

**Peralta Community College District
Benefits Fringe Committee Meeting**

May 12, 2016

Meeting Start 9:00AM

Attendees

Erin Thomas, Tom Sher, David Yang, Sally Covington, Laura Leon-Maurice, Ronnie Roberts, Jennifer Seibert

Transcribed by: Constance Koo

Discussion

Follow up Action

Agenda Item	Topic	Follow-Up Action
<p>Sally Covington, consultant</p>	<p>SC: "How many families are enrolled in PPO plan?"</p> <p>SC: "Do you offer high deductible plans"</p> <p>We are looking for a productive collaboration on cost control; looking to avoid conflict. Our goal is to reduce employer and patient costs, or a mutual gain for both sides.</p> <p>See graph (slide 3): Converse to what is displayed, premiums and the contributions to premiums should be on the bottom and wage growth on top. Must use purchasing power in a different way.</p> <p>What is driving this trend? (Slide 4): Even if you are self-funded, not paying an insurance company a premium (you are to KP, not to Anthem) you are still relying on a PPO contract network that Anthem lends to you on a member per-month basis to access this network, paying "discounted" rates. (Otherwise you are paying bill charges that are exorbitant). There is no price transparency. Patients and purchasers have no idea what the cost of anything is until the services are delivered and billed. It is crazy. Prices that are secretly negotiated are fixed between insurance plan and provider and not competitively set. The prices have nothing to do with quality or the cost of care. Big inefficiencies: high administrative costs.</p> <p>Slides 5 & 6: Prices under managed care model. The USA is a price outlier. There is a price problem. There are enormous inefficiencies.</p> <p>Slide 7: Huge growth of health care administrators in 1980's vs. growth in physicians. This creates a huge administrative cost burden that gets shouldered by patients (customers). Community Campaigns for Quality Care is trying to solve this problem.</p>	<p>"Roughly 50/50"</p> <p>"No"</p>

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Slide 8: Two Paths. You can continue to pay the higher prices, or you can pay lower prices.

Slide 9: Competitive Bidding: the suggested alternative to PPO networks and payment methods. Service providers out of network can be offered as an option, not just in-network providers. Pay out of network provider (any who want to participate) a bidded price. Price has been set by provider rather than the contract. This is best done on a voluntary basis. #3 is operationally, mechanistically easy to do. (Side note: We are public interest advocates, researchers, policy organization that allies with unions and their purchasers to help you move forward. It's simple and straightforward, but we are not trying to sell this to you.) This is only an option available for self-funded employee medical plans. Core Source can administer on the District's behalf this suggested cash-based method.

Slide 10: How does this help? Cash pricing in the Bay Area is well below insurance companies' rates.

Slide 11: An example of how much lower the cash price is vs. PPO contract rate.

Slide 12: The Overcharge: What you are paying now. (Anthem PPO Contract rates). PPO Contract price as an average vs. cash price open market rates currently available. We want to make the PPO Contract rate match the cash price rate (we want it to come down). Goal: Wants transparent open market pricing. We need a different business model.

Slide 13: Projected Health Plan Savings. 22 months of paid claims data from a Bay Area employer (larger than PCCD) shown here. Gross savings is 18%. Performance risk is taken on by the delivery system. This is a performance-based approach to fees.

Slide 14 & 15: Plan and Member Benefits, Plan Infrastructure. Test run/pilot this competitive bidding – contract with a competitive bidding vendor and offer it as a service enhancement to your plan. There is no

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risk to self-funded plans for doing this, you aren't paying them anything upfront, simply offering this to members and financially motivating them to take up this service. We have been working with unions and educating them. If an employer was going to impose this on their own without collaboration, it would be met with greater suspicion. Trying to bring labor management in.

Questions

Slide 13: Sally – test run the simple procedure and see how it works.

Ronnie: Problem: employee has an option to select bidders – what if they end up going to the most expensive? PCCD is on the hook for the huge difference in procedures. Employee may pick a bidder who charges way over the price of the contract PPO. Contract pricing can serve as protection as well.

