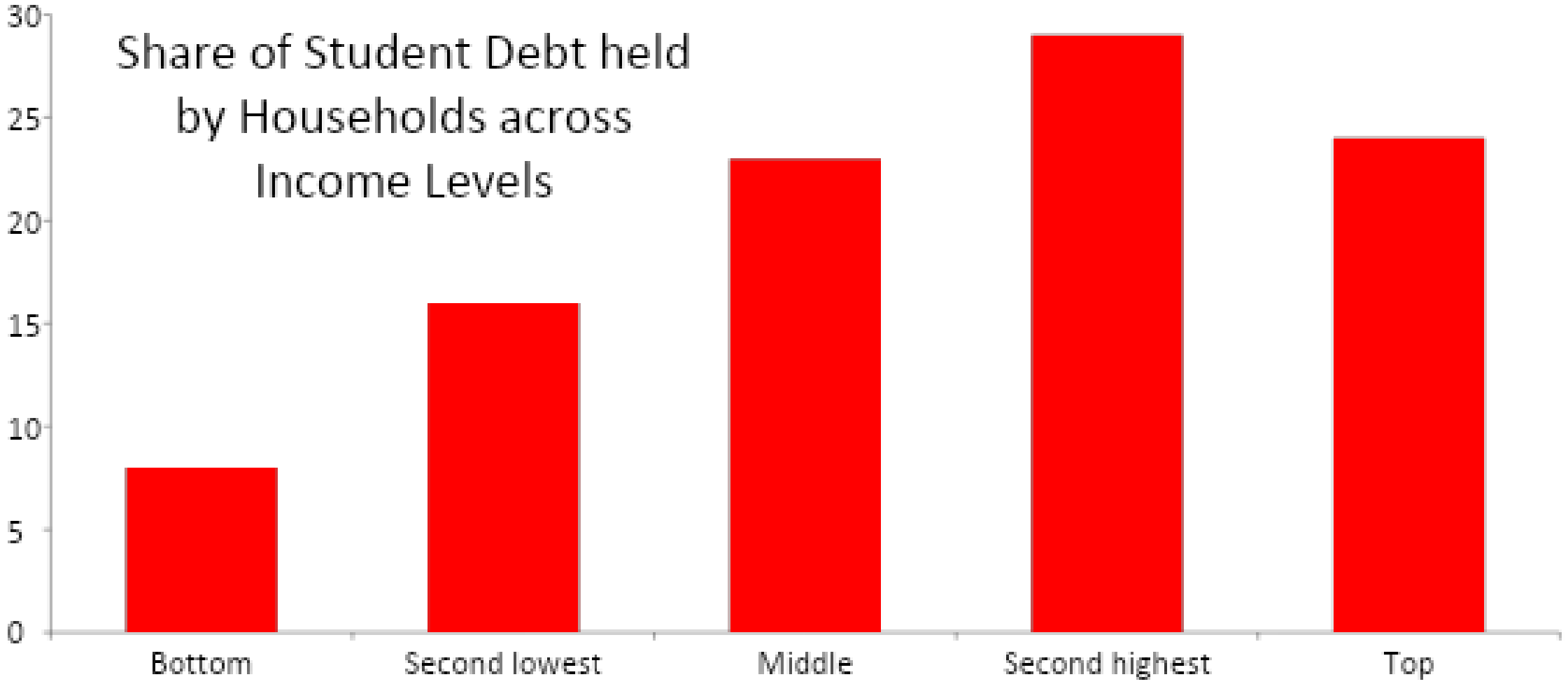
Tangelo Park PROGRAM

Student Debt

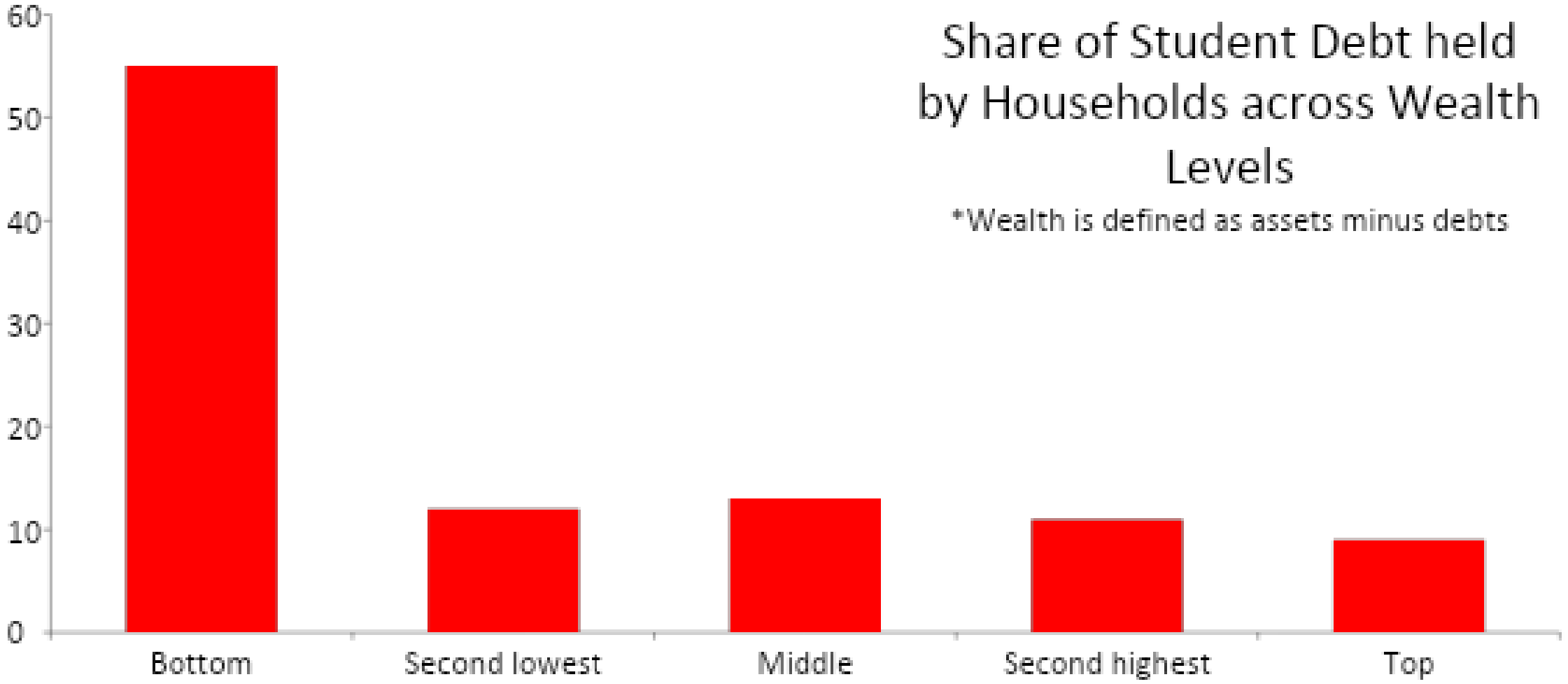
- Total US Student Debt [12] (2020): $1.56 trillion

If student debt in the United States was a Gross Domestic Product it would be the 13th largest economy in the world (Silver, 2020).

Tangelo Park
PROGRAM

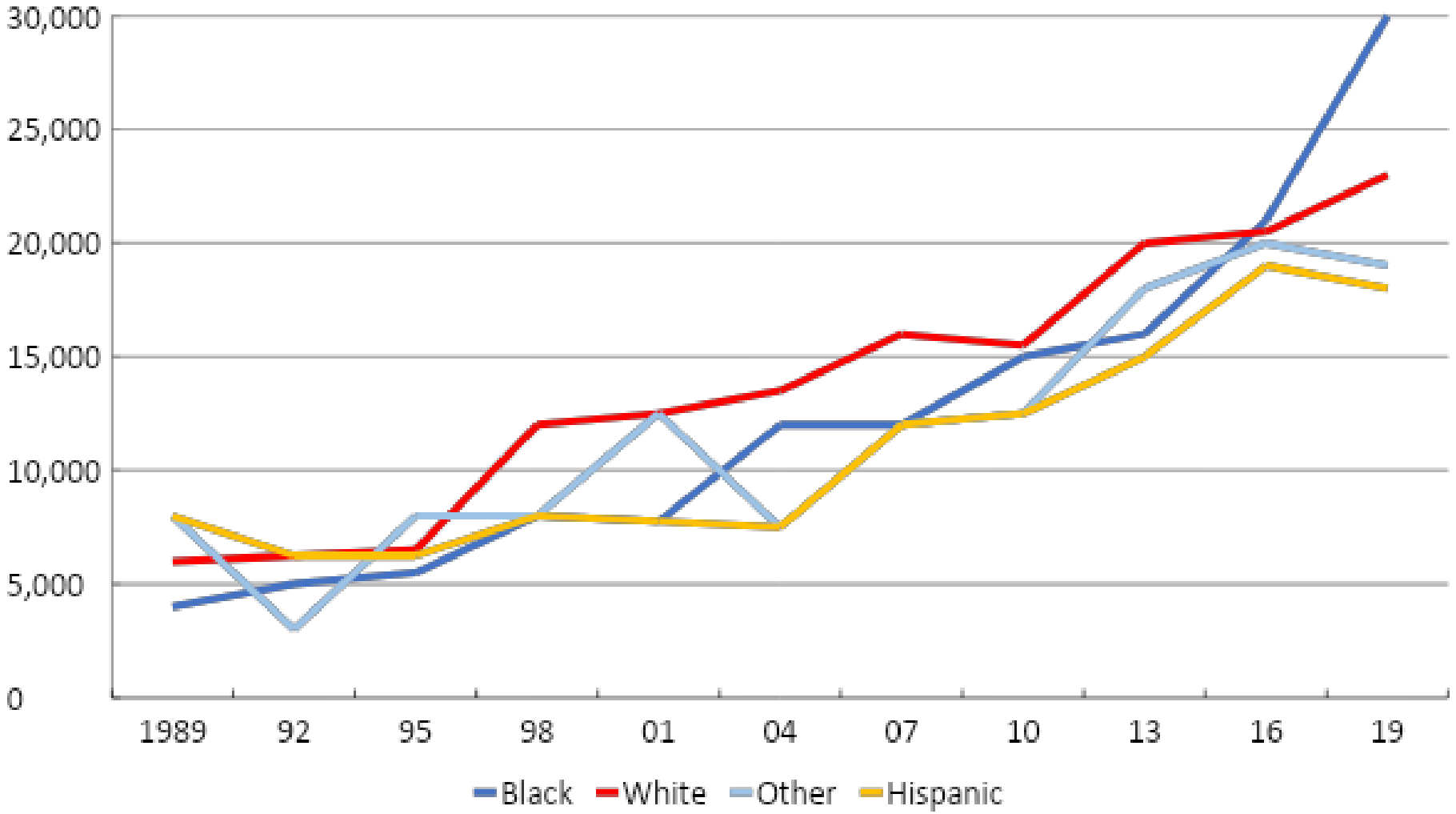


Tangelo Park
PROGRAM



Tangelo Park PROGRAM

Median Student Debt



Tangelo Park PROGRAM

Median Student Debt Snapshot: % Change From 2016-2019

Tangelo Park PROGRAM

References

- Silver, C. (2020). The Top 20 Economies in the World: Ranking the Richest Countries in the World. *Investopedia.* Retrieved from https://www.investopedia.com/insights/worlds-top-economies/

Morning Break

Which common high-cost events are most effectively addressed with employee screening and coaching programs?

A Premature births

B Heart attacks

C Lung cancers

D Diabetes admissions

Which common high-cost events are most effectively reduced with employee screening and coaching programs?

A Premature births

B Heart attacks

C Lung cancers

D Diabetes admissions

1.	470	Major joint replacement or reattachment of lower extremity w/o mcc
2.	775	Vaginal delivery w/o complicating diagnoses
3.	460	Spinal fusion except cervical w/o mcc
4.	3	Ecmo or trach w mv 96+ hrs or pdx exc face, mouth & neck w maj O.R.
5.	790	Extreme immaturity or respiratory distress syndrome, neonate
6.	766	Cesarean section w/o cc/mcc
7.	247	Perc cardiovasc proc w drug-eluting stent w/o mcc
8.	885	Psychoses
9.	765	Cesarean section w cc/mcc
10.	871	Septicemia or severe sepsis w/o mv 96+ hours w mcc
11.	795	Normal newborn
12.	392	Esophagitis, gastroent & misc digest disorders w/o mcc
13.	330	Major small & large bowel procedures w cc
14.	743	Uterine & adnexa proc for non-malignancy w/o cc/mcc
15.	621	O.R. procedures for obesity w/o cc/mcc
16.	473	Cervical spinal fusion w/o cc/mcc
17.	853	Infectious & parasitic diseases w O.R. procedure w mcc
18.	945	Rehabilitation w cc/mcc
19.	329	Major small & large bowel procedures w mcc
20.	791	Prematurity w major problems
21.	4	Trach w mv 96+ hrs or pdx exc face, mouth & neck w/o maj O.R.
22.	774	Vaginal delivery w complicating diagnoses
23.	25	Craniotomy & endovascular intracranial procedures w mcc
24.	793	Full term neonate w major problems
25.	234	Coronary bypass w cardiac cath w/o mcc

8 of the Top 25 hospital inpatient expenses are:

Birth events

Walking the talk with maternity: Typical top 10 highest-cost claims can include 3 neonates!

Morning Panel

Policy and Regulatory Approaches Pursued by State and Local Governments

Christopher Whaley PhD, Economist, RAND Corporation

RAND Hospital Price Transparency Project

32BJ Health Fund Fall Conference

Study funding provided by Robert Wood Johnson Foundation and participating employers

RAND CORPORATION

September 2022

Christopher Whaley | cwhaley@rand.org

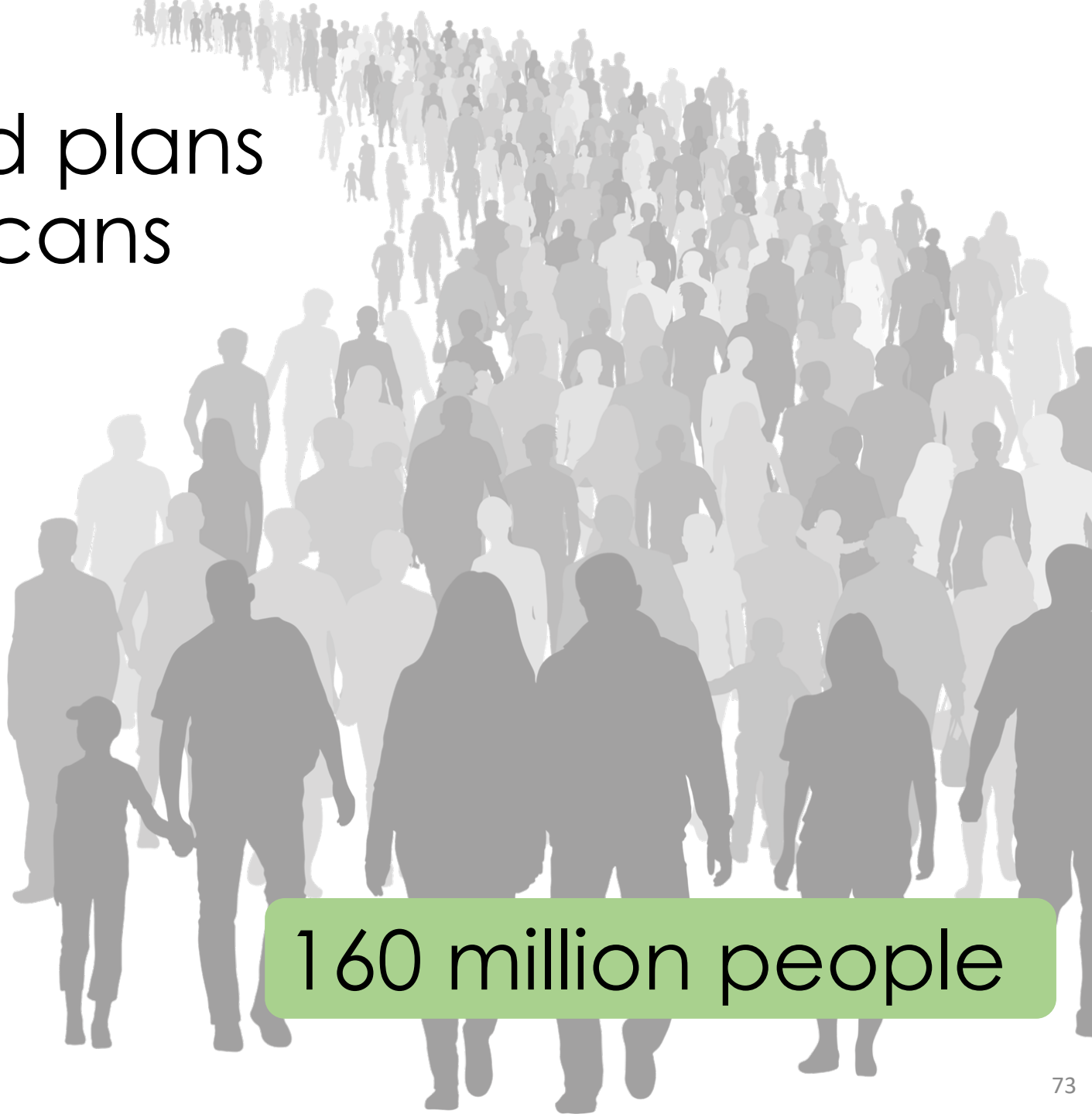
Employer-sponsored plans cover half of Americans

$1.2 trillion

health care costs in 2018

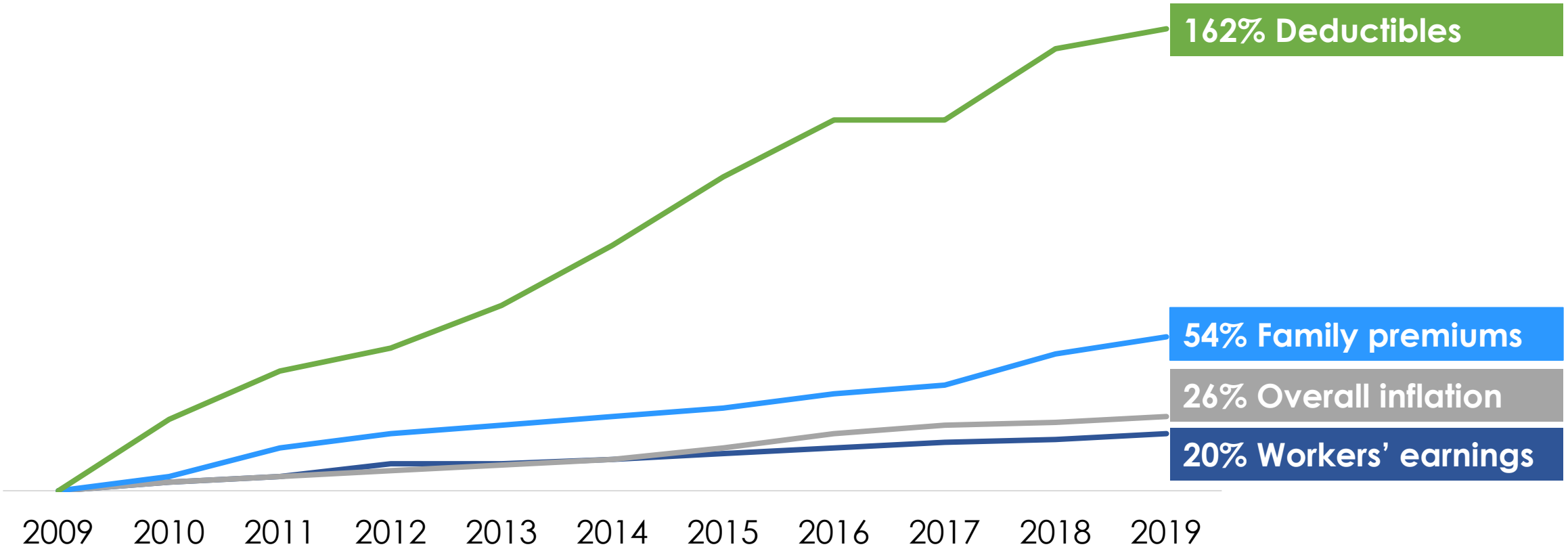
$480 billion

hospital costs in 2018



160 million people

Over the past decade, premiums and deductibles have outpaced wages



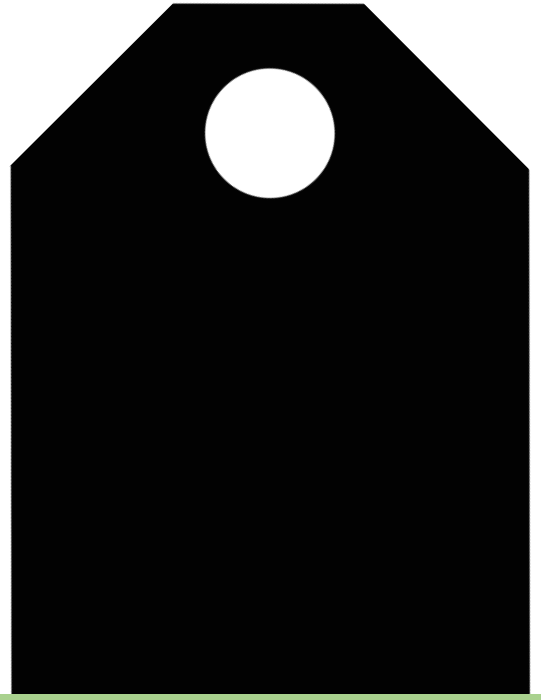
SOURCE: Kaiser Family Foundation. (2019) Health Benefits Survey

Self-funded purchasers have a fiduciary responsibility to monitor health care prices

> Fiduciaries have a responsibility to "act solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them."
>
> —Department of Labor

How can self-funded plans fulfill fiduciary obligations without knowing prices?

Why did RAND undertake this study?



- We do not know what the "right" price is for hospital care
- Self-funded employers and purchasers cannot act as responsible fiduciaries for their employees without price information

Employers and purchasers can use the information in this report—together with knowledge of their own employee populations—to decide if the prices they and their employees are paying align with value

RAND 4.0

Obtain claims data from

- self-funded employers
- APCDs
- health plans

Measure prices in two ways

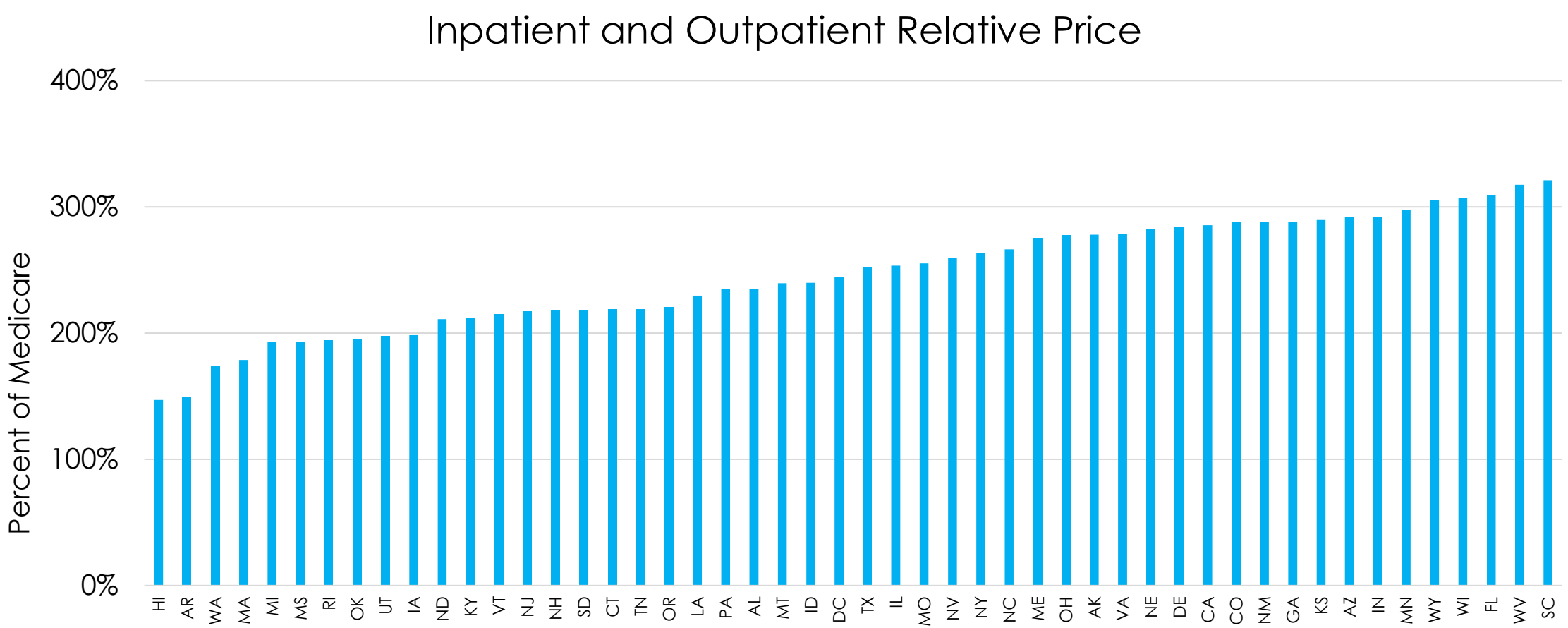
- relative to a Medicare benchmark
- price per case-mix weight