Sally: how do you encourage employees to find out the price of services in advance and go to PPO contract providers to get better rates?

Ronnie: We have PPO Lite. Take traditional (out of network), then employees pay more.

Sally: If you're focusing on in-network, because they have higher cost share in out of network, there is still enormous price variation within in-network providers. Within the context of the network, is there any way/mechanism that the plan financially encourages members to choose a lower cost plan?

JS: We are consistent with what other colleges do. Part of the draw to work at PCCD is that members don't have to shop around.

Sally: I in no way intend to criticize. Just suggesting taking advantages of innovations in the marketplace. Now we have a program to pick providers who offer better pricing and quality care. Offer this service as an enhancement.

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Ronnie: Problem is creating an incentive for employee to choose cash price bidding. (Paying zero out of pocket is currently what they want. Not a cumbersome process of shopping around). You have to convince them to choose someone who is lower than our contracted price.

Sally: the patient needs to be rewarded.

Laura: how do I know I'm getting the same quality? (Price reflects quality in the eyes of employee). I wouldn't trust a system that shops the cheapest contractor. I like my benefits and coverage as is.

JS: Page 6 – mountain of administrative costs – reduce this amount of PCCD administrative costs?

Sally: No. Simply contract with the vendor who does not charge anything. It is an incorrect assumption that providers are scummy. Lastly, substantial incentives can be built into the program even where there is no deductible.

David: Looking at the numbers, are there other organizations that have adopted this cash plan?

Sally: Not in CA, it's new. Patient Purchasing System (PPA) – would be the entity to receive the claims/data, not us. They would return to you an analysis of savings.

JS: at what point does PPA generate revenue? How long have you worked with PPA?

Sally: They say they take 25% of savings. We don't work with PPA, per se. We've investigated them on behalf of labor clients. I have developed through this investigation a lot of confidence in their business and clinical approach.

The second organization investigated to a lesser extent is Mini Bid (based in Texas). Founder is an insurance broker, not a physician. They do not

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have a process for putting together medical service requests. It needs capacity to know all the medical codes, without which you can't put together providers to bid. Only PPA has this.

On prescription drug requests – PPA does not want pharmacy information or patient identifying information.

Question no. 7: Ask PPA directly (I'm not PPA), but I believe PPA uses the claims file that you would transfer as the baseline to determine the difference that you would pay without competitive bidding and what you would save under competitive bidding.

Question 9: It introduces competition in a way that will be beneficial for the district and employees.

No. 10: We will find out. Task force process will likely set up local publications and engage. It doesn't have a position at the time. (JS: No fast track on this, just an idea we can explore. Early adopters will occur).

Sally: No risk to PCCD. You don't have to provide costly vendors.

Part of step by step process: patient gives PPA their selection of vendor.

JS: What is the role of CCQ outside of PPA? Is there a financial relationship?

Sally: No. No financial ties with any vendor on principal. Only work with labor unions and large purchasers of health care under contract.

Ronnie: re emergencies: the cash price remains the same on initial procedure. The emergency procedure is priced differently. The employee would be out of network for any additional services taking place?

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Sally: for emergency procedure – you can include into the medical service request by PPA/bid a stipulation on emergencies. I don't know on emergency arrangements.

Ronnie: as a result of an emergency treatment something happens – how to deal with this? Or define emergency in cash bids? In out-of-network facility?

Sally: the provider would submit claims going to your administrator (Core Source) – paid by Anthem or PPO rate. Discuss with Dr. Gibson. Issue medical service requests only to contract PPO providers is one suggestion. You can limit bidding to providers within the PPO network, you don't have to though.

JS: No CA employers who have successfully implemented the program?

Sally: No.

JS: Dr. Gibson is the contact for PPA. Yes.

Cash bidding is not possible for Kaiser Employees?

Sally: Not unless you had a high deductible plan with significant out of pocket rates. KP will disclose their fee schedule under PPO and HMO plan. KP published fee schedule does not include all costs.

JS: confidentiality agreement – do we need one with you?

Sally: no.