Create a *public* hospital price report

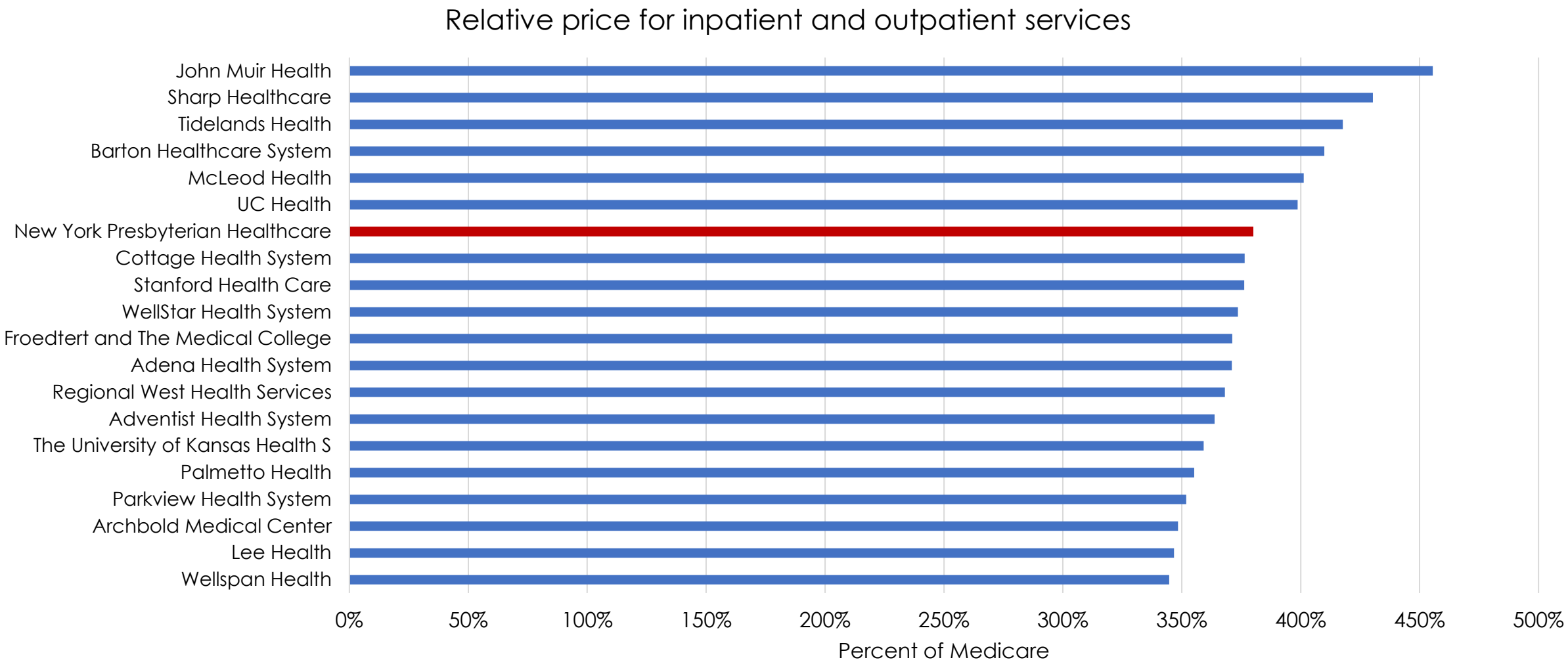
- posted online, downloadable
- named facilities & systems
- inpatient prices & outpatient prices

Create *private* hospital price reports for self-funded employers

Relative prices vary widely



Top 20 highest-priced hospital systems



How can purchasers and policymakers use price transparency?

Purchasers are collecting information about prices

- The Colorado Business Group on Health used RAND 2.0 data to produce a report on value of Colorado hospitals
- The report proposed options for Colorado employers to address prices in their specific markets

Purchasers are using data to benchmark prices

Modern Healthcare

Self-insured employers go looking for value-based deals

> A similar RAND study commissioned by self-insured employers in Indiana spurred action…In response, 12 self-insured companies asked Anthem Blue Cross and Blue Shield to develop new health plan options.

*Harris Meyer (2020) "**Self-insured employers go looking for value-based deals**" Modern Healthcare*

And they're citing our study in their negotiations

The New York Times

Many Hospitals Charge Double or Even Triple What Medicare Would Pay

The Journal Gazette

Insurer pushes Parkview on costs

Says charges too high, citing study hospital calls unfair

> Anthem is attempting to support a core goal of the RAND study by holding hospital systems accountable for their prices, which in turn will benefit our employees' mental and physical health and their financial wellness.
>
> ***—Purdue Senior Director of Benefits***

Conclusions

Rising healthcare costs place pressure on employers and worker wages—especially during the COVID-19 pandemic

The wide variation in hospital prices presents a potential savings opportunity for employers and purchasers

Employers and purchasers need to demand and use transparent information on the prices they—and their workers—are paying

Christopher Whaley
cwhaley@rand.org

Vikas Saini MD, President, Lown Institute

Are NYC nonprofit hospitals earning their tax breaks?

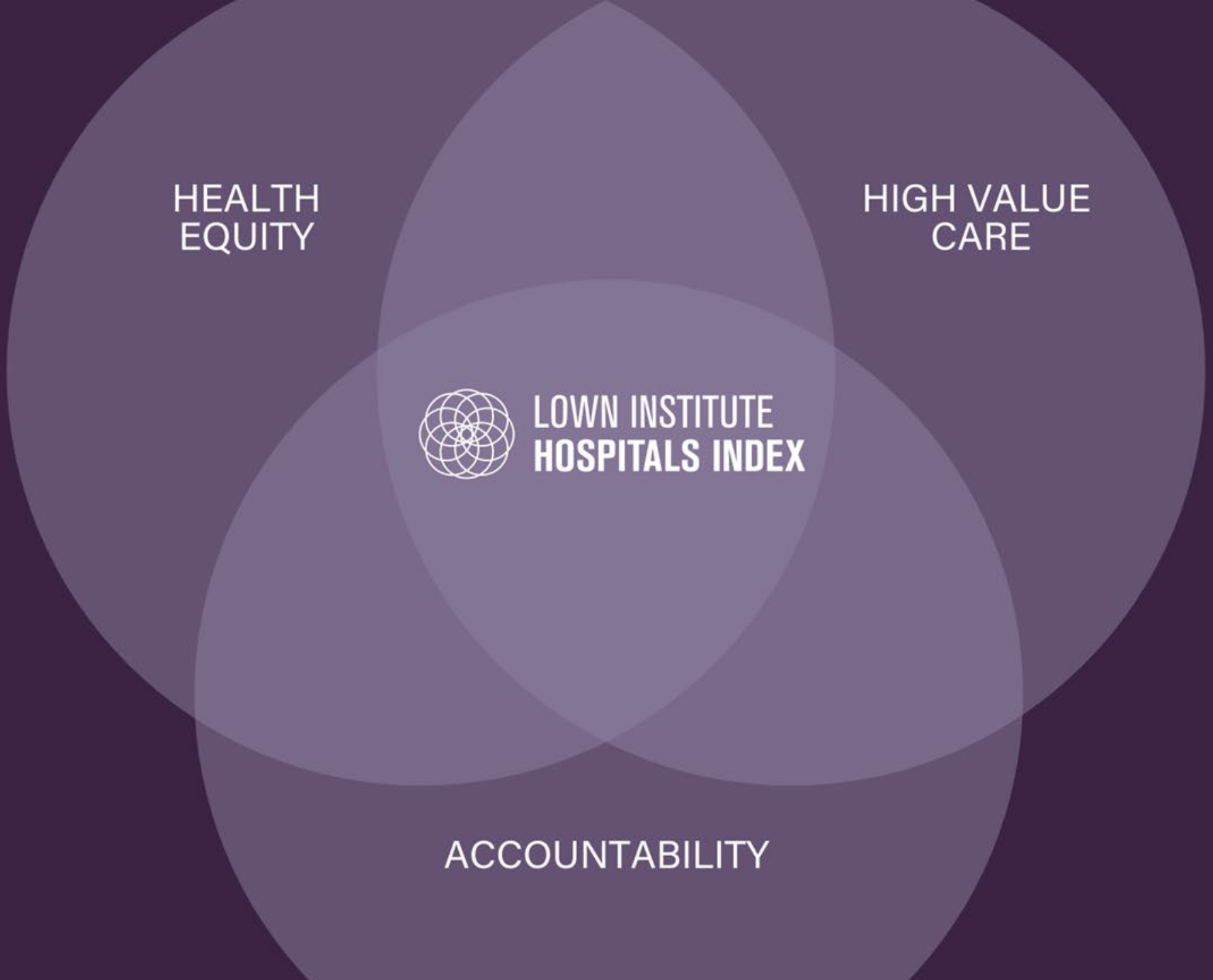
Dr. Vikas Saini
President, Lown Institute

32BJ Health Fund Fall Conference
September 22, 2022

DR. BERNARD LOWN, MD

- Nobel Peace Prize, 1985
- Defibrillator and cardioverter
- World renowned Harvard cardiologist
- Expelled from JHU for desegregating bloodbank
- Founded LI, 1973

LOWN INSTITUTE
HOSPITALS INDEX
for SOCIAL RESPONSIBILITY


HEALTH
EQUITY
HIGH VALUE
CARE
LOWN INSTITUTE
HOSPITALS INDEX
ACCOUNTABILITY

www.LownHospitalsIndex.org

LOWN INSTITUTE HOSPITALS INDEX FOR SOCIAL RESPONSIBILITY

EQUITY

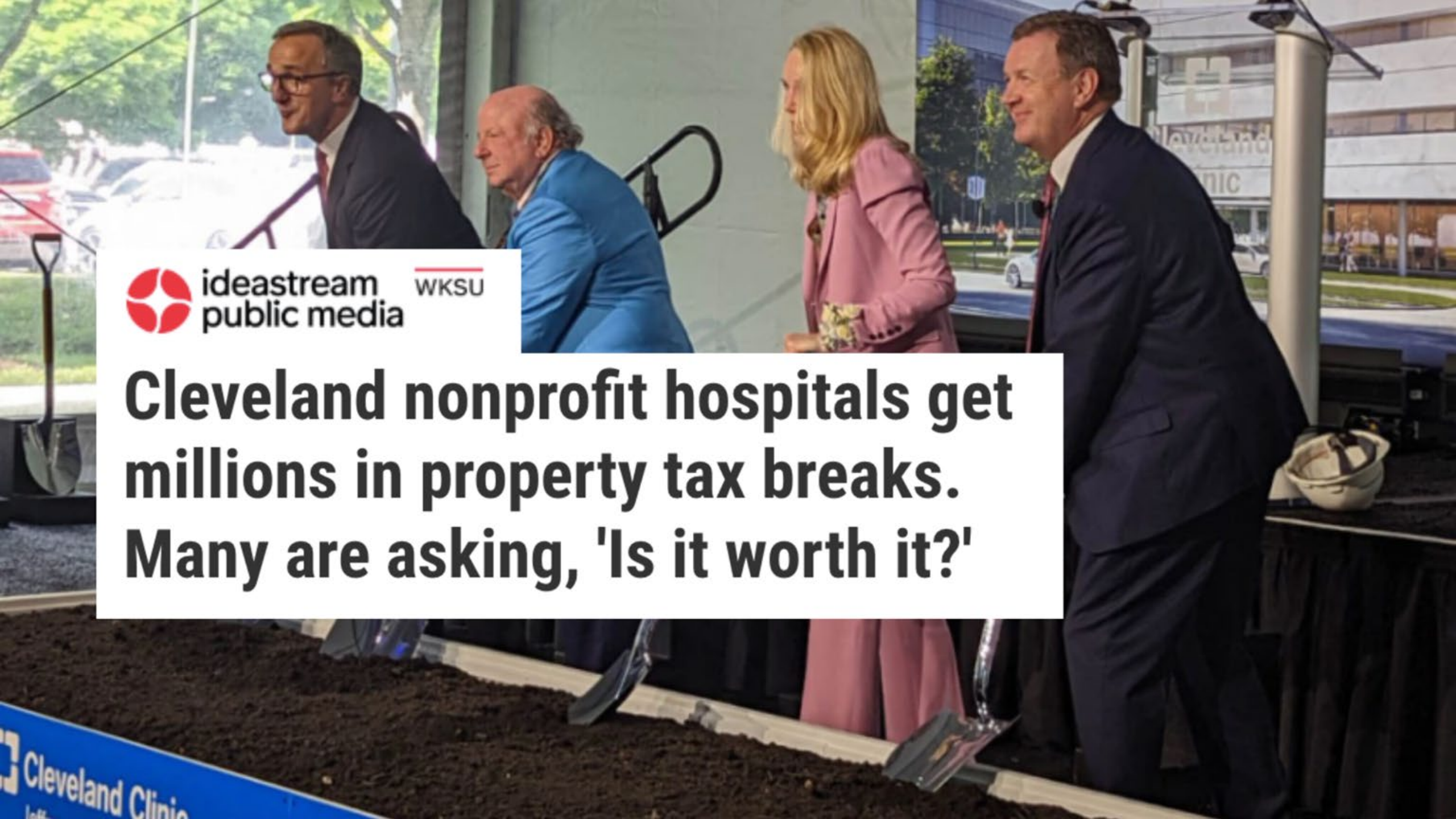
- INCLUSIVITY
- PAY EQUITY
- COMMUNITY BENEFIT

VALUE

- COST EFFICIENCY
- AVOIDING OVERUSE

OUTCOMES

- CLINICAL OUTCOMES
- PATIENT SATISFACTION
- PATIENT SAFETY



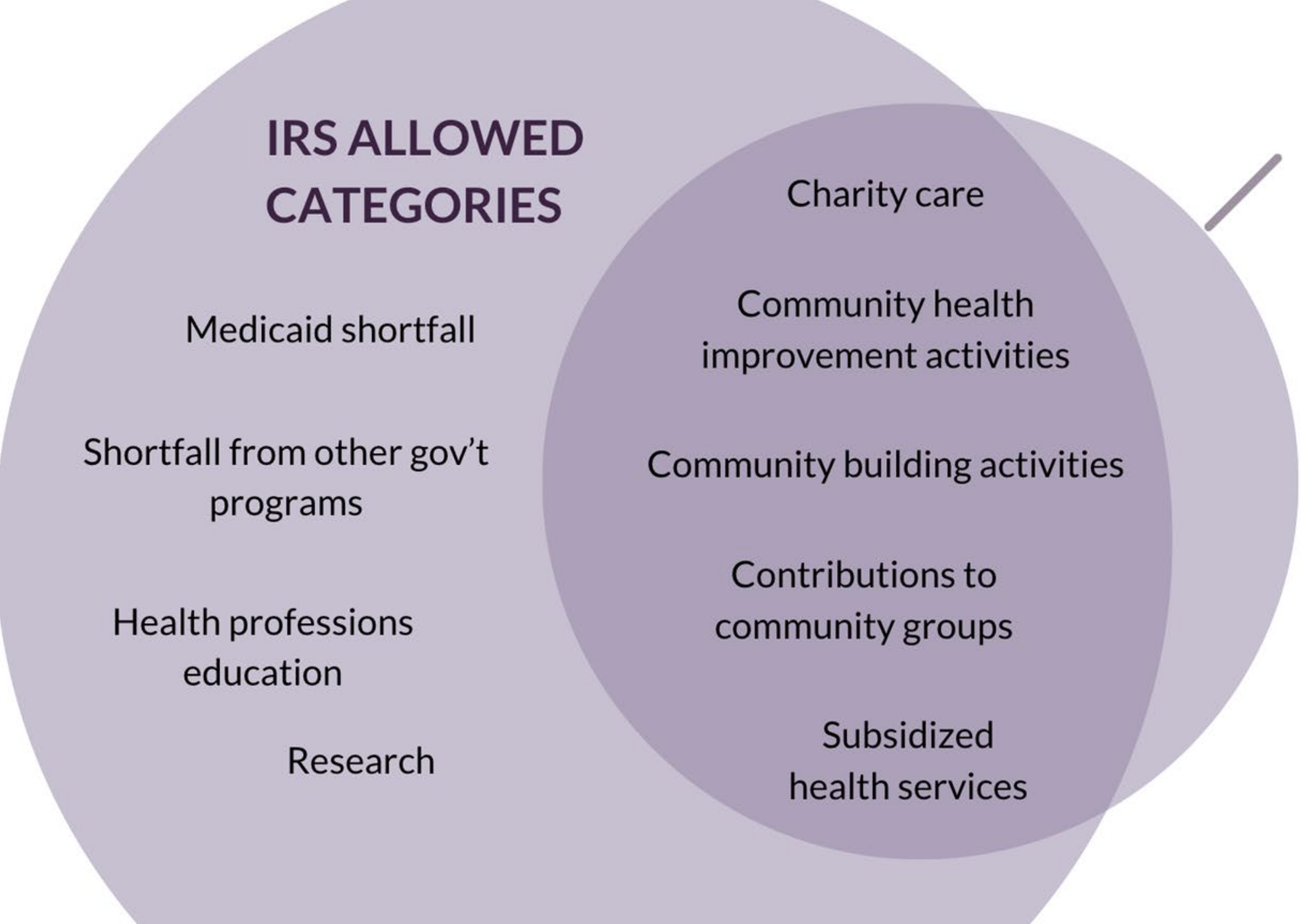
ideastream public media WKSU

Cleveland nonprofit hospitals get millions in property tax breaks. Many are asking, 'Is it worth it?'

FAIR SHARE SPENDING

CHARITY CARE
+
COMMUNITY INVESTMENT

TAX
EXEMPTION



LOWN ALLOWED CATEGORIES

Must show direct and meaningful benefit to local community.

In 2019, US hospital systems had a total Fair Share Deficit of

$18.4 billion.

Top 10 Largest Fair Share Deficits

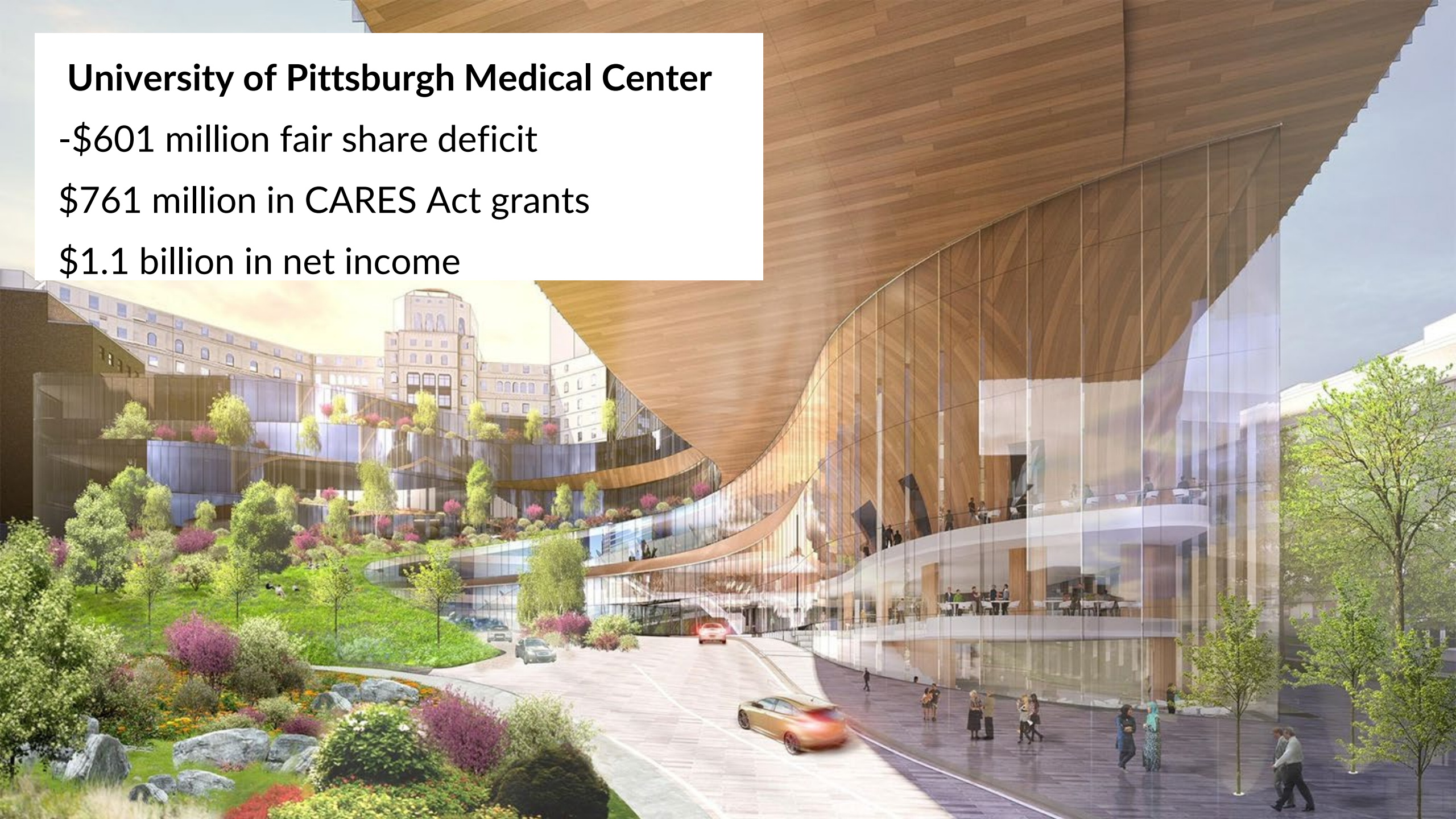
RANK	SYSTEM	FAIR SHARE DEFICIT
1	Providence St Joseph Health	-$705 M
2	Trinity Health	-$671 M
3	Mass General Brigham	-$625 M
4	The Cleveland Clinic Health System	-$611 M
5	UPMC	-$601 M
6	University of PA Health System	-$571 M
7	Catholic Health Initiatives	-$515 M
8	Advocate Aurora Health	-$498 M
9	Dignity Health	-$456 M
10	Ascension Healthcare	-$498 M

Cleveland Clinic Health System

-$611 million fair share deficit

$423 million in CARES Act grants

$1.3 billion in net income



University of Pittsburgh Medical Center

-$601 million fair share deficit

$761 million in CARES Act grants

$1.1 billion in net income

States with $1 billion+ in Fair Share Deficit

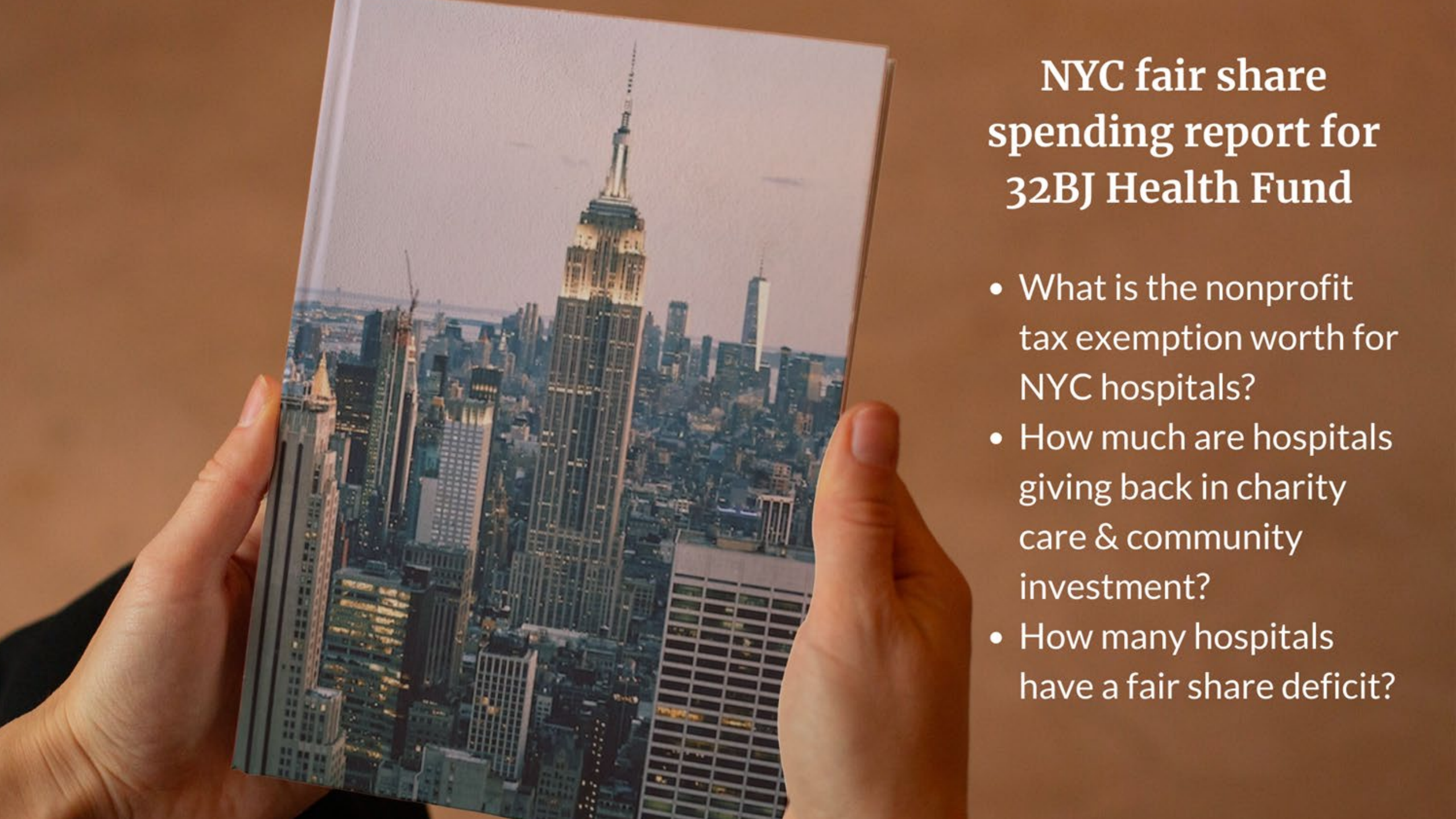
STATE	FAIR SHARE DEFICIT
California	-$2.57 billion
Pennsylvania	-$2.11 billion
New York	-$1.78 billion
Ohio	-$1.65 billion
Illinois	-$1.34 billion
Michigan	-$1.26 billion
Massachusetts	-$1.05 billion

Customized fair share spending for NYC

Estimated value of tax exemption

- Federal & state income tax exemption (applied to hospital net income)
- State & local sales tax exemption (applied to hospital total supply cost)
- Property tax exemption (NYC property assessment data)
- Value of tax-exempt bonds (IRS data on bond prices)
- Value of charitable donations (applied to hospital-reported donations to CMS)

Methods based on:
Herring B, Gaskin D, Zare H, Anderson G. Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits.
The Journal of Health Care Organization, Provision, and Financing, 2018.



NYC fair share spending report for 32BJ Health Fund

- What is the nonprofit tax exemption worth for NYC hospitals?
- How much are hospitals giving back in charity care & community investment?
- How many hospitals have a fair share deficit?

How can we hold hospitals accountable?

- Increased transparency in community benefit reporting and value of tax benefit
- Advocate for a spending minimum for meaningful community benefit
- Community participation in health needs assessment process
- Community control of community benefit monies
- Reporting of community benefit outputs, not just inputs

Bold ideas for a just and caring system for health.

LOWN INSTITUTE

www.LownInstitute.org

info@LownInstitute.org

Vicki Veltri, Founding Executive Director, Connecticut Office of Health Strategy

State Regulatory Efforts

Vicki Veltri JD, LLM

Connecticut - OHS

- Office of Health Strategy – Why?
  - Cost containment efforts started in 2016
  - OHS had insight into Massachusetts and other states
  - Pulled together three streams of work into one
  - Separated from other health agencies – on purpose
  - Coordinating role
  - Certain market oversight responsibilities
  - Data responsibilities

OHS Streams

Innovation Team

- Large scale delivery and payment reforms
- Benchmark Initiative
- Community Benefits Policy

Data Team

- Working oversight of APCD
- Working oversight of HIE
- Oversight of data integration from hospital data
- REL data collection

Health Systems Planning

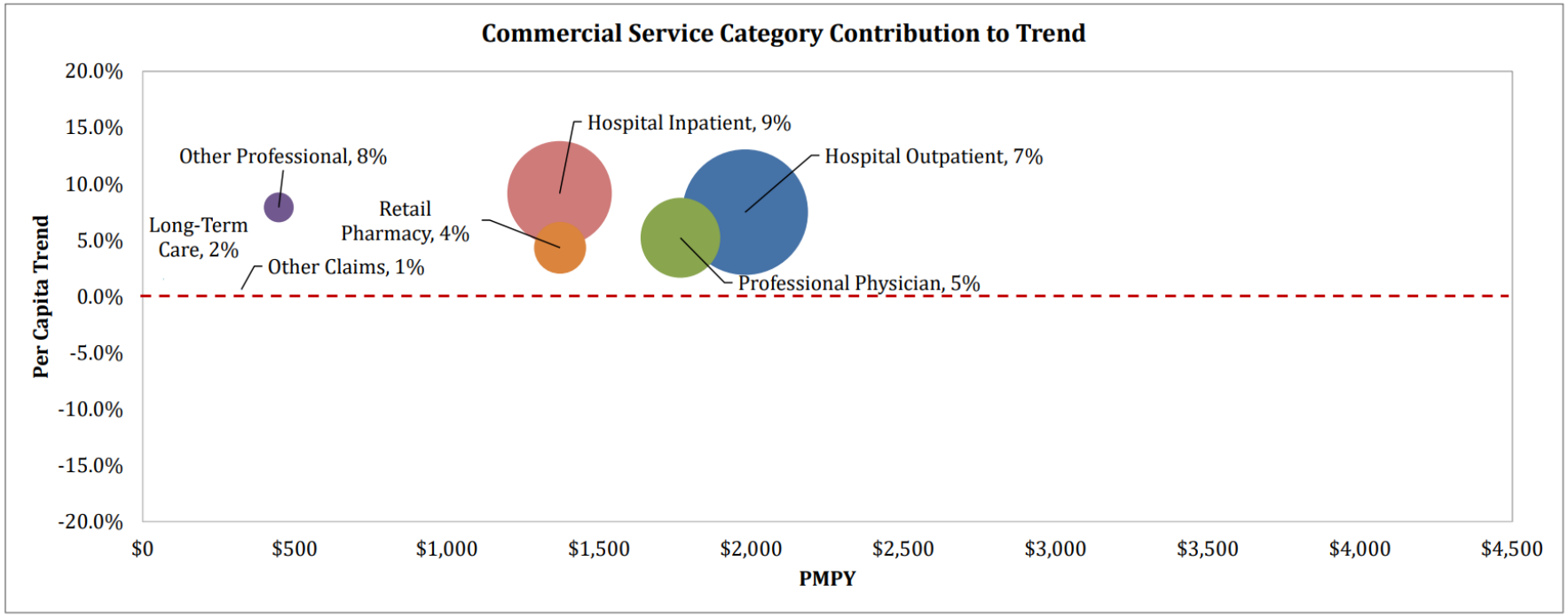
- Certificate of Need
- Cost and Market Impact Review – limited authority
- Hospital and group practice financial and organizational data
- New market study authority

Benchmarking – Cost, Quality, Primary Care Spending

- Effort started in 2019
- Executive Order No. 5 issued January 2020
  - Budget includes funds for initiative
- Governor's bill introduced in 2020 session
- Session canceled
  - Early support from Peterson-Milbank program
- No Gov's bill in 2021 – working to solidify process and share early data
- Gov's bill passes in 2022 session. Passed House by 90 votes—bipartisan. Passed as part of budget implementer.

Pre-Benchmark Findings

Hospital Outpatient and Hospital Inpatient Drove Connecticut's Commercial Market Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

OHS CONNECTICUT Office of Health Strategy

Source: OHS Presentation, January 24,2022 OHS

CT APCD Trend Analysis 2015-2019

Service Category	2015 PMPM	2015 %	2018 PMPM	2018 %	2019 PMPM	2019 %	2018-2019 change (%)	Average annual change (%)	Total change (%)	Change in category as percent of total PMPM change
All services	$480.24	100.0	$565.02	100.0	$589.13	100.0	4.3	5.3	22.7	100.0
Professional	$169.69	35.3	$183.77	32.5	$188.73	32.0	2.7	2.7	11.2	17.5
Inpatient acute	$78.57	16.4	$94.02	16.6	$98.71	16.8	5.0	5.9	25.6	18.5
Outpatient	$126.03	26.2	$151.53	26.8	$163.82	27.8	8.1	6.8	30.0	34.7
Other	$5.61	1.2	$4.87	0.9	$4.72	0.8	-2.9	-4.1	-15.8	-0.8
ED*	$27.10	5.6	$32.76	5.8	$35.74	6.1	9.1	7.2	31.9	7.9
Pharmacy	$100.34	20.9	$130.84	23.2	$133.14	22.6	1.8	**7.6**	32.7	30.1

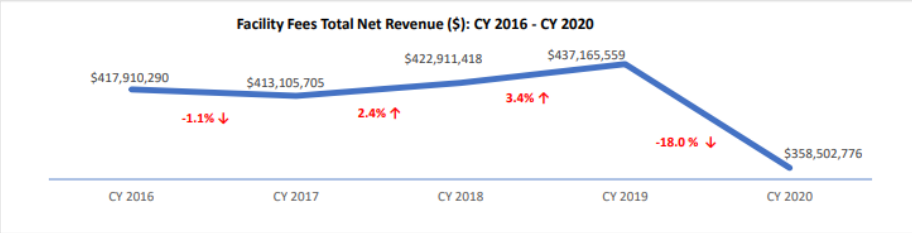
* ED includes both professional and outpatient ED claims if delivered in an ED, and thus overlaps with Professional and Outpatient.

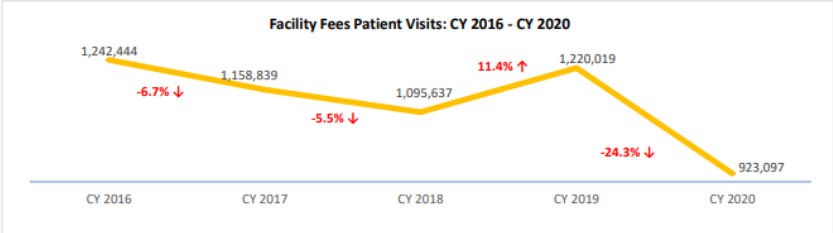
**During this same period, OOP spending grew by 28% or 21% PMPM

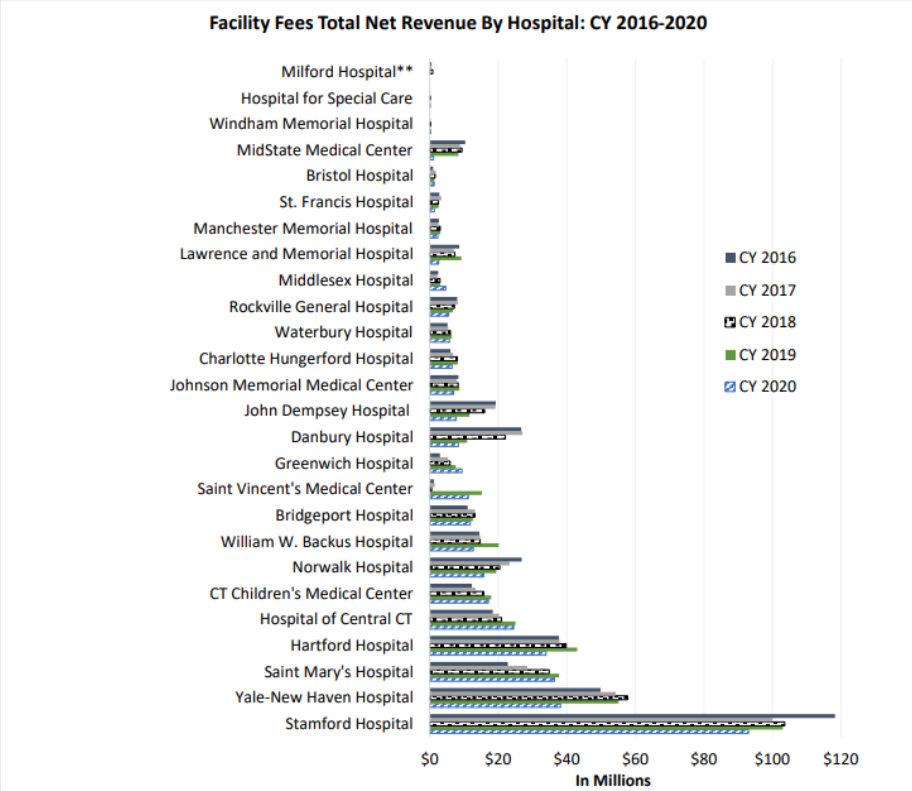
OHS CONNECTICUT Office of Health Strategy

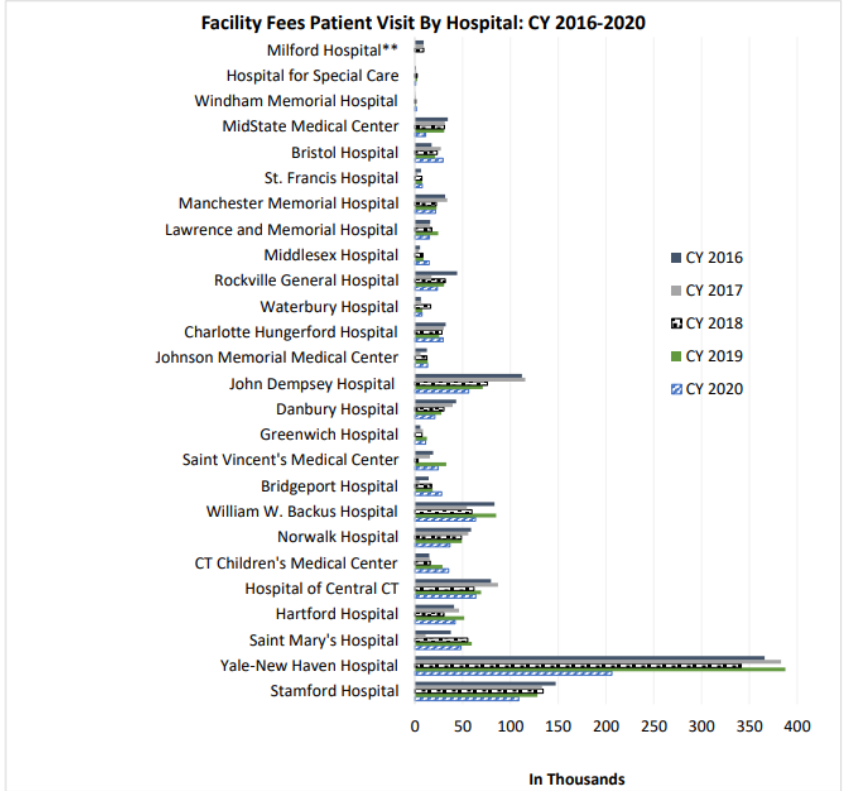
Source: OHS Presentation March 28, 2022

Facility Fee Reporting CY 2016-CY 2020









Source: [OHS Facility Fee Trend Report](), 2016-2020

CT Hospitals v. Cost-Shifting

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

Percentage of Payments from Private Payers in 2019	Average Annual Percent Change in Payments per CMAD 2016-2019
<50% private pay hospitals (median)	4.30%
≥50% private pay hospitals (median)	6.92%

- This table shows that CT hospitals receiving a greater proportion of payments from private payers had higher growth in payments per CMAD than those more dependent on public payers.
- If there was a "cost shift," those with fewer private pay patients would have had *faster* growing payments per CMAD, not *slower* growing payments.

Source: OHS Presentation March 28, 2022

Market Oversight

- CT efforts
  - More complete regulation of hospital related market activities
    - Removal of group practice size limits for CON review
    - Facility fee bans – accomplished legislatively and in CON, but more to do
    - Community benefits – changes made but minimum floor rejected
    - CON definitional changes to increase filing fees, address terminations of services
      - Remainder rejected – increased penalties, standard for penalties, budget for economic expertise, statutory powers
    - CON admin changes – price caps on M&As, no system-wide negotiation, community benefit conditions, AG's office discussions
    - Anti competitive practices – amendment to raised bill not called in time
  - OHS requested and received funds in budget for market study to reset picture and assist for future planning activities

States are Unique

- CT – Transparency was CRITICAL FIRST STEP
  - Data needed to be credible
  - Education necessary for public audiences/legislature
- OHS positioned as objective—not tied to other agencies
  - Part of executive branch
  - Most states have offices in exec branch tied to Gov's office directly or through Cabinet position
- The benchmark/target effort is not enough on its own
  - Need action-dynamics in the state affect this
  - Employer/Union voices critical
- States have different markets but similar problems – learn from each other


PRICES

Morning Panel

Policy and Regulatory Approaches Pursued by State and Local Governments

Which is true about the most common use of stents (for stable angina)?

A They are a breakthrough for patients with clogged arteries.

B They provide no long-term benefit and limited short-term benefit.

C They provide considerable benefit but come with high risk.

D On average, every 10 minutes an American gets a stent.

Which is true about the most common use of stents (for stable angina)?

A They are a breakthrough for patients with clogged arteries.

B They provide no long-term benefit and limited short-term benefit.

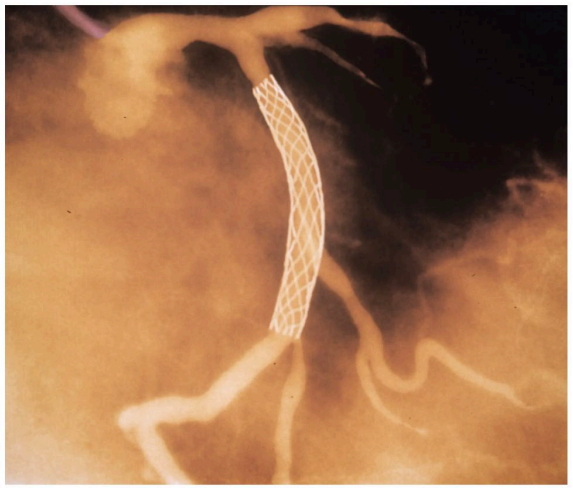
C They provide considerable benefit but come with high risk.

D On average, every 10 minutes an American gets a stent.

Stents may provide symptom relief…but may not.
Let's teach members to ask the right questions before agreeing to this very profitable elective procedure

'Unbelievable': Heart Stents Fail to Ease Chest Pain

Give this article 403



A new study has found that while stents can be lifesaving in opening arteries in patients having a heart attack, the devices are ineffective in relieving chest pain. GJLP, CNRI, via Science Source

Why Are Stents Still Used If They Don't Work?

Michael Greger M.D. FACLM · April 5, 2021 · Volume 53

4.6/5 - (78 votes)

Over and over, studies have shown that doctors tend to make different clinical decisions for patients based on how much they will get paid personally.

NIH National Heart, Lung, and Blood Institute

NHLBI NEWS | News Release

NIH-funded studies show stents and surgery no better than medication, lifestyle changes at reducing cardiac events

March 30, 2020, 8:00 AM EDT

Morning Wrap-up

Howard Rothschild, President,
Realty Advisory Board on Labor Relations

Lunch

How does the radiation in a CT scan compare to the radiation in an x-ray?

A 50 to 1000 times more

B 2 to 10 times more

C About the same

D None, but other hazards

How does the radiation in a CT scan compare to the radiation in an x-ray?

A 50 to 1000 times more

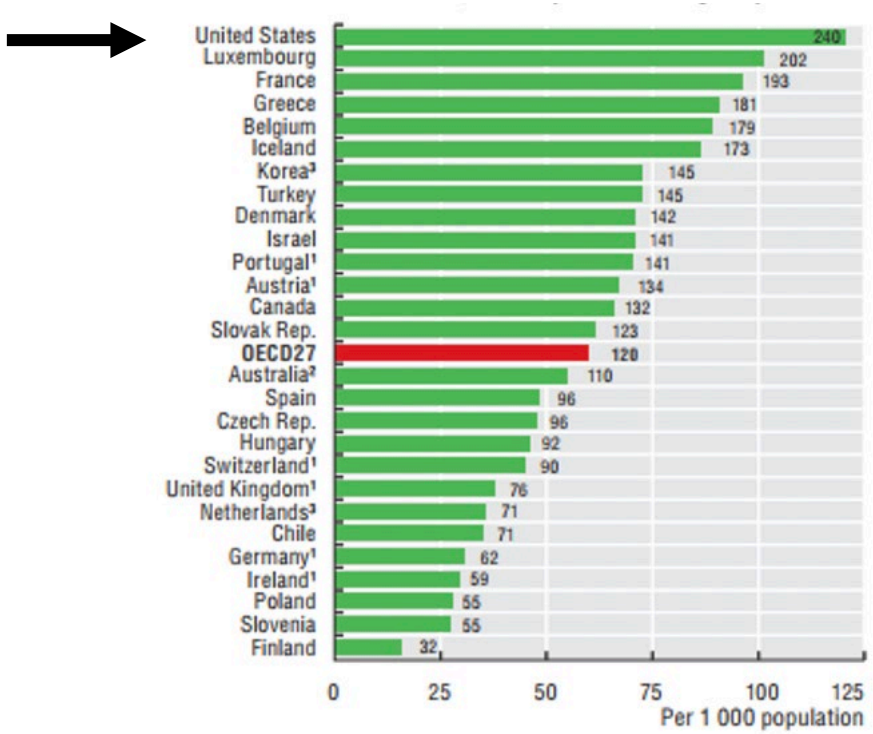
B 2 to 10 times more

C About the same

D None, but other hazards

The only way to stop overuse is through education on the harms and risks

CT Scans per 1000



Working Session

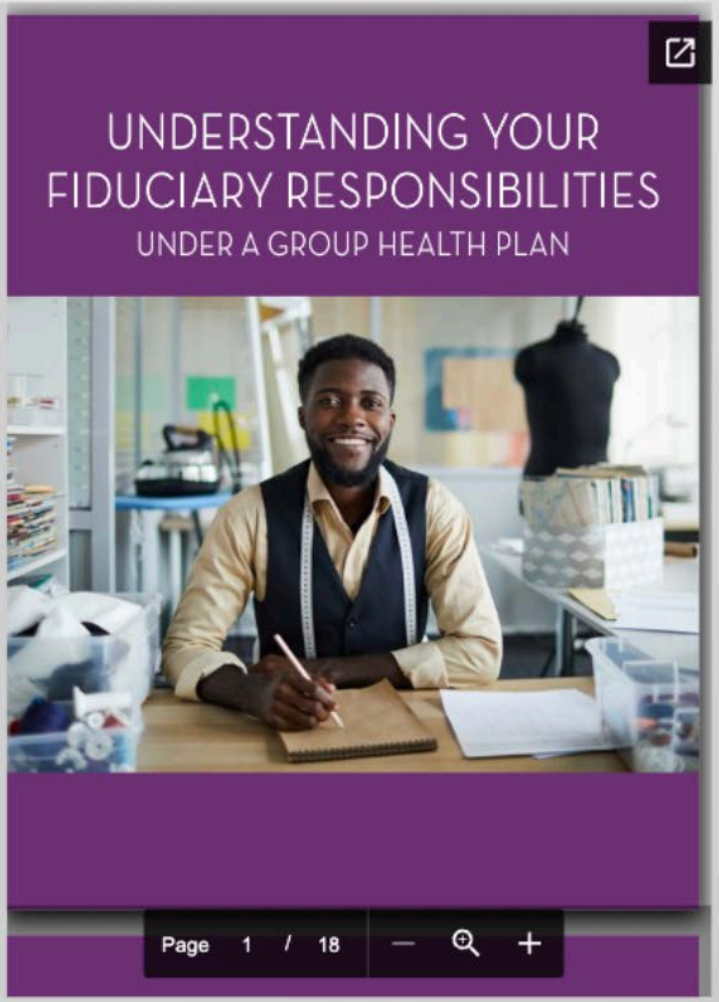
Christin Deacon, VerSan Consulting

Working Session

- Introduction to Topics
- Call to Action - Video
- Fiduciary Landscape
- New Tools – Data, Data, Data
- HEAL
- Workshop Questions and Discussion

*Facilitated by Chris Deacon

“It Starts with Data”



Understanding the Who and What of Fiduciary Status

- Act in the Sole and Best Interest of Plan and Plan Participants
- Carry Out Duties Prudently
- Follow Plan Documents
- Hold Plan Assets in Trust
- Pay Only Reasonable Plan Expenses

Hot Take!

Mass Laborers' vs. BCBS Mass

DOL Filed an Amicus Brief Asserting BCBS exercises fiduciary roles when they are solely responsible for setting price and when they pay claims out of plan assets.

The Outcome of This Case is Important for Many Reasons?

If the appeal is unsuccessful, the only defendants left to sue will be the trustees or employers themselves. If it is successful, every BCBS (and BUCA plan most likely) will be considered a fiduciary under this standard.

HOW CAA MODIFIES ERISA Compensation and Transparency

Section 201 – Removal of Gag Clauses on Price and Quality Information

Section 408(b)(2) - Disclosure of Compensation to Brokers and Consultants

HOW CAA MODIFIES ERISA

CAA's Goals

- To inject **compensation transparency** into an historically opaque space
- To assist plan sponsors in evaluating and verifying **reasonable** plan expenses

- §202 of the CAA amends ERISA at 408(b)(2)(B)

> *[Effective December 27, 2021,] the new disclosure requirements . . . apply to persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans who reasonably expect to receive $1,000 or more in direct or indirect compensation in connection with providing those services.*

* Quote excerpted from Field Assistance Bulletin No. 2021-03. Actual CAA amendments are granular modifications to pre-existing ERISA statutory language, which is hard to quote.

WHAT MUST BE IN THE DISCLOSURE

Brokers/Consultants must disclose to you in writing descriptions of:

1. The **services** to be provided to your health plan
2. Compensation that will be **paid by the health plan** for the services it receives
3. All **direct and indirect compensation** the broker/consultant reasonably expects to receive in association with your account in excess of $1,000. (**Non-monetary**: Anything valued ≥ $250)
4. Identifying information about the **nature and the payer** of that compensation
5. Any compensation that the broker/consultant expects to receive **upon contract termination**, and how any prepaid amounts will be calculated and refunded

- Ask for the compensation disclosure in terms of **actual dollars & cents.** Although this is *not* currently required,* it is a best practice and enables you to make meaningful comparisons.

* Per the Department of Labor's December 30, 2021 Field Assistance Bulletin, No. 2021-03. See **Q5** on page 5.

"SEC. 9824. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION. 26 USC 9824.

"(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

"(1) IN GENERAL.—A group health plan may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan from—

"(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan;

"(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

"(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

"(ii) provider information, including name and clinical designation;

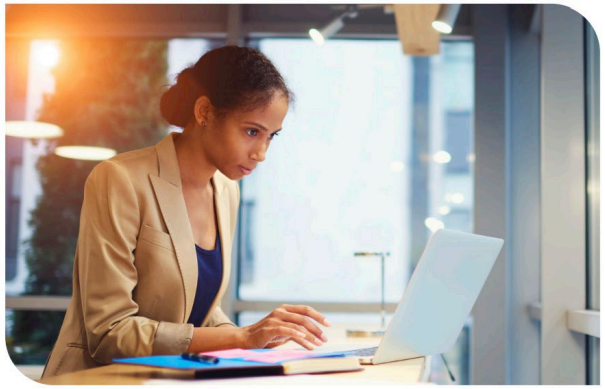
"(iii) service codes; or

"(iv) any other data element included in claim or encounter transactions; or

"(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated

Summary:

- A plan sponsor may NOT enter into an agreement with a TPA that would directly or indirectly restrict the plan sponsor from—
  - providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, enrollees, or individuals; or
  - electronically accessing de-identified claims and encounter information or data.. on a per claim basis— [including] financial information
    - Allowed amount, provider information, all data elements on encounter transaction, service codes, etc.



August 16, 2022

A CFO's Guide to Health Plan Fiduciary Leadership

How to Establish a Strategic Fiduciary Framework to Enhance the Value of Employee Health Benefits

PBGH Purchaser Business Group on Health

Multiple Tools Available to Employers

National Academy for State Health Policy – **Hospital Cost Tool** – released in April 2022

RAND 4.0 Hospital Price Transparency Study – released in May 2022

Sage Transparency – Hospital Value Dashboard – released in May 2022

What is NASHP's Hospital "Break Even"?

- **Commercial patient hospital "operating costs"** — derived from the Medicare Cost Reports based on the Cost to Charge Ratio for that hospital. (***includes overhead costs***)
- **Shortfall or overage from public health programs** — Medicare Cost Report includes the detailed costs for Medicare. All other public health programs are calculated by the Cost to Charge Ratio ***reported by the hospital***
- **Charity and uninsured patient hospital costs**—based on actual operating costs rather than being shown at charge master rates. The hospital is required to report the actual COST of uncompensated care
- **Medicare disallowed costs** — any costs not associated with direct patient care, so will include ***research, meals to non-patients, unrelated home office costs, physician direct patient services***
- **Hospital other income** — any COVID-19 funds, investment earnings, joint venture earnings, ***340B profits***, facility fees, grants, contributions, etc.
- **Hospital other expense** — Besides expenses described above, there may be expenses incurred for joint ventures, hospital owned and rented property, penalties and fines, etc.

“NASHP Commercial Breakeven” – Covers More than You Think

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National Alliance
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Driving Health, Equity and Value

Hospital Directory | Hospitals by System | **Hospitals by State** | Clinical Categories | States | Glossary

Controls

Select State(s): New York

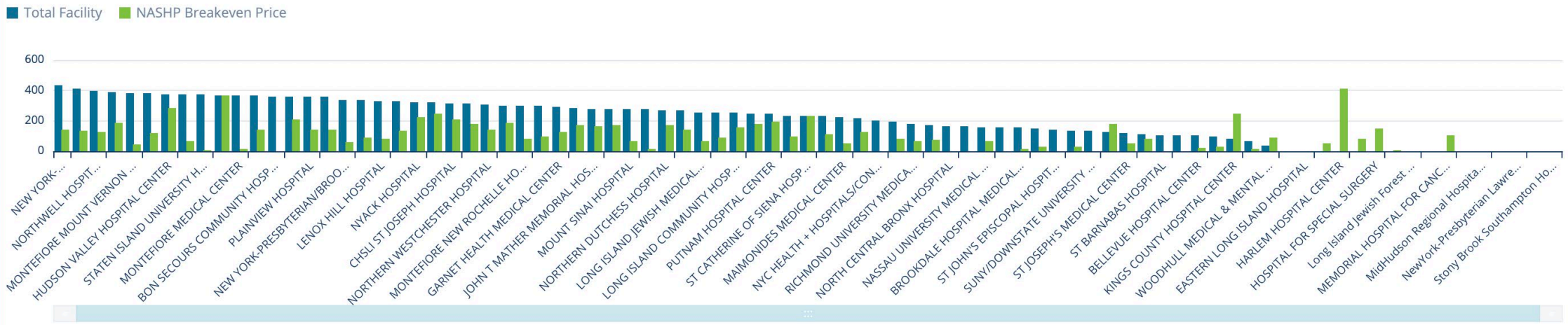
Select Region(s): New York-Newark, NY-NJ-CT-PA

Select System(s): All

Select CMS Star Rating(s): All

RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)

The difference between what is paid (blue) vs breakeven price (green) is the potential opportunity for payers to negotiate with hospitals to help contain prices.



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Employer Hospital Price Transparency Project

Return | Feedback

Hospital Directory | **Hospitals by System** | Hospitals by State | Clinical Categories | States | Glossary

Controls

Select System: Mount Sinai Health System

Select State(s): All

RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)

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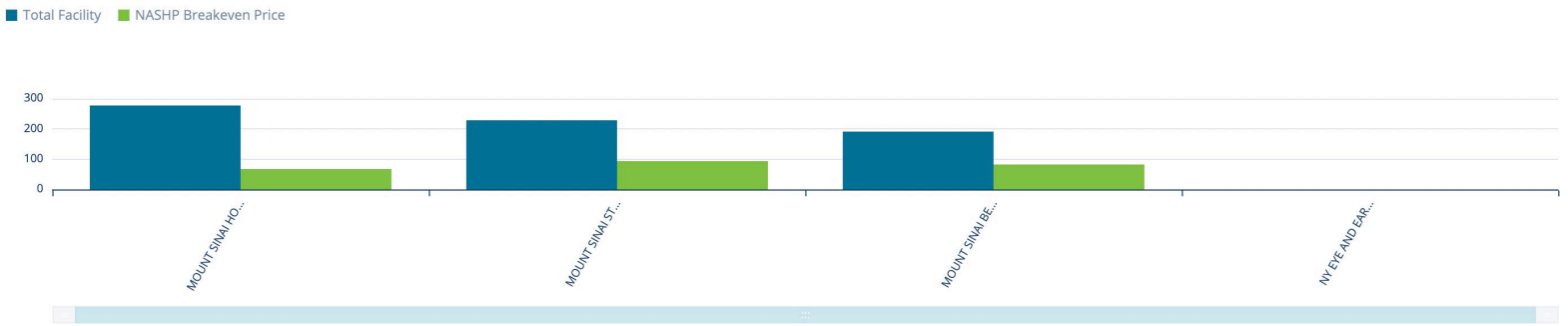

Employer Hospital Price Transparency Project

Hospital Directory | **Hospitals by System** | Hospitals by State | Clinical Categories | States | Glossary

Controls

Select System: NYU Langone Health

Select State(s): All

RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)

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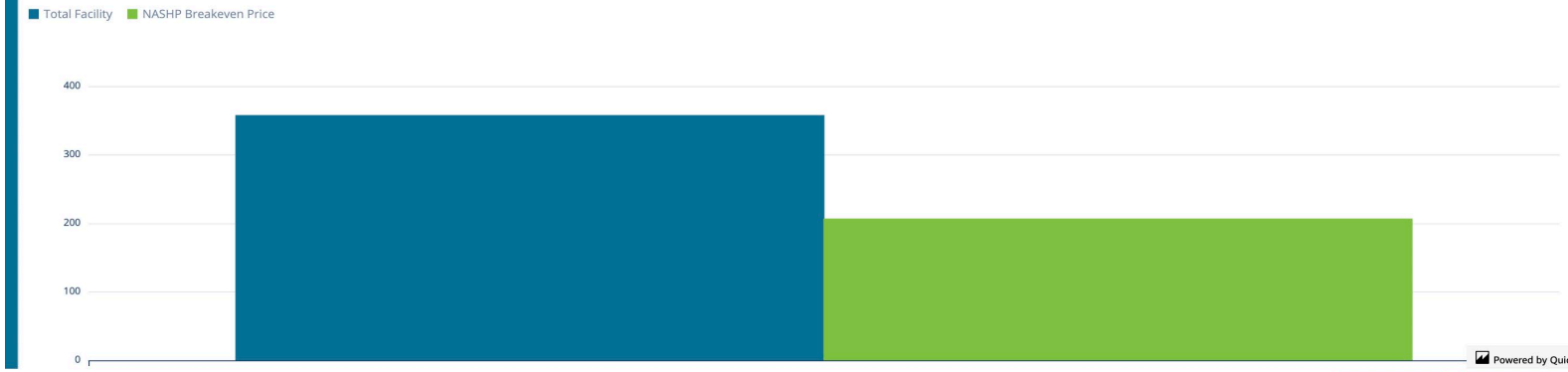

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Hospital Directory
Hospitals by System
Hospitals by State
Clinical Categories
States
Glossary
Controls
Select System
Northwell Health
Select State(s)
New York
Total Facility
NASHP Breakeven Price
400
300
200
100
0
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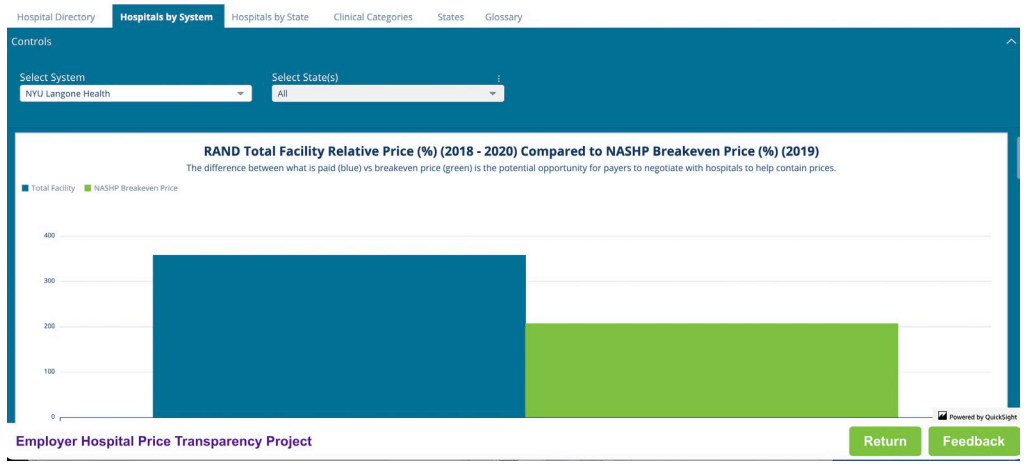
Employer Hospital Price Transparency Project
Return
Feedback


Hospital Directory
Hospitals by System
Hospitals by State
Clinical Categories
States
Glossary
Controls
Select System
NYU Langone Health
Select State(s)
All
RAND Total Facility Relative Price (%) (2018 - 2020) Compared to NASHP Breakeven Price (%) (2019)
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NASHP Breakeven Price
400
300
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100
0
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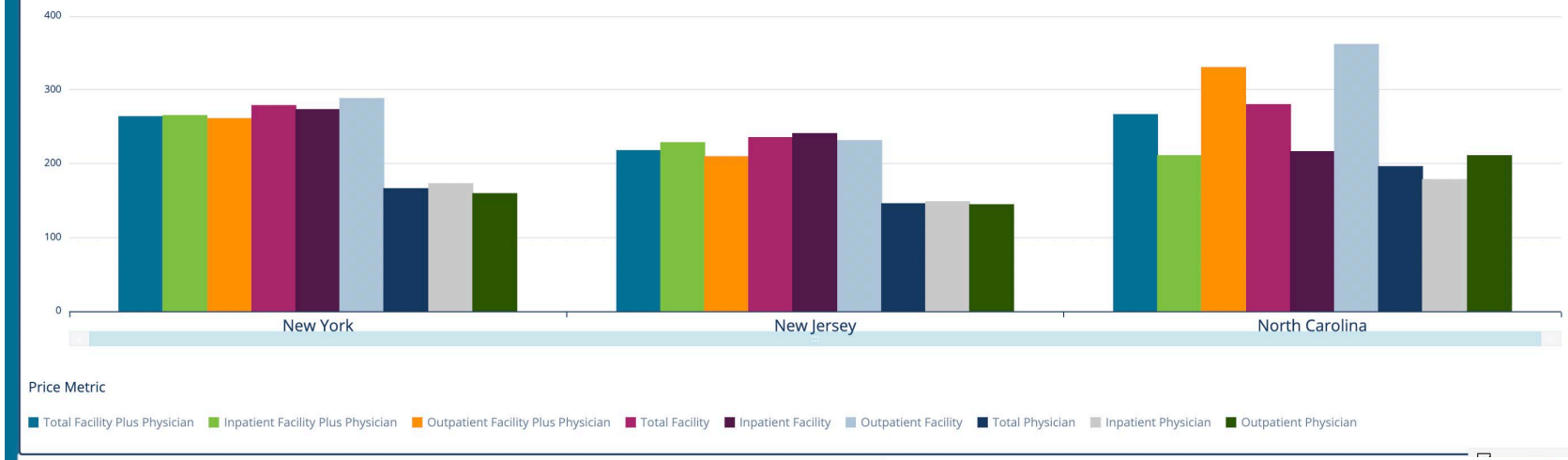
Return
Feedback

Hospital Directory | Hospitals by System | Hospitals by State | Clinical Categories | **States** | Glossary

Controls **Select State (s)** New Jersey, Ne... **Select Price Metric** Total Facility Pl...

RAND Hospital Prices Relative to Medicare by State (%)

2020



Price Metric

Total Facility Plus Physician | Inpatient Facility Plus Physician | Outpatient Facility Plus Physician | Total Facility | Inpatient Facility | Outpatient Facility | Total Physician | Inpatient Physician | Outpatient Physician

Employer Hospital Price Transparency Project

Hospital Directory | Hospitals by System | Hospitals by State | Clinical Categories | **States** | Glossary

Controls **Select State (s)** New Jersey, Ne... **Select Price Metric** Total Facility Pl...

Selected States' Ranking in the U.S. for RAND Total Facility Plus Physician (Relative to Medicare) (2020) (1 represents highest price, 50 represents lowest price):

North Carolina at **#20**
New York at **#21**
New Jersey at **#37**

Highest RAND Total Facility Plus Physician Price (Relative to Medicare) (2020) in the U.S.:

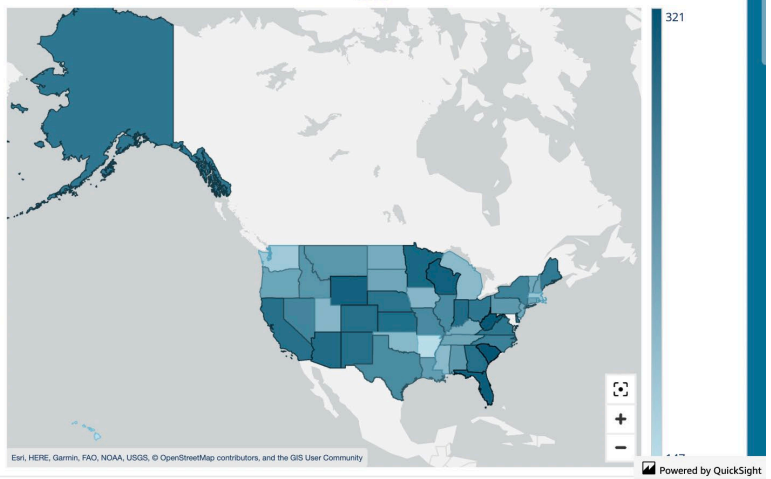
South Carolina with **321%**
West Virginia with **317%**
Florida with **309%**

Lowest RAND Total Facility Plus Physician Price (Relative to Medicare) (2020) in the U.S.:

Hawaii with **147%**
Arkansas with **149%**
Washington with **174%**

RAND Total Facility Plus Physician by State

2020



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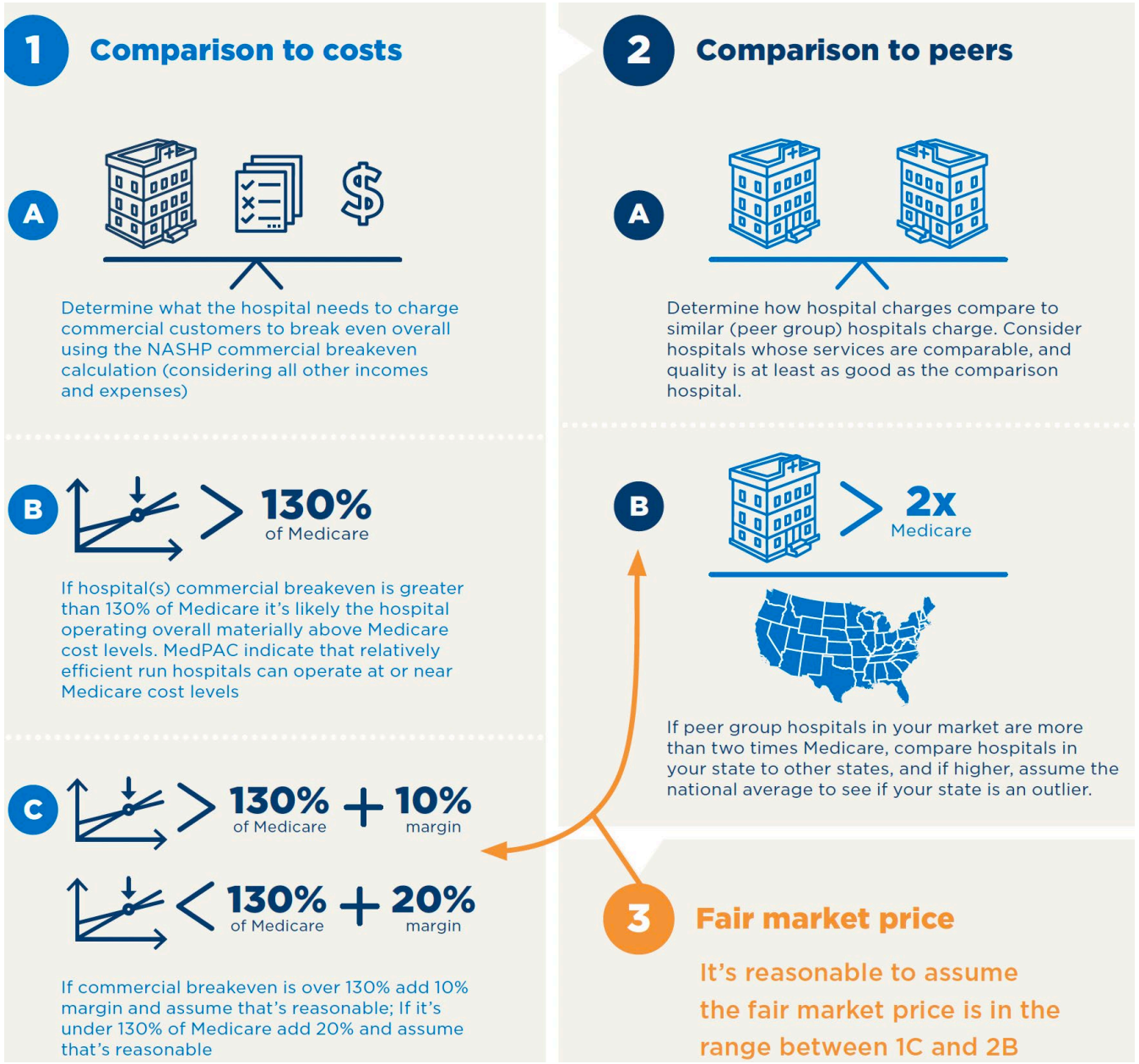
Fair Price Methodology

- Cost plus Margin
- Comparison to Peers
- Other Considerations
  - Are Costs Very High?
  - Are Peers Very Costly?



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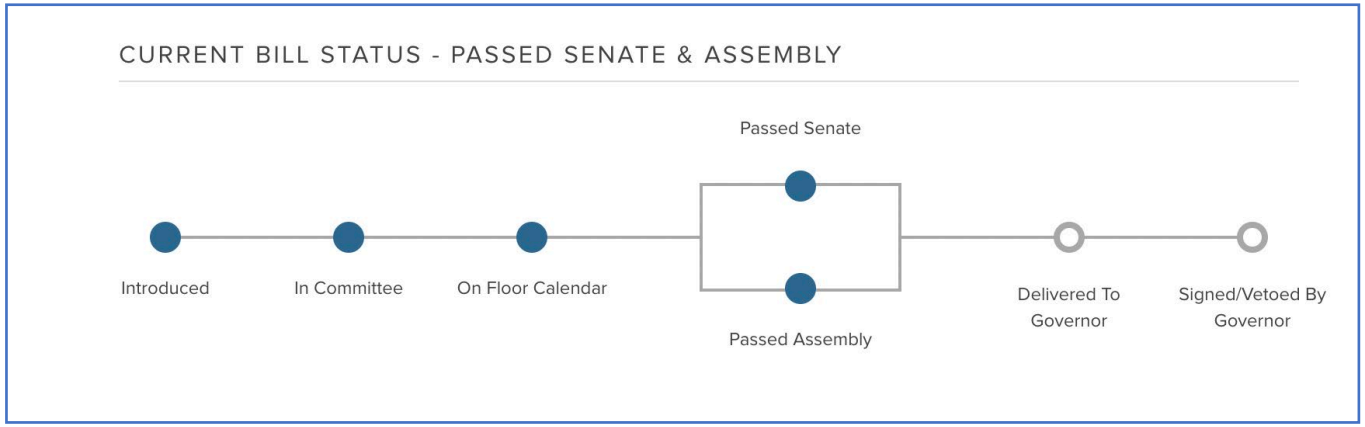
Passage of the Health Equity & Affordability Law ("HEAL")

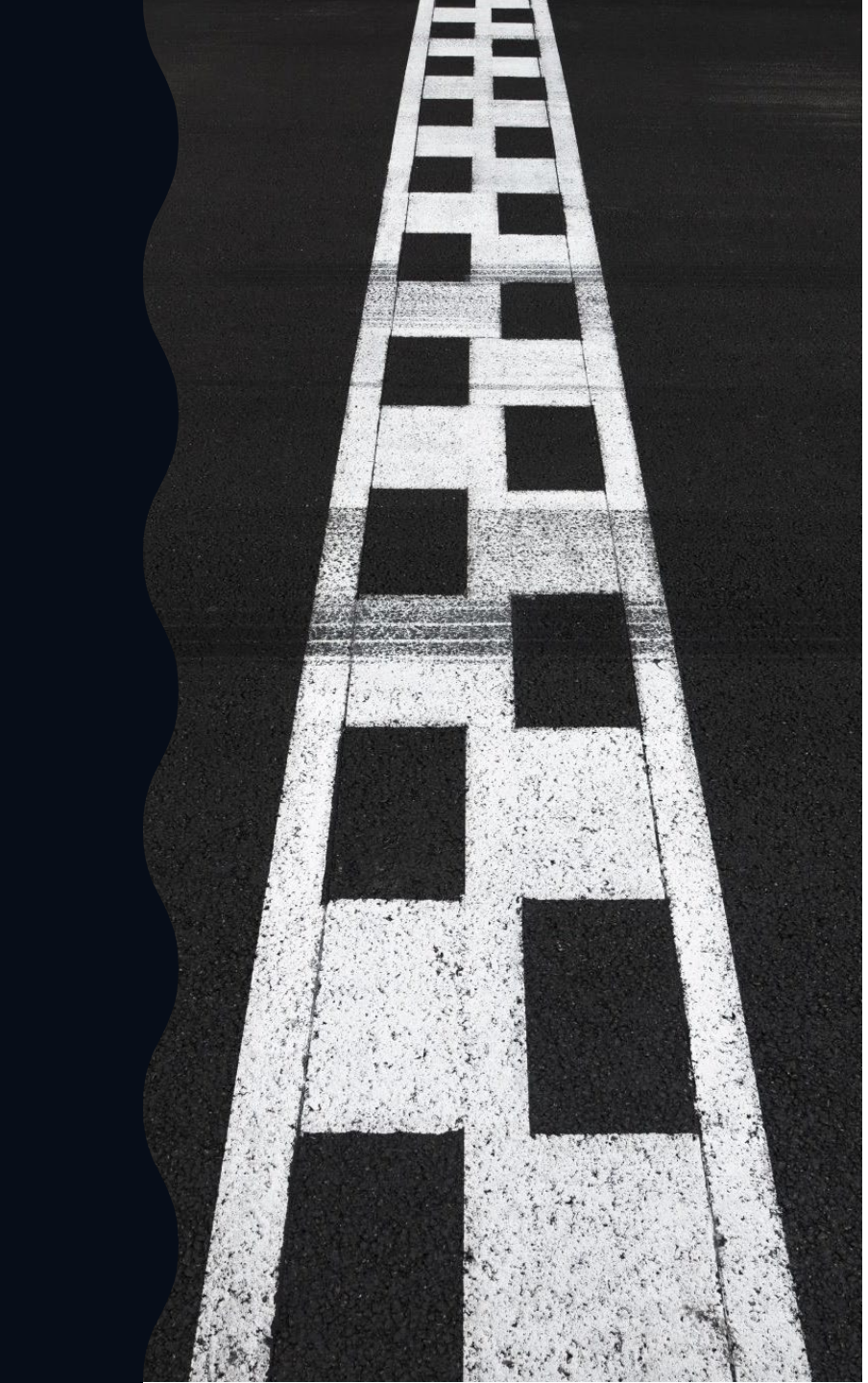


(O) (1) NO CONTRACT OR AGREEMENT BETWEEN A HEALTH PLAN SUBJECT TO THIS ARTICLE AND A HEALTH CARE PROVIDER, OTHER THAN A RESIDENTIAL HEALTH CARE FACILITY AS DEFINED BY SECTION TWO THOUSAND EIGHT HUNDRED ONE OF THE PUBLIC HEALTH LAW, SHALL INCLUDE A PROVISION THAT:

(A) CONTAINS A MOST-FAVORED-NATION PROVISION; OR

(B) RESTRICTS THE ABILITY OF A HEALTH PLAN, AN ENTITY THAT CONTRACTS WITH A HEALTH PLAN FOR A PROVIDER NETWORK, OR A HEALTH CARE PROVIDER TO DISCLOSE (I) ACTUAL CLAIMS COSTS OR (II) PRICE OR QUALITY INFORMATION REQUIRED TO BE DISCLOSED UNDER FEDERAL LAW, INCLUDING THE ALLOWED AMOUNT, NEGOTIATED RATES OR DISCOUNTS, OR ANY OTHER CLAIM-RELATED FINANCIAL OBLIGATIONS, INCLUDING, BUT NOT LIMITED TO, PATIENT COST-SHARING COVERED BY THE PROVIDER CONTRACT TO ANY INSURED, GROUP OR OTHER ENTITY RECEIVING HEALTH CARE SERVICES PURSUANT TO THE CONTRACT, OR TO ANY PUBLIC COMPILATION OF REIMBURSEMENT DATA SUCH AS THE NEW YORK ALL PAYER DATABASE REQUIRED BY LAW OR REGULATION, PROVIDED THAT NO DISCLOSURE SHALL INCLUDE PROTECTED HEALTH INFORMATION OR OTHER INFORMATION COVERED BY STATUTORY OR OTHER PRIVILEGE.

Workshop



Questions for Discussion – Set 1

- What are some business uses for this “Fair Price” exercise?
- What do you expect that roadblocks to be to some of these use cases?
- What other data points would be useful, if any, to proactively address these roadblocks?

Questions for Discussion – Set 2

- Would you consider this information valuable for managing your relationship with your third-party intermediary? Would it be more helpful in engaging in direct discussions with your hospital systems?
- How would you use this information to engage in direct contracting discussions with your facilities?
- What do you expect the roadblocks to be in these discussions?
- What other data points would be useful, if any?

Questions?

Which are true about long-term heartburn control with Prilosec, Prevacid, or Nexium?

A	You should take them every day for them to continue working
B	Long-term use can lead to flatulence
C	Long-term side effects not listed on the label include heart attacks, kidney problems and fractures
D	All of the above

Which are true about long-term heartburn control with Prilosec, Prevacid, or Nexium?

A. You should take them every day for them to continue working

B. Long-term use can lead to flatulence

C. Long-term side effects not listed on the label include heart attacks, kidney problems and fractures

D. All of the above

Closing

Cora Opsahl, Director, 32BJ Health Fund

Thank You

Questions?

Email: HealthFund@32bjfunds.com
Twitter: @CoraOpsahl

Information

https://www.32bjhealthfundinsights.org